THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 4—IDA GROVE, IOWA

AUGUST 17, 1976

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The Nation's Rural Elderly:
Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove, Iowa, August 17, 1976.
Part 5. Sioux Falls, S. Dak., August 18, 1976.
Part 6. Rockford, Iowa, August 18, 1976.
Part 7. Denver, Colo., March 23, 1977.
(Additional hearings anticipated but not scheduled at time of this printing)

CONTENTS

THE NATION'S RURAL ELDERLY

TUESDAY, AUGUST 17, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Ida Grove, Iowa.

The committee met at 2:40 p.m., pursuant to notice, in the community hall, Third and Main Streets, Ida Grove, Iowa, Hon. Dick Clark presiding.

Present: Senator Clark and Representative Bedell.

Also present: Deborah K. Kilmer, professional staff member; David Harf, legislative assistant to Senator Clark; Margaret S. Fayé, minority professional staff member; and Donna Gluck, resource assistant.

OPENING STATEMENT BY SENATOR DICK CLARK, PRESIDING

Senator CLARK. If I may have your attention, we are delighted that so many of you came out on such a warm day. We are very happy to be here in Ida Grove.

This is an official hearing of the Special Committee on Aging. We have several scheduled witnesses and then we are going to try to have some time at the end for people in the audience to make statements or ask questions that they may have.

On my left is a stenographer who will record what is being said and we will then issue a printed transcript of these proceedings. If any of you are interested in getting a copy, it probably will be about a month or two before it is printed. I hope you will write to me or leave your name and address here and we will be very happy to mail you one.

I might also say that we have a form for people who do not get the opportunity to testify here but who may have something they would like to say. It simply says: "If there had been time to testify, we would like to have said the following." That will be made a part of the official record [1] of this hearing as well, so anyone and everyone who wishes to participate in that way, may.

Our subject at this and five other hearings that we are holding this week in Iowa, Nebraska, and South Dakota is "The Nation's Rural Elderly," and I emphasize the word "rural." I suggested that such hearings be held about a year ago since, as I said at our opening hearing yesterday in Winterset, we can't hope to know what is happening in rural America if we simply stay in Washington, D.C.; that is not rural America. Our chairman, Senator Frank Church,

[1] See appendix 3, p. 243.

of Idaho, agreed with this suggestion. The committee will visit many different States of the Union and talk to people in rural areas.

We are starting here in Iowa. As I said, we were in Nebraska this morning and we are going to be going to South Dakota later tonight for hearings tomorrow, and then back in Iowa again.

I want to make my statement very brief because we have a number of witnesses. We also want to hear from Congressman Berkley Bedell. So let me just try very briefly to make three or four points.

Are the Programs Working?

One of the prime objectives of these hearings is to determine the responsiveness and the practical help provided to the rural elderly by programs such as the Older Americans Act, medicare, housing programs, transportation programs, nutrition programs—all of these programs that have been set up. We would like to know whether they are working, whether you think they ought to be kept, whether you think they ought to have less funding or more funding, whether there is too much redtape—anything that you feel you want to say about it by way of trying to improve these programs.

There is a real need for this kind of evaluation because, in our view, we failed to do what we said we were going to do at the 1971 White House Conference on Aging. We really stopped at the beginning of this decade and said, "What is it we want to accomplish in the area of aging?" We have not yet arrived at a national policy on aging, particularly on rural issues. Part of the lag has been caused by lack of leadership in the executive branch. Another part has been caused by economic uncertainties that have been related to such things as inflation and unemployment.

Nationally, about 8 million people—that is, about 28 percent—of all the people in this country over the age of 60 live in rural areas like Ida Grove, but in some States that percentage actually rises to as high as 50 percent. In fact, here in Iowa about 45 percent of all people over 60 live in small towns in the countryside. So there are major differences among the States. Even though each of our hearings has a rural theme, we find that there are special circumstances in each locality that call for close inspection. That is why we are here in Ida Grove.

Delivery of Health Services

We will be especially concerned here about the lack of health services and the problems with delivery of services of this kind into rural areas. Shortage of health services in this country has reached a point, in my judgment, of extreme concern. In 138 rural counties nationwide residents do not have a single resident doctor. Now that figure is up about 37 percent—over a third from what it was in 1963. Unfortunately, it is getting worse, not better. In Iowa, the rate has dropped well below the national average.

Here in Ida County the shortage of medical care is particularly acute. The county has been designated as a medical shortage area by the Department of Health, Education, and Welfare, and today we are going to hear from health professionals of this area who will describe the barriers for the elderly persons to obtain adequate health care.

We also hope to hear from some successful programs to try to combat these barriers. The other panel of witnesses will detail the difficulties in providing any service to a rural area: The geographical obstacles, the low density of population, and the cost factors involved in providing services to the rural residents. This is what we will be discussing.

In a hearing last spring in Washington, D.C., on this very subject, I heard a great number of recommendations for removing obstacles of delivery service under the Older Americans Act. I hope that our witnesses today will have additional suggestions for improving the Older Americans Act and other Federal statutes.

Lastly, I would like to say that with the Older Americans Act programs, and in all of the others, the rural elderly must feel that no one is dictating to them. The progress that we are making in aging is due in no small part to the initiatives and the determination of older persons who are making things happen. The Federal share of their effort, if one is needed, ought to be part of the solution and not part of the problem. I think we have made much progress in the area of assisting elderly people, primarily because older people have organized themselves. Government responds to that kind of organization, whether it is at a local level, a State level, or a national level, and I congratulate you for that.

Now I would like to ask Congressman Berkley Bedell of this congressional district if he would like to make some comments before we start with the panel.

STATEMENT OF HON. BERKLEY BEDELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Representative BEDELL. Thank you, Senator Clark.

On behalf of the people of northwest Iowa in this sixth district and, more particularly, on behalf of the people that are here and our senior citizens all across the area, I want to tell you how appreciative we are of the fact that you would take your time and the committee's time to come out here, as you state, to try to learn firsthand about the problems that exist in the field.

I would like to echo what you said. I think so frequently we find people who think they know what the problems are in their organization or out in the field. I can tell you from having been in management myself that the only way you find out what the problems are anywhere is to get out there among the problems, and we certainly are grateful that you would take the time to do this.

I would like to say that I think it is important that we concern ourselves with the lives of all of our people in America, and some of those people are indeed senior citizens. So frequently I fear that they tend to be forgotten as we look at some of the issues that may be somewhat more exciting.

As we look at our senior citizens, I think we have two important things that we need to do. First, we need to help so that they can live meaningful lives. Second, I think we need to tap the assets and the capabilities that they have or that they can contribute. If any of you question that at all, you should have been here a little earlier to see the band that we had up here. Somebody mentioned to me, "Well,

I don't really have to worry about getting old when I see that band up there and the great fun that they are having."

Inflation Decreases Net Benefits

As we look at our problems, there are some specific problems that I think we need to address ourselves to. One of them is that, as the laws now stand, people who get social security cost-of-living increases frequently find that they have other problems—such as veterans pensions and this sort of thing—cut back even more than their increase. Legislation which was meant to help people get better benefits because of inflation sometimes actually decreases those benefits. I think it is important that Congress address itself to this problem and do something about it.

Senator Clark has already mentioned the problem of availability of medical care. I think that is a problem that exists all across our country—certainly it exists in rural America. We need to look at that problem.

Equally important in rural America is the problem of transportation for all of our people, particularly our senior citizens. All of our senior citizens in rural America are not where they can walk to the grocery store or walk to church or to the doctor, and it is important that they have some type of transportation available to them.

Finally, if there is one other thing, I believe it is that we have to change our value system in America. I believe we have to come to agree that we judge our success by the quality of the lives we live rather than the quantity of goods that we consume. If we are going to change that value system, I believe that it is going to have to come from rural America—from people like you. I think it is going to have to come from people who have their feet close to the soil, who have a religious heritage, who care about one another, and who are willing to do what they need to in order to help build the society. When we say what those values are and show that we care for one another and love one another, it will really change our society.

I am thankful to you people for being here and I am deeply thankful for Senator Clark and his staff being here. I am thankful for all the people who are here participating in this program.

Thank you very much, Senator.

Senator Clark. Thank you for an excellent statement, Berkley.

I think I will introduce the staff members that are here before I introduce the mayor, so if you need to contact somebody in the process of the hearing you will know who they are.

First let me say Annabelle Short is the court reporter; back here is Dave Harf, my legislative assistant, who will be happy to help any of you; Debbie Kilmer, on my right, is a professional staff member of the Committee on Aging; Peg Fayé is a professional staff member who represents the minority side of the committee; and Donna Gluck is resource assistant with the committee.

Now let's go ahead with the first panel. We came here basically to get the judgments of the people from their area. First and very appropriately we are going to hear from Theo Murphy, the mayor of Ida Grove, who serves on the county task force on aging. He is going

to describe, I understand, what it is like to be a rural official who is responsible for the needs of the elderly people.

Theo, go right ahead. We are going to try to ask each of you to limit your comments to 5 minutes because we would like to ask you some questions and have some discussion.

Mayor Murphy.

PANEL ON DELIVERY OF SERVICES

STATEMENT OF HON. THEODORE E. MURPHY, MAYOR, IDA GROVE, IOWA

Mayor MURPHY. Thank you, Senator Clark and members of the Senate Special Committee on Aging.

My remarks basically will pertain to housing, because it is my firm belief that to give dignity to people you have to provide adequate shelter—clean, well ordered, secure—something that they can live in and feel proud of in their declining years. We have not been able to do this in most of rural America.

For many years most communities in northeast Iowa—and I am familiar with most of them—have been trying to develop a housing program to provide low-rent housing to the elderly people of their community, housing that they can afford to live in with a very moderate income. I know some of you would be surprised at the income that a lot of our people are living with—under $2,000 a year. When you measure that against a need for rent and utilities that will be at least 25 percent, that means that they will be paying less than $50 a month for Ida Grove, and you know that is an impossibility.

For a number of years we in Ida Grove, and many other areas of northwest Iowa, have been trying to develop a housing program and we have had our frustrations. We have employed architects and we have employed developers. We have tried to move this thing along so we could develop 30, 40, or 50 units in a town the size of Ida Grove and it has been impossible to do this.

We have moved away from any attempt to develop housing under the so-called HUD program. It just seemed like we could not get HUD interested in a small community that needed a lesser number of units.

We went to the Farmers Home Administration 2 years ago. A low-rent housing corporation made up of individuals of Ida Grove, we raised $10,000 as our proportionate share of the cost to develop housing. We secured land to build on and then we moved along with the Farmers Home to build eight one-bedroom apartments and four two-bedroom apartments. They were completed on January 15, 1976, and they were completely occupied in 3 days' time.

EVEN LOW RENTS TOO HIGH FOR SOME

Of these 12 families that moved into the housing unit we developed, 4 of them could not afford to pay the rent that we needed, which was very minor: $100 a month for a very beautiful compact one-bedroom apartment, or $125 for a two-bedroom apartment with all utilities furnished. We tried to get a rent supplement through section

8 of HUD to help these people get along, and that was impossible. We just could not get it off the ground. By talking to relatives of these elderly people, we did get enough supplemental rent from these children to move these elderly people into the housing units.

Now we didn't stop looking for rent supplement. We went to Washington last October and met with Berkley Bedell and his Northwest Iowa Conference; we talked to Mr. Dale Elwell of the Farmers Home Administration; Department of Agriculture; and with the man representing HUD. We tried to get these people together so that they might agree that in a small community we should have a rent supplement to help you people. We could not get it off the ground at this meeting.

However, by writing letters we have got a statement that now they have an understanding between HUD and Farmers Home. They are hoping to get this implemented so we can develop 24 more units in Ida Grove. We are starting on this at the end of this month by letting the contract, and then get low-rent housing subsidies for you people who may be moving in. Right now we have 27 people on our list, and of these 27—we note from the financial statement they have given us—several cannot afford to rent our housing units.

What do we have to do? We have got to go back and beg Farmers Home to go ahead and implement this part of the program to give us these low-rent subsidies, or we have to go out and contact the relatives again to give them some kind of a rent subsidy from their pocket.

Senator Clark, we have not quit in our endeavor to get a low-rent housing subsidy from Farmers Home. With your continued help through your office and your Senate Committee on Aging, I think we can get the job done in time to get the rent supplement for these two new 24-unit buildings which are beginning this fall and hope to have completed in May 1977.

I have two copies of my statement as you requested. With them I have copies of letters to Mr. Elwell,[1] copies of letters I have received from Mr. Elwell,[2] a letter that I sent to Mr. Pim [3] who is the Iowa director of housing under Farmers Home, and a reply from him [4] in which he states: "We anticipate getting this program going in the near future." This is the place where we need the aid.

Now in our small communities we can do a lot for ourselves. As Senator Clark and Congressman Bedell stated, we can pick up a lot of the loose ends. We are organized to do a good job in helping the elderly. We cannot do it all. We have to depend on the State or the Federal Government for assistance. This low-rent housing supplement that we need is the best we can get from your office.

Thank you for this opportunity.

[The prepared statement of Mayor Murphy follows:]

PREPARED STATEMENT OF MAYOR THEODORE E. MURPHY

For several years Ida Grove, as well as many other smaller cities in northwest Iowa, have endeavored to develop low-rent housing for the elderly. There have

[1] See appendix 1, item 1, p. 237.
[2] See appendix 1, item 2, p. 237.
[3] See appendix 1, item 3, p. 238.
[4] See appendix 1, item 4, p. 238.

been many frustrations along the way: lack of funding by Congress, plans were for a lesser number of units than HUD would go along with, etc. You people have heard many times from community leaders about the housing situation for the elderly.

Two and one half years ago Ida Grove organized a nonprofit low rent housing corporation. They raised $10,000 to qualify for FmHA assistance, employed an architect, and developed eight one-bedroom units and four two-bedroom units. The only additional assistance we needed were low-rent subsidies under section 8, HUD, and this we have not been able to get. Our 12 units of housing were completed on January 15, 1976, and were filled within 3 days. Four of the tenants had to have assistance from their relatives to pay the rent of $100 per month.

Attached to this testimony is a copy of my letter to Mr. L. D. Elwell, Assistant Administrator for Multiple Family Housing, FmHA, relative to a discussion I had with Mr. Elwell and Mr. Howard L. Huttman, Jr., policy planning division for HUD, at a conference in Washington, D.C., November 10, 1975. Mr. Elwell's reply dated May 12, 1976, is also attached hereto.

As suggested by Mr. Elwell, I wrote to Mr. Robert R. Pim, Iowa State director for FmHA. On August 10, 1976, Mr. Pim replied. Copies of both letters are attached.

At this time Ida Grove has qualified with FmHA for 24 additional one-bedroom, low-rent housing units for the elderly. From our list of applicants on file at this time we know there will be many who cannot pay the required rent because of their low income status. Somehow they will need a rent supplement from HUD which we know at this time is impossible to get; from FmHA which, from Mr. Pim's letter, may be forthcoming; or from relatives of the applicants, which in several cases is quite unlikely.

So, somehow, the impetus for low-rent subsidies must be placed on FmHA. This is the big reason why I am appearing at this hearing. I know we have to do as much as possible on all matters pertaining to the needs of the aging, by the individuals concerned, by the communities in which they reside, but we also need much assistance on the State and Federal level.

Statistics show that nationally, and especially in Iowa, the elderly population continues to grow. In a survey made in Ida Grove as late as November 1975, 27 percent of our people were over age 60. This figure applied to an Ida County population of 9,300 means that over 2,500 elderly people reside here. We have just begun to take care of the needs of these people, and the situation will continue to grow from year to year.

We feel confident that you, Senator Clark, and the Special Senate Committee on Aging, will give careful consideration to our problems.

Senator CLARK. Thank you very much.

I think it is an excellent statement and Congressman Bedell and I will be very happy to work with you on it. I know that both of us supported a $750-million appropriation for elderly housing. We voted for that. We believe that people in the rural areas pay their taxes just like people in metropolitan areas and that is what this hearing is all about. That is really our purpose, to make certain that people in the smallest communities and people in the rural communities have that kind of assistance.

We are going on and hear from the other three witnesses, then we will have questions.

We are going to hear now from George Marsh, a resident of Sioux City, who is the chairperson of the State Advisory Committee on Aging. As I understand it, he is going to give us a brief description about communities in and around Sioux City and relate it to our topics of delivery of services in rural areas. I know as chairperson of the State advisory committee Mr. Marsh will be able to compare the Sioux City needs with those of the entire State of Iowa.

Mr. Marsh, you proceed in any way you think appropriate.

STATEMENT OF GEORGE E. MARSH, CHAIRPERSON, STATE ADVISORY COMMITTEE ON AGING, SIOUX CITY, IOWA

Mr. MARSH. Thank you, Senator Clark.

Appearing as a member and chairman of the State advisory committee, I would like first to indicate that this position is entirely elective and I want to describe for you the setup of this job. As a member of the various committees created to work with those who produce the services that we need, it is entirely voluntary. I began this voluntary service as a member of the Woodbury County-Sioux City group of the Woodbury County Task Force attempting to obtain financing for the Sioux Senior Citizens Center. We proceeded to attempt to develop financing from the city council and also from the Woodbury County Board of Supervisors. We were successful with one group, but not with the city council in Sioux City.

Along the way we learned of the availability of Federal funds that might be obtained on proper application. I got acquainted with the fact that we had to have an organization, not just locally, but that the requirements were such that we had to have an area of organization. I want to describe for you a little bit of these organizations that I have become acquainted with, worked with, and developed.

We did not at that time have the area organization required by the Older Americans Act which made provisions for the funds that might be available. This caused us to have to go to work to set up the organization we needed. At that point in time I discovered the existence of the State Commission on Aging and the fact that we had to get material assistance from them and the State staff in organizing the area that was allotted to us. This included the five counties up here—Monona, Ida, Plymouth, Cherokee, and Woodbury—and we worked with that organization in getting that thing together. It took a great deal of time. I want to thank the organization in Sioux City which became our sponsoring agency for the work that was done. This was very important to getting the thing set up and in place.

"WORKING FOR THE WHOLE AREA"

As the thing developed and I became a member of the advisory committee of the area, I discovered that we were not working just in the city, but we were working for the whole area, including the counties I just mentioned. The applications for services are to the State commission since the funds the State has available would have to be reviewed and passed through our hands.

We also discovered we would have a representative on the State advisory council to both the commission and Governor of the State of Iowa. For reasons rather dim to me, I became that member and went on to Des Moines and met with representatives from the other areas in the State and again became elected to the office of chairman of that group. I have had an opportunity to see the workings of the machinery that it takes to organize and deliver the services and get the funds out to local projects throughout the State.

The problems are not all local; they are areawide and statewide. I see one problem that has developed in the last 5 or 6 months, in terms

of the rural areas, in a feeling that their share of the funds that were allocated is inadequate and, perhaps, that they should have a higher proportion. I say this because these people representing those areas tell me that it costs more—and I am sure they are right—to deliver services to an individual in a rural area where the distances are great and where either the people have to be transported those distances or the services have to go out to the individuals.

Over the period of time that I have served with the committee in developing the Sioux City Center, we have come to believe that a center of the type that you people have right here is one of the important elements in reaching the people who need the services. In this way the problem of identifying the individuals or their becoming aware that the services are available is one of communication with those people who provide the services and who have the know-how to get the job done.

You have a fine center here which I believe is of the type where it will become so visible to the general public in the area that older people will recognize it as the place to go for any type of problem that they might have. Our elderly people can come to a center of this type and find the kind of services offered, although it may not be available at that particular point. At least they can find out about the service, get the information that they need, help in getting to it, or having it brought to them. This is one of the things they have learned to accomplish.

I think that is it.

Senator CLARK. Thank you very much. We appreciate your comments.

I might say you referred last to the multipurpose senior centers that you have in Sioux City and other places. The Congress has taken a particular interest in developing these centers and I know Iowa's allocation of money for this next year is about $75,000. We are hopeful that more and more of these centers will be developed.

We will have questions in a little while, but I would like to go now to Beulah Webb who is from Sioux City and who, as I understand it, has independently organized, developed, and implemented a senior center in Sioux City. She has won awards from many organizations and from the Governor of Iowa for her services to the elderly. I think she knows everyone in Sioux City and certainly everyone in Sioux City knows her. She has the kind of experience to be a good witness on problems of the elderly.

Beulah, we are very interested in hearing you now.

STATEMENT OF BEULAH WEBB, SIOUX CITY, IOWA

Mrs. WEBB. Thank you, Senator Clark.

Good afternoon to Ida Grove and thanks to the mayor for having us here. I think it is a marvelous program. The one thing that I want to say concerns our problems as senior citizens of the center. I want to let you know that I was the first black delegate, and the only one, from the State of Iowa. I was selected by our Governor to represent the senior citizens at the White House Conference in 1971. I went because I knew the housing need. My main purpose was hous-

ing, because we had just as much trouble with housing in Sioux City as you do in Ida Grove, and we are just beginning to get it. Our State and National representatives know me so well. I have sent out many letters on my own in order that they would know our need and our problems with aging.

I want you to know something about senior citizen centers. Sioux City is the only registered, nationally known center in the State of Iowa. We do not have enough centers today in our State. We are open 5 days a week from 9 to 4:30. We accept the area council and say "thanks" to those who came to our rescue. I want you to know—starting out, we went to our city, and we went to our county. I will be ever grateful to our Woodbury County. Our peers of the city didn't accept us the first year, nor did our State. That meant those who were around and helped to open the doors—some of you have heard of Arthur Samford. He is a philanthropist, and he gave us our first year. We started out with a small amount of $15,000, and from that we have grown.

The next thing that I would like to let you know is that we are here to stay. We are senior citizens and our agency is growing. Consequently, what we need is the people to back up whatever you want. Right now we have a dilemma. I don't know where to put the thing—whether to put it at the city, the State, or the Nation, but I am quite upset. I have these papers before me, but I am unable to see them. Consequently, it is very difficult for me to do the reading that I would like to do.

Many Seniors Live in Area

Project grants are slow coming in. I have four on my staff today. We have an attendance of better than 75 people a day who come in 5 days a week. I don't know how many of you get our bulletins that we put out stating our activities there. It is ongoing and I don't know how many of you know how many senior citizens we have in our area. We have better than 10,000 in Sioux City, so you can imagine how many are in area IV. If you multiply the five counties, you come up with a vast number.

The thing that is troubling me today is the delay of our grant. We are working from day to day not knowing whether we are going to be funded or not, and it is definitely known. On the way of positive thinking, we have to have operations. Our grants, when they get to us, are so very meager that I am almost out begging.

They want to know whether I am going to close the center. No. By faith we will survive. People have been very kind in the last few weeks with tremendous donations that are keeping us alive.

Our county has given us their allocation. They allocated us $7,500. As we grow we have expanded, and it takes something like $32,000 to operate our center. We have expanded into the basement; we are going to make people happy. I wish we had $32,000 on the new building. This is our third year and we are on our last appropriation grant. We have to have it by September. This shortness of time to fill our grant is the thing that has disturbed me. There is so much paperwork that our area representatives cannot come down or get ours to come to them—and the things that we need.

If you could just see the paperwork alone. I am hoping the Government some way will find out that it has become so repetitious—of all the paperwork that has to be done. When you do that, you don't get to the rural. They don't know the people. We are in the centers and know our people. Neither do our State representatives know the people in the rural areas because they are bogged down again with a lot of paperwork. We in the community are developing the funds. On the other hand, I am hoping some way that there will be more funds to be allocated.

Now I just learned that a lot of you do not know about the Community Development Act. We have a title V that has just come up and we do have a Community Development Act. I don't think any of you know anything about it. We did not know that we have title V which we could use to ask for funds. When I went to Washington last year I asked them to listen. I wanted to know what was going on. I hope to make it to Chicago to the National Council on Aging Convention.

I asked some of the heads of our agencies if they would in some way bring in title V, which I find has been passed. There are two; the State has one. I bypass the State and am going to the national, because in our State we do not have a multiple-purpose center as yet. I don't know how the multiple-purpose center is classified. At present, we don't have the facilities for a multiple-purpose center. It is not that we don't want it, but you must have the facilities to correspond with your State needs, and there is no way at the present.

Center Serves in Many Areas

We do what we can. We have marvelous programs, but health, education, and welfare, and on down the line—homemakers and everything—comes within the center. We hope in the future to appeal to both the people, our Congressmen, and to our State. They will see our need.

I would like to leave these few words with the northwest part of Iowa; it is a thought to remember. You see, I have been working for 52 years in the States and whether you know me or not, I have learned a lot and I know our needs.

First, rise up and be counted. You don't know the strength we have as senior citizens. We have the voting power.

Second, if you don't like a thing, let them know about it. Our representatives we elect, but if they don't know our problems, how can they solve them? Just remember that.

Third, state what you want when you are with them. The time is now, not tomorrow. So keep in touch with your representative and yourself.

Keep in mind. "Not for myself but for others," because we are sitting around today building bridges for those who would pass over after we are gone.

Thank you.

Senator Clark. Thank you very much, Beulah. I could not agree with you more, particularly on the closing part of your comment. I think in a democracy if people, of any age or any group, are not prepared to organize and work, and meet with their representatives at a

local level, the State level, or the national level, then it is not going to work. You really have to be organized and prepared, and have your views known, because only in that way is it going to work effectively in a democratic process.

Before we have questions, we are going to hear from Jean Sandman who is director of the AID center—that is, the assistance, information, and direction center. We are going to find out what that is first. She serves Sioux City and the vast area surrounding Sioux City—the rural areas as well. This program is an information and referral system which contacts the elderly and attempts to match them with any of the services that they might need in their area, or as individuals. In other words, they go out and try to find people and match them with the services that are available so that they are not just services and people, but that they get the two together. It is a very, very important job. We would like to hear from Jean Sandman on how she thinks it is going, what this program involves, and anything she would like to cover.

STATEMENT OF JEAN SANDMAN, DIRECTOR, AID CENTER, SIOUX CITY, IOWA

Mrs. SANDMAN. Thank you, Senator Clark.

First of all, I had better tell you what the AID center is. AID center is just a year old. We started in August of last year. We were funded by both Federal and local funds and we do serve a five-county area, which includes Woodbury, Plymouth, Monona, Ida, and Cherokee.

AID center is primarily a telephone service. You will find our cards on the table over here. We also have some brochures that tell you what we do. These are provided for you people so you will be able to call us. We have a toll-free number so there is no charge to you at all. If you have any questions about services, if you want to report something, if you feel you have some of these needs that we are talking about today, you can call AID center.

AID makes monthly reports, quarterly reports, and annual reports. We give that information to anyone who wants it. We document what people want, what they really feel—in other words, what they need. We see how satisfied they are with services or whether they are able to find what they want. We document what people call about and how many resources are available. We are probably the most complete source of information on services in northwest Iowa. We document and have information on every service that we know of.

TOLL-FREE NUMBER AVAILABLE FOR QUESTIONS

If you call us and ask us where you can write to the American Cancer Society, we can give you the local, the regional, and the national address. Any information like this that you want, we will give you. If we don't have it, we will find it. As I said, it won't cost you anything. You can call us with this toll-free number and we will answer any questions that you have. You do not have to identify yourselves if you do not wish to. We are very happy to answer your questions, even if we don't know who you are.

Senator CLARK. Jean, these look very, very practical. Were those passed out, or are they over on the table?

Mrs. Sandman. There are some on the table and I have some more with me.

Senator Clark. Fine. I think everybody here might well want that, and you have a brochure as well to explain it.

Mrs. Sandman. And the brochure has the numbers on it, too. If you don't get a card, you can take a brochure.

As I said, we are a year old and we do document what is needed by the people, which is really what we are paid for. We are not paid to answer your questions, although we provide that service. We are funded primarily by title XX and through this we are allowed to have people call us. Through these calls we document needs, and needs are used for title XX planning. So because of funding, we are not allowed to call ourselves an information and referral service.

Funding is a very difficult thing to find, although under title XX, information and referral is included in the national plan. Information and referral is not included in the Iowa State plan; an agency like ours is rather unique in Iowa. I think we are lucky in northwest Iowa to have it. We can thank Chuck Sweeney, district director of the department of social services, because he worked very hard to get this service for us.

We also discussed whether AID would be an area service. For a while the State Commission on Aging had a toll-free telephone which one could call and get his questions answered. We feel that it is difficult enough being an area service without providing statewide services. My workers and I are trying to get out into the area. We are talking to people directly so that they know us and they will feel more comfortable when they talk to us. We are very interested in serving them.

Within the past few weeks, AID staff has gone to the congregate meal sites to gather information for this hearing. I know persons from Onawa and different places have seen me there. We talked to 119 people—they were all senior citizens—and we asked them what they thought they needed. We had a very simple questionnaire and we asked them to fill it out and state their needs in preparation for this hearing. Their needs are not too different from those we are now hearing about.

In health, for example, about 47 percent of the respondents said we need more doctors, and I think we all know that.

Transportation was another big item that they mentioned.

Income maintenance, as it is termed, they wanted more coverage on medicare. Some of them need larger social security payments.

Mr. Bedell was talking about the fact that senior citizens' incomes might be cut when they have income from two or three different sources and social security is increased. They were very concerned about that.

They were concerned with inheritance tax.

Needs Documented

We documented all these needs and we are going to give this report to Senator Clark so he can find out what, at least, 119 people felt were the needs of the senior citizen in northwest Iowa.

80-462—77—3

Senator CLARK. Thank you very much. We appreciate having the report [1] and we will make it a part of the record so we will have it printed.

I would now like to ask a couple of questions of each of you.

Jean, on your AID program, how do you advertise your assistance program? How do elderly people know about your services? Now these people know about it because they can go over and pick up a pamphlet and call you because your number is on it, and so forth. But what about the tens of thousands of other elderly people in this part of the State? How do you get to them?

Mrs. SANDMAN. Yes. You have talked about our most difficult problem, because it does seem that no matter how much publicity we get, people forget about us the next day. We have been on all the radio shows that come out of Sioux City and even one in Lemars. The TV stations have all given us publicity. We sent articles to all the local newspapers. We follow up on this every few months. Getting known is our most difficult thing. We finally decided we are going to have to go out and meet the people and pass out the literature ourselves. AID center is free; anyone can call us without charge. Our one purpose is just to help people. I should mention we are getting over a thousand calls a month so you know somebody knows we are around. But publicity is a big problem.

Senator CLARK. Let me ask you—you are available to guide people to those services. What service do most people in this part of the State want or need?

Mrs. SANDMAN. That is very easy. It is housing.

Senator CLARK. Housing.

Mrs. SANDMAN. Without a doubt, it is housing, yes. We have more problems with that than anything else.

Senator CLARK. Does this AID service that you have offer any method of followup contact with the elderly persons you direct to services? In other words, do you often actually see elderly persons or follow up to find out whether they were helped by the services you put them in contact with?

Mrs. SANDMAN. Yes, that is part of our service. We do follow up. But you can understand if we do not ask persons calling to identify themselves, that does limit the amount of followup we can do. We follow up on anyone who identifies himself and accepts this service. We ask their permission to call back and find out whether they got the service they asked for and if they were satisfied with it. This information, too, is documented.

STUDENT USED AS COUNSELOR

We provided a service this summer which was rather interesting. I am sorry it has to end and that it was just for the Sioux City area. We took a college student, made him a housing counselor, and had him spend all his time looking for housing, asking people their housing needs, and trying to match people with houses. This was very successful but it is the type of program there is no funding for.

Senator CLARK. Well, that has been very good.

[1] See appendix 2, p. 239.

As I understand what you are saying, Jean, you provide any service that is available; you simply match them with the people who call you.

Mrs. SANDMAN. Yes.

Senator CLARK. What about matchmaking. Do you do any of that? [Laughter.]

Mrs. SANDMAN. You would be surprised. We get that question all the time.

Senator CLARK. I want to ask Beulah some questions.

Beulah, you have come in contact with seniors every day who come into your center in Sioux City. What do you think is the No. 1 service that they seek from your center?

Mrs. WEBB. I think one is housing, transportation, and counseling. We do have the senior citizens who do not want to go up to the AID center since they are not able to climb the hill. Through AID, Mr. Littlefield is our counselor down there.

Senator CLARK. What kind of counseling do you do?

Mrs. WEBB. Anyone who comes into the center and so desires, they get it. It may be on taxes; it may be on rent; it may be they don't understand the water bill or they don't understand the lawyer. You can go to him and he will work through with the lawyers on real estate or anything like that with the person who is confused and does not understand.

Some of the people in their home—there could be something that maybe he could help. We average from five to six people a day in that particular field.

We are the referral agents for the congregate meals. In that way, instead of them calling the average person, they call the Sioux City Senior Center. They will call and ask us rather than call the site, and so we do that.

Then we have a community action bus for out-of-the-county which serves 14 communities in Woodbury County. They come up to Sioux City, which is where they come in and register. We keep track of the people who are registering in it so we might know, and then they come back and pick them up. They come in 5 days a week for the congregate meals. The community action bus comes in and takes people. They register there for the meals for the next day, and she cares for five to seven. That bus goes to their home, picks them up, and takes them back.

Senator CLARK. Now, Beulah, I want to answer a question. I promise not to tell the answer to anybody. I understand you were the one that ran the center almost entirely on contributions, that you got the TV station to give you part of the kitchen, and that you talked the police department into giving you donations, and so forth. How do you do it?

Mrs. WEBB. Telling the truth.

Senator CLARK. What do you mean?

"I CALL THE NEWS MEDIA"

Mrs. WEBB. If they ask a question about what we need, I tell them. Consequently, if our landlord does not come across, I tell them, and I

call the news media. We had leaks in our center, and so I called the news media. I said to the landlord, "If you see me on TV mopping floors or catching this water in buckets or coming before the public asking for funds"—I just call the news media. The city does not want to always be faced with the facts of our needs, and we still are going to apply to our city for our grant. The thing that is troubling me is the revenue sharing and why our center does not get it.

Senator CLARK. Let me ask you one last question, Beulah. You come in contact with a number of elderly people, as you are right now, in other communities that would like to start a center. How do they do it? How do you recommend that they get started so that their communities could have a multicenter? You talked about this multipurpose kind of center that people could come to for services. How do you do it?

Mrs. WEBB. Well, I am not going to send them to Rick, but I do want to call for the cooperation of our director of the area agency. But how I did it—I don't know whether anybody would want to walk alone. I fought this battle since 1971. I saw the needs of our community. I saw the need of the rural elderly. There was no place for people to sit down.

I said if the opportunity for them ever presented itself, I would go out. I started out—not bellringing, but with a cry for the needs. So it materialized from the Woodbury County Council on Aging. I was the president at that time. Consequently, I sold the idea to them. We started to build up. You have to have people that work together. The most important thing in the world is the togetherness and belief in the thing that you are undertaking to do.

Everybody came in the door when they did open in July 1973. I was a volunteer, too; I was not paid then. I don't think there was any money involved, because I was the president of Woodbury. "Do you want to be my volunteer?" Everybody in the door. "Can you give me this much time?" They don't know how much. I said, "It is not how much, but what you can give."

Consequently that is the way we do it.

People had the faith and the belief in the things that were needed. They really are enjoying it, and we are growing. When you say you have, on average, 1,500 to 1,600 people a month coming in 5 days a week, it is something you needed in the five areas. They come from South Dakota and all over the Nation—dropping in. They hear about us and come to see what has been accomplished.

MANY MAN-HOURS VOLUNTEERED

The one grand thing—we have one man that I would like for you all to know. The different stations came to our rescue. We have an electric kitchen, believe it or not. Many homes don't have it, but we do. They volunteered their labor. We counted the money and figured it would cost over $17,000. You could figure out how many man-hours five or six men put in.

I will tell you a funny story and stop. For every urban renewal torn down, we would creep in and get the material to build or expand. The city inspector came and said, "You can't put that in because it isn't fireproof."

I said, "We moved it from across the street; it was fireproof over there. Does it cease to be fireproof because we bring it across the street?"

He said, "Yes."

I said, "I will see about that. I will put it in the news."

So I got it without having to call the media. [Laughter.]

Senator CLARK. Thank you, Beulah.

I want to ask George Marsh just one question, but it is a very important question. As chairman of the advisory council, I think you are in a good position to give us your judgment. It is simply this. What, in your judgment, have you found to be most lacking in the Older Americans Act—in the services that it provides? In other words, if you could tell the Congress or the President what it is that we are not doing that needs to be done, what would you recommend?

Mr. MARSH. I think, as to provisions, the Older Americans Act covers the field very well. I think probably the principal need at the present time is additional funding to get the job done. This is the biggest item. I am concerned with our local situation, particularly with our—well, we have it in Sioux City. There is a requirement in the Older Americans Act have to do with—or at least if not in the act, then in the regulations relating to it—a percentage of local public matching which I think is necessary. The problem, however, is a little involved, in that we have a need for—the term is not "project," but that is the best I can do right here—a new item coming on.

Senator CLARK. When you undertake a new program?

Mr. MARSH. Yes. If we happen to start it. If we can only get it started in one county, for example, or one town, we are eligible for 90–10 in terms of matching.

Senator CLARK. In other words, the Federal Government pays 90 percent and the locals pay 10 percent.

Mr. MARSH. Yes.

Senator CLARK. When you start new programs.

TROUBLE OBTAINING MATCHING FUNDS

Mr. MARSH. When we start a new program. Now we have run this with regard to those funds that are available. We have the area set up, and some of these programs that are regarded as areawide, we get it in one locality. Then we wind up being behind the eight ball when the next community wants to set it up in that we have already existed with this program for a year or more in the area. We have a little trouble about getting any 90–10 or 25–75. I think that is a mechanical thing that needs to be corrected. It has to do with the definition of what constitutes a component—the program in that area.

Senator CLARK. Thank you very much.

Now I would like to ask the mayor a question.

As I understand it, you have a new minibus for the elderly in Ida Grove. In fact, it is right outside here, isn't it?

Mayor MURPHY. Yes, sir.

Senator CLARK. How is that going to operate in this area?

Mayor MURPHY. It is going to operate countywide. We are going to cooperate with the sheltered workshop people in Holstein, so we will be hauling seven of their clients to begin with, and probably more

at a little later time, from the south part of the county to the workshop area. We will be making a trip up there at 9 o'clock—to arrive there at 9 o'clock each day, Monday through Friday. Then we will pick those people up from the workshop at 3:30 in the afternoon and deliver them back to their homes, wherever they may be, in this part of the county.

At the same time we will be hauling people to Battle Creek, to Arthur, to Galva, and to Holstein from Ida Grove, and from those communities back to Ida Grove or to other parts of the county. We intend to schedule regular trips every week. We intend to meet with a bus from Cherokee County at Holstein on a particular day of the week so if people from this area want to go into Cherokee County or to the city of Cherokee, they may do so on this particular day. Then we will meet them later in the afternoon at 3 o'clock and deliver them back to their homes in other parts of the county.

We expect to work the same way with Woodbury County; we may come into Holstein either on Thursday or Friday. I believe at this time they are thinking Friday. We will meet them there at 9 or 9:30 in the morning—I am not positive. They will have an express run from Holstein into Sioux City and then they will allow the people to stay there for a period of approximately 4 hours. Then they will deliver them back in express down to Holstein to be there at 3 or 3:30 in the afternoon.

We expect the Monona County bus to drive into Ida Grove from the west through Danbury, Battle Creek, and into this area. Just how often we are not sure, but it could be 1 or 2 days a week.

Trips Scheduled for Elderly

So with this kind of cooperation, we hope to have a wider area that we can cover to take these elderly people over to the places that they want to see. This runs Monday through Friday in this way. We expect to schedule trips from nursing homes and from the senior citizens centers to as many of the communities as they wish to have them scheduled, on holidays, Saturdays, and Sundays.

Our bus will haul 15 people. We expect to load in 15 people and take them to Strong Lake, Sioux City, and Ida Grove. We feel this thing can work very well throughout the entire county, and somewhat throughout this northwest Iowa area.

Senator Clark. Thank you very much, Mayor. You covered a lot of territory there and it was very valuable material. I know there are a lot of people in this room who wonder what day it is going to be where. Who would they contact to find out how to get this particular question answered?

Mayor Murphy. We have set up a special phone in the city hall in the clerk's office, and we will have a schedule out to all of the people of the county in the very near future. We have it out somewhat now as to the needs of the senior citizen groups in the various communities. They can call on a special line to our office, tell the clerk over there that they would like to have the bus stop and pick them up, even in the rural areas between here and Holstein or between here and Lamar. We can drive off the regular route and pick up people and take them into the community in which they want to go.

Senator CLARK. I want to congratulate you for providing this bus and making it available to the whole county. I know it is going to be an enormous help. Transportation continues to emerge as a major problem for older Americans and, in fact, I understand some of you came in on this bus today.

Those who did, raise your hand.

[Show of hands]

Senator CLARK. Good. Excellent.

Well, it has already been put to use.

I want to thank this panel very much.

We have one more panel with three people and we hope you can stay for that. This panel did an excellent job and gave very helpful information. We thank you very, very much.

Mayor MURPHY. Thank you, Senator.

Senator CLARK. The next panel is on health services and it is made up of Anne Snell, R.N., regional supervisory nurse, Iowa State Department of Health, Ida Grove, Iowa; Dennis Tobin, director, Department of Social Services, Ida County, Iowa; and James Krick, Ida Grove, Iowa.

Please come up to the table. We will hear from each witness and then have a question period.

We will hear first from Anne Snell. Anne has worked for years here in Ida County and she knows the health service needs of the residents here. As I understand it, she is going to relate what health services are severely lacking for the elderly now, and the consequences of what must be activated to compensate for the lack of health services in such rural dwellings.

PANEL ON HEALTH SERVICES

STATEMENT OF ANNE SNELL, R.N., REGIONAL SUPERVISORY NURSE, IOWA STATE DEPARTMENT OF HEALTH, IDA GROVE, IOWA

Mrs. SNELL. Thank you, Senator Clark.

The goal of most elderly persons is to retain their independence and live in their own homes as long as possible. This goal can be reached only through expansion of existing home health services. Are public health nurses who assume responsibility for most of the home health services provided in our rural counties serving the elderly population?

Let us look at some 1974 statistics of two counties in the area. Ida County, which we are now in, has a population of 9,100, with 1,900 persons—or 21.3 percent—being age 60 or over and 1,400—or 15.9 percent—being age 65 or older. During the fiscal year July 1, 1975 to June 30, 1976, the one public health nurse in the county made a total of 1,397 visits; 1,202—or 86 percent—of the visits were to persons age 65 and older; 112—or 8 percent—of the services were to persons between the ages of 45 and 64; and 83—or 6 percent—to persons under age 45. About 19.5 percent of the 16,000 residents in neighboring Cherokee County are age 60 or older. Of the 2,210 home visits made by two public health nurses during the past fiscal year, 1,862—or 84 percent—of the visits were to persons 65 years of age or older. So when we think about the number of visits for 65 and older, we see

that nurses are spending over 80 percent of their time in this area and still are not beginning to meet the needs of the people.

Last fall the public health nursing services and departments of social services in Calhoun and Pocahontas Counties established there was a need to provide health screening for persons age 60 and older as many of these persons do not see a physician regularly due to physician shortage, transportation problems, lack of finances, or they do not recognize the need. Around 22.7 percent of the 14,300 residents in Calhoun County are over 60 years of age, and Pocahontas County, with a population of 12,700, has 20.5 percent age 60 and older.

Screening Clinics Established

Grant funds were obtained from the Iowa State Department of Health to establish well-elderly screening clinics. These clinics are held in each of the towns in the 2 counties on a rotating basis. There are 21 towns in the 2 counties with 7 physicians located in 1 town, 3 physicians in 1, 2 in another, and 1 physician in each of 2 towns—leaving 16 communities with no physician. A hospital is located in 2 towns, and nursing homes in 8—leaving 13 communities with no health care facilities.

The well-elderly screening clinics have been in operation only 5 months. During that time, 180 persons who had not seen a physician within a year were screened. The screening program includes obtaining a social and medical history, vision screening, including glaucoma testing, blood and urine testing, a complete physical assessment, counseling regarding the findings, and referral.

To show that these clinics are needed, 107—or 57 percent—of the persons screened were referred; 71—or 66.4 percent—of the referrals were to physicians; 22—or 20.6 percent—to public health nurses, and 14—or 13 percent—to others, such as dentists, ophthamologists or optometrists, department of social services, and mental health centers. Many other counties recognize the same need but are unable to provide a similar program due to lack of funds.

A recent survey showing the length of time persons had not been seen by a physician was done at the well-elderly clinics in Powesheik County by the public health nurses. Of 245 elderly persons seen at the clinics, 43 were seen by a physician 1 year ago, 67 between 1 and 2 years, 78 between 2 and 5 years, and 57 had not seen a physician for 5 years. There were many reasons given for not seeing a physician, but the most common were, "My doctor doesn't have time to talk with me," "I can't stand to sit in the waiting room 2 or 3 hours and then see the doctor for only 5 or 10 minutes," and then, of course, the common one, "I can't afford to go."

I feel that the primary problem in providing adequate home health care services to the elderly population in our rural communities is lack of funding. Local health fund moneys are appropriated from the county's general fund, which creates problems. Many counties in Iowa receive shared salary appropriations from the State department of health for one nurse, but there are several counties in northwest Iowa who receive none as there is no money available. These counties were able to establish home health agencies through use of Federal Grant 314d funds which were available for 3 years, after which they went

on county funding. The 9 percent limit placed on increasing expenditures from the general funds has created problems in several counties. Studies show that to provide adequate public health nursing service there should be one public health nurse for each 3,000 population, whereas there usually is one nurse for 8,000 to 12,000 population. This nursing shortage is not due to lack of available personnel—there are plenty of trained personnel. It is due to lack of funding.

Limited Funds Hamper Services

Less than half of the home health agencies in northwest Iowa are certified for medicare, thus depriving many persons of the benefits they should be receiving. These people should be entitled to services provided by nurses, home health aides, physical therapists, speech therapists, occupational therapists, and medical social workers. Personnel are not available to provide these services due to lack of funds.

Studies are being done throughout the State to compare costs of home care and nursing home care. One study recently submitted to the home health agency surveyor showed the following expenses in the care of an 84-year-old lady with cardiovascular disease who was admitted to a home health agency in June 1972.

There were 100 visits by public health nurses from June 1972 through April 1976 at a cost of $1,160, and 396 visits by home health aides at a cost of $2,962—for a total of $4,122. Nursing home cost in the community from June 1972 through April 1976—1,418 days at $17.59 per day—would have amounted to $24,814.

So think of the savings in being able to keep them in their own homes.

We have found to be true what Senator Clark said in his support for the Church-Kennedy home health care amendments. People are better off when they can take care of themselves in their own homes with some assistance. Our public health services can provide that help at less public expense than institutional care. There is no other provider for this service that can meet the needs as well.

Thank you.

Senator Clark. Thank you for a very comprehensive statement—a very complete one. We thank you for it.

We are going to hear now from Dennis Tobin, who is the director of the Department of Social Services for Ida County. He has worked chiefly with the homemaker-home health programs and will relate what his aides find to be the most requested services, those which are lacking, and those which are attempting to suffice the need in predominantly rural areas.

Dennis.

STATEMENT OF DENNIS TOBIN, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, IDA COUNTY, IOWA

Mr. Tobin. Thank you.

I have been asked to speak to this committee regarding the health needs of the elderly and, more specifically, the homemaker-health aide program. In order to discuss the homemaker-health aide program, it is first necessary to explain the context in which the program functions.

The department of social services has two very basic goals: to maintain people as independently as possible, and to protect those persons unable to protect themselves.

The homemaker-health aide program and the chore service program work toward these goals while combating some of the other basic problems of the elderly, such as loneliness, boredom, special dietary needs, and lack of knowledge of existing programs.

We find few persons who are really physically unable to leave their homes. The program finds itself in a continuum of services ranging from simple financial assistance, so the elderly can avail themselves of existing services, to complete institutionalization, hopefully of a temporary nature.

Programs Listed

These programs include, but are not limited to:

(1) Financial assistance, social security, SSI, and SSA.

(2) Chore service.—A program designed to arrange for persons to perform simple daily tasks that a client is unable to do himself such as lawnmowing, snow shoveling, and heavy cleaning.

This is a very efficient program, helping a lot of clients for very little expenditure. It should be expanded substantially as an alternative to higher levels of care.

(3) Homemaker-health aide program.—Performing many types of services for clients under the supervision of a PHN and/or a social worker to make it possible for a person to live in their own home rather than leaving their home for a higher level of care. We feel that a great majority of elderly can function at this level and would prefer it to higher levels of care.

(4) Family life homes, adult foster homes, and board and room homes.—These programs allow the client a degree of freedom; however, they are no longer in their own home. We have a definite need for more of these facilities as an alternative to institutional care.

They are currently bogged down with bureaucratic problems.

(5) Custodial care.—The least confining and most flexible level of institutional care. This level of facility can care for many elderly persons as well as younger persons who do not need a great deal of physical care. This type of facility is practically nonexistent in rural areas due to the strict requirements for physical plants and low payment level. Many current nursing care patients could function in a custodial home.

(6) Nursing homes.—These facilities have, in the past, been a catchall for all types of patients unable to function in their own home. With the availability of alternative types of care, it is hoped that clients will be allowed a number of choices other than the classic home or a nursing home.

(7) Extended care facilities.—These are special highly skilled nursing homes designed as an alternative to long-term hospitalization. In rural America they have simply been strangled by Government regulations and redtape. Since this is a program paid by medicare, many elderly are cheated out of part of their medicare benefits by the lack of these facilities.

(8) Hospital care and institutional care.—We are blessed with a number of good facilities in this area. We need many lower levels of care to avoid unnecessary hospital or institutional care.

We have found the homemaker-home health aide program to be a viable alternative to these higher levels of care and ask that this committee attempt to see that State and local governments are allowed the resources and flexibility to develop these programs to their fullest.

Thank you.

Senator CLARK. Thank you very much.

We will hear next from James Krick who is, as I understand, the former mayor of Ida Grove, and I believe someone who has experience in what Dennis Tobin was just talking about in terms of homemakers and the chore aide program, and so forth. You proceed in any way you think appropriate, Mr. Krick, and then I will have some questions.

STATEMENT OF JAMES R. KRICK, IDA GROVE, IOWA

Mr. KRICK. I think you sure picked a bum person to talk after all these good talks that have been given. I suppose I would have to say most everybody here has been in contact with me or my wife since I was in the transfer business for 46 years. My wife was 79 and I am going on 83, so if there are any mistakes made, just forget it.

Friends, Senator Clark, and Mr. Bedell, Mr. Tobin wanted me to tell my experience that I have had with the new social service of Ida Grove, Iowa.

Twelve years ago my wife, Rose M. Krick, had a stroke which left her a very much crippled person, and 10 years ago she had her second stroke. She stayed in Ida Grove Hospital for, I think, 46 days, and then went to St. Vincent's for a month to learn to walk again. She got along very well and I took care of her in our home.

Then 10 years later she had another bad stroke. She stayed in the hospital for a month or so. After a long stay, I was notified that her time of medicare was up and she could not stay any longer under medicare. I could not take her to a rest home or to another hospital, it had to be a private home so that she would get her privileges back from medicare.

I talked with her doctor, J. B. Dressler, and asked him if I could get a nurse to come once or twice a week to help. He said, "Yes," so I brought her home. Mrs. Anne Snell here—my wife was one of her first patients under this new program. At that time she was a county nurse. I took my wife home and we took care of her for about a month or so. Then she went to a new job in other counties.

SOCIAL SERVICE PROGRAM HELPED

So the county got Mrs. Betty McGuire as a nurse. She did a nice job and said the new social service was here in Ida Grove and that I could get a nurse's aide and chore women to help us out. I asked her to get someone to help out, which she did, and Mrs. Delores Peffer came five times a week to take care of Rose. Later, Joan Segebart came to help and then the chore women 3 hours a day per week. Nobody knows what that meant to me after 10 years of this trouble.

Mrs. SNELL. May I interrupt to say the first two ladies mentioned are home health aides in the county.

Mr. KRICK. Yes.

They came to help me out then in any way, shape, or form.

Then in May I got my heart attack with my diabetes and could not care for my wife. I went to the hospital for 23 days and in the meantime they took Rose, my wife, to the nursing home—Morningside Manor—June 7, 1975. She stayed there for 10 months before she died on April 7, 1976. I came home from the hospital after 13 days. In the meantime the flu got bad and took my wife on April 7, 1976. We would have been married 57 years on April 9, 1976. She was buried on the 10th. She was 78 years old and would have been 79 the 15th of October. I am going on 83. I was born January 9, 1894.

I have had this social service ever since my wife died. They have been a wonderful help to me and I cannot praise them enough. I cannot say enough for the care this social service has provided. I cannot thank Mr. Tobin, Phyllis Fick, Larry Bayliss, and Delores Peffer, Joanne Segebart, and Mae Brookbank enough for their wonderful help. I feel I owe something to the social service and these wonderful people who can't do enough for the aged.

I thank Dick Clark and his staff for their help. They have done a good job for the aged. We all get there sooner or later. Phyllis Fick has done a good job for the aged in this social service work. I also want to thank my daughter Barb, her husband, Al, my sister-in-law, and all of my friends.

I thank you all for listening to me.

Senator CLARK. Thank you very much, James, and thank you for your kind comments.

Mr. KRICK. This is my first talk. I don't need to tell you that—you know it. I did the best I could, and I am surely glad to be here and help you out. There are just a few here a little older than I am. My friend over there, John Shultz, is 87. Is that right, John, 87?

Mr. SHULTZ. Eighty-eight.

Senator CLARK. Eighty-eight he said.

Mr. KRICK. I'm just a kid at 83.

If you ask me anything in the transfer business or gray line, I could have done it—most anything of that kind. I had 46 years there. I don't believe there are very many in Ida Grove that I have not been in contact with one way or the other.

I want to thank you for listening. Excuse me for my bad language.

"BEST KIND OF TESTIMONY"

Senator CLARK. I think that was the best kind of testimony that this committee could receive about the value of the chore aides and the value of the homemaker services, because it has made it possible for Mr. Krick to stay in his own home for a very long period. This simply would not have been possible had we not had these programs.

I would like to ask Dennis Tobin and Anne Snell a couple of questions before we see if there are any questions or comments from the audience.

First, Mr. Tobin. I recently conducted a survey of the title XX services that are provided to Iowa. We wrote to virtually everyone who was associated with this program and one of the expressed points

of concern was the State matching requirements of 25 percent. In other words, the Federal matching share is 75 percent and the State share is 25 percent in this program.

My question is this. Is 25 percent a reasonable share, in your view, or is it too difficult for a State like Iowa to come up with this amount?

Mr. TOBIN. I don't know what the official opinion is supposed to be, Senator Clark, but we have not found the problem to be getting match money. Our problem has been to run into the federally assigned maximum for the State. We have been able to raise the match money wherever we made people aware of the programs and how they would function. We have a breakdown in Iowa two different ways. Many programs are matched by State dollars, many of them are local dollars—and there has been some problem in some areas with the local dollars—but in this area that has not been a big problem.

Senator CLARK. Good.

Now the second question. What percentage of your service program participants are elderly? In other words, of the services that you provide, to what degree do you serve the elderly as distinguished from others?

Mr. TOBIN. I don't believe I could tell you the absolute statistics, but I think the statistics that Anne came up with would come awfully close. The vast majority of the services we provide are either to the elderly or from the handicapped.

Senator CLARK. Another question. We just heard from Mr. Krick about the benefits of the chore services and homemaking. Can you be more specific about just what that means? If they go into the home once, twice, or three times a week, what do they do? What does a homemaker do, or what do you do with the chore aides?

Mr. TOBIN. There is a basic difference between the three functions. A chore service person, at least the way we are using it, is generally a neighbor lady or a friend who can come in and do any of the simple daily tasks such as heavy cleaning, helping someone go for the groceries, and that type of thing—the type of task that a neighbor or a friend could do. We do this on a contract basis, and on an individual basis.

The homemakers, when they are functioning as homemakers, do skilled types of functions: Teaching people how to do tasks of daily living, teaching some how to function when they are physically handicapped—for example, helping them prepare special diets—this type of thing.

GRAY AREA IN SUPERVISION

There is a gray area between the homemaker and the health aide, however. When they are doing specifically health aide work they are under the supervision of the public health nurse and she has received orders from a physician. So when they are doing health aide work they are doing the types of things required for health reasons to keep them in their own home.

Senator CLARK. Fine. Thank you very much.

I would like to ask Anne Snell a question. As I understand it, approximately 90 percent of all the persons that you serve as a public health nurse in Ida County are elderly people.

Mrs. SNELL. That is correct.

Senator CLARK. Are you trained to care for the elderly specifically in that kind of program?

Mrs. SNELL. All of the public health nurses have basic nurses training, of course. Our goal is to find nurses who have public health experience or who have public health training in the program, but this is not always possible. So through some of our area technical schools, as well as the State department of health, in-service training is given so that they do learn while they go along. There does not seem to be any problem finding qualified personnel.

Senator CLARK. Suppose someone here at some future time wanted the services of a public health nurse. When you find someone, do you make regular calls or do you simply respond to telephone calls? How does that work?

Mrs. SNELL. Anyone may be referred to the public health nurse in the county. Many of them are doctor referrals, the patient, the patient's family, or a concerned neighbor.

Senator CLARK. How do they reach you?

Mrs. SNELL. Just simply call the phone number in the phone book. There are many different ways—through newspapers, and so on. They call the office, the public health nurse makes a home visit to assesss the situation and, upon an assessment, if she feels that she can provide a service she then contacts the family physician for orders. The public health nurse only works under direct supervision of the family physician unless it is general health supervision, and then she may function without a physician's orders.

Senator CLARK. Good.

I want to thank this panel very much. Please stay seated because we are going to see if there are any comments or questions from the audience.

I do want to thank you very, very much. I know that it is very warm and we are not going to take more than about 5 minutes or so. There is a microphone up here in the center and anybody that would like to walk to the microphone and make any statement or ask any questions, we welcome you to do so. I will then see if Congressman Bedell has anything to say. I am going to take about 30 seconds and that will complete the program.

Come up to the microphone and identify yourself for the record.

STATEMENT OF BOB TORRY, CHAIRMAN, CITIZENS ADVISORY COMMITTEE, CHEROKEE COUNTY HOMEMAKER/HEALTH SERVICE, CHEROKEE, IOWA

Mr. TORRY. Senator Clark, Congressman Bedell, I am Bob Torry, a farmer in Cherokee County. I have been on the health board of Cherokee County since it started. I have been on the homemaker service since that started. I report that both of our organizations in Cherokee County have been very successful.

What we need is a comprehensive program which will meet the social, psychological, and physical needs of the homebound elderly. These people who are testifying are not as concerned with health programs because they are well enough to be here. The ones that I am talking about are the ones that are found in their home.

As chairman of the Citizen's Advisory Committee for the Cherokee County Homemaker/Health Service, I respectfully recommend that Federal assistance is necessary for continuance of this vital service to the elderly and handicapped.

The Cherokee County Homemaker/Health Aide Service is designed to place responsible workers in homes where illness, disability, or other crisis threatens normal family living. Aides are assigned to the home to perform whatever duties are required to meet the needs of each individual situation.

While services are available to all citizens in need, the majority of cases involve the elderly. In the month of June, 50 individuals were provided this service in their homes. Forty-seven of the individuals served were over 60 years of age. Seventeen were unable to pay full cost for services provided. Consequently, funds generated from other sources provided the resource for subsidizing the services for those financially incapable of paying full cost of services provided.

Inflation Causes Funding Problems

We have mobilized funds to subsidize the program for those in need, such as social services, department of health, Commission on Aging, Cherokee Board of Supervisors, Mid-Sioux Community Action Agency, and citizens' contributions. Any decrease in Federal or State funding plans place an added burden on local resources. Local resources are inadequate to sustain the homemaker/health aid service. Ever-increasing costs, because of inflation, complicate the problem. This inflation really eats us up.

The Cherokee County Homemaker/Health Aide Service has citizen support in evidence by financial assistance from the county board of supervisors and concerned citizens.

We feel the program has a twofold benefit. First, many of our senior citizens can remain in their homes living with dignity and respect for an indefinite period when a helping hand is provided by the homemaker/health service. For many, the only other alternative would be institutionalized facilities. Our program is a human approach to satisfying a need for many of our elderly and others plagued with sickness.

Second, we feel it is good economics to provide this service within the home as compared to institutional care. A few hours of aide service in the home each week will satisfy the needs for many of our elderly.

We feel our citizens and county officials have responded to the need by providing financial assistance within their capability. As stated previously, local resources are inadequate to sustain the program. Without continued Federal assistance, the services of the program will have to be curtailed or discontinued.

It is the concern of the advisory group I represent that services should be expanded, but limited funds compel us to do the best we can with what we have.

I thank you.

Senator Clark. Thank you very much. That was a very good statement.

I wonder if there is anyone else in the audience who would care to say anything or ask any questions.

Rick Motz.

Let me say, by the way, that if you want to speak for only a moment or two, if any of you have a longer statement we will put that in the record as if given.

So you go right ahead, Rick.

STATEMENT OF RICK MOTZ, DIRECTOR, AREA AGENCY ON AGING FOR AREA IV

Mr. MOTZ. The first thing I want to say to you is that now is your chance to speak up. The second thing I want to say, and you already know that, I am Rick Motz. I am the director of the area agency on aging for area IV.

First of all, thank you, Senator Clark, and Congressman Bedell also, for coming to our area to listen to our concerns regarding aging programs. Your efforts at the National and State level on behalf of older Iowans are to be commended.

Aging programs have come a long way during the short time in which Older Americans Act funds have been available to our area. Transportation is evolving from a one-county, one-bus system to a multicounty, tristate system. Senior centers or clubs exist in almost every town of area IV. Other programs, such as meals-on-wheels, homemaker-health, and winterization programs have enjoyed similar success.

We have been involved with the aging concept for about 3 years now. I have two concerns regarding programs for older persons. First, I would recommend to you the elimination of the 25 percent local public cash match requirement. The rule, in effect, does not recognize cash match from entities other than local taxing bodies. For example, if a program needed a total of $10 match, $5 of it would have to be cash and $2.50 of the $5 would have to be identified as being received from a local taxing body. If a service club would give $5 for match, the program could only use $2.50 of it and hope to get the other $2.50 from local and county governments.

Second, as you are very aware, there is a large river running down the boundary of area IV. This boundary, called the Missouri River, prevents services from being delivered to many counties in Nebraska and South Dakota. The Older Americans Act has fostered a separation of State's policy thus far. I would suggest to you that future legislation encourage interstate agreements. Interstate area agencies on aging would provide the potential to serve many more older persons in the most efficient way possible.

I appreciate this opportunity to express my comments at this time.

Thank you, Senator Clark.

Senator CLARK. Thank you very much.

Anyone else who would like to make a statement, comment, or ask a question? Is there anything you would like to say?

STATEMENT OF BERNICE DAHL, WHITING, IOWA

Mrs. DAHL. I am Mrs. Bernice Dahl. My husband, Willard R., and I live in Whiting, in Monona County. Thirteen came in on the mini-

bus today. My request is: please, when you get our proposal for transportation, do all you can and all Mr. Bedell can do. We are really land locked. The Missouri River is on the one side, there are no buses going down the middle, and no trains—only on the outer edge. We would really appreciate anything you can do.

We have worked and retired from the Monona County Task Force and we have a new one, but I have been with it since it started. I am a member of the transportation committee so I ask you, please help all you can to get more transportation to our part of Monona County. The Sioux City agency is working with us. That is my need.

Also, for some of the senior citizens, we got a raise on our social security, yes, but we also got a raise in our medicare payments, so it didn't mean much. Those are things that need to be looked into because for a lot of our people, their money does not reach what they need to reach. I did learn that if a person is eligible, SSI welfare can help.

Many of our senior citizens are disturbed over the cost of hospital costs. That is the initial payment, cost of medicine and doctors. Some of us squeeze through, but it is difficult sometimes. What can be done? I don't know, but I feel that you and the committee will come to some satisfactory or helpful solution.

I certainly appreciate today and I thank you very kindly for listening.

Senator CLARK. Thank you for an excellent statement.

STATEMENT OF MARY RUTLEDGE, YOUR, INC., WEBSTER CITY, IOWA

Ms. RUTLEDGE. I am Mary Rutledge and I work in Webster City, Iowa, for a community action agency, YOUR, Inc. About a month ago I went to Washington about a consumerism program about the high cost of utilities for the Midwest. I would like to be told why utilities are low on the priority list of Senators and Congressmen in our area. It upsets me a great deal.

Senator CLARK. What do you mean by "low"?

Ms. RUTLEDGE. Liaisons from Senators' and Representatives' offices informed our agency that lifeline and energy stamps are the lowest on their priority lists. The bills have not been polished off as of now. This upsets me quite a bit because in some areas the cost of utilities has been raised 100 percent or more, and it is very difficult for elderly persons with the small amount of social security they get.

When the elderly do receive raises in their income, they are cut back or denied other necessary services. Because of these reasons, utility bills are prohibitive. This is why I would like to see the rising costs of utilities top on the priority lists of our Senators and Representatives.

Senator CLARK. Fine. That was a very good statement.

I think all of us who have paid any attention or followed the problems of the elderly are particularly concerned about the problems of inflation. One of the major reasons for inflation, obviously, is the increased cost of energy, and so it is very high on our priorities.

Yes, sir.

STATEMENT OF KEVIN BEAUVAIS, EXECUTIVE DIRECTOR, WOODBURY COUNTY COMMUNITY ACTION AGENCY, SIOUX CITY, IOWA

Mr. BEAUVAIS. Senator, my name is Kevin Beauvais representing the Woodbury County Community Action Agency in Sioux City. I have already submitted a copy of the statement that my board chairman had prepared for the committee. [See below.]

Senator CLARK. Good. It will be made a part of the record.

Mr. BEAUVAIS. I want to thank you very much for coming to the area and giving us an opportunity to be heard. Essentially the Woodbury community has identified three major concerns. Mayor Murphy talked about the problem of housing and Jean Sandman mentioned housing. We are of the opinion, after having operated a winterization program, to do some work especially in the elderly homes. There is a need to service at least the homes that we presently have.

Many people are living on a subsistence level of fixed income which makes it difficult for senior citizens to maintain a home and to keep it in a safe and sanitary condition. Also, as their lives change and their physical capability changes, sometimes that home needs to change with them. We think that comprehensive home rehabilitation or home maintenance programs for the elderly would actually be protecting two of our valuable American resources: The housing supply that we presently have, minimizing the additional need to replace housing, and also protecting the lives and health of the senior citizens that live in what was formerly a family home, which maybe now has only one or two of them left in it.

The other aspect we think, as was mentioned earlier, is in terms of counseling. Senator, we think that the governmental maze of regulations and bureaucracy, as well as the change in the economic systems of our country, various businesses and economic institutions often leave the senior citizens entirely confused by the encounter. Many times it takes a paralegal assistant, a legal aide, an attorney, or somebody that has a great deal of time to deal with them, to take them by the hand and show them the regulations, and also deal with the bureaucracy that they are encountering in order to handle or to solve the particular problem, whether it is a social security check that didn't arrive or some problem with paperwork. The regulations that they encounter as senior citizens are extremely confusing to them.

Also, concerning the aspect of consumer education or consumer rights, paralegal assistance could go a long way to help alleviate some of the complicated problems that the elderly citizens run into.

[The statement prepared by Donald Graham, chairman, board of directors, Woodbury County Community Action Agency, follows:]

STATEMENT OF THE WOODBURY COUNTY (IOWA) COMMUNITY ACTION AGENCY

Ladies and gentlemen, the Woodbury County Community Action Agency appreciates this opportunity to appear before and submit testimony to this Senate Special Committee on Aging as our comments on the problems of the rural aging in our area from our perspective.

First of all, the Woodbury County Community Action Agency is a nonprofit Iowa corporation which exists to identify, mobilize, and utilize available public and private resources to assist the low income, the minorities, and

the elderly to improve their economic conditions and standard of living. Toward this end the Woodbury County Community Action Agency applies for and receives programmatic funding from a variety of sources, principally of a categorical nature, to provide certain select services for these target populations. Our major sources of funding are the Community Services Administration (CSA), Department of Health, Education, and Welfare (HEW), Older Americans Act—Title III—Area Agency on Aging, the State of Iowa, and local county boards of supervisors, specifically Woodbury County and Monona County.

With these various resources, the Woodbury County Community Action Agency conducts a wide variety of programs; those of service to and of interest to the elderly persons included in our service area: our neighborhood center and outreach (personal contact and information and referral services) community nutrition program which funds food stamp outreach, emergency food, and related assistance, our winterization/weatherization housing energy conservation program, and a developing rural transportation program.

Participant statistics for these programs have previously been submitted to the Kansas City regional office of the Community Services Administration for submission to this Senate special committee. All of our agency's programs, except for those specifically targeted for economically disadvantaged children, include a high percentage of elderly participation as our area includes an extremely high percentage of elderly citizens. According to the 1970 census, Woodbury County contained 17,618 persons 60 years of age or over. This is over 17 percent of the entire population in Woodbury County. Of the 17,618 persons 60 years of age or over, in excess of 28 percent of this number was identified as being 65 years of age or over and living below the recognized governmental poverty level income figures.

Elderly Often "Threatened" by Change

The Woodbury County Community Action Agency comes into contact with many of these elderly persons existing on subsistence level fixed incomes in an economic environment which is continually placing essential needs and services at spiraling costs. Among these essential needs and services are food, housing, energy, medical, and transportation. We also find the elderly persons to oftentimes be intimidated and even threatened by the rapidly changing political and economic world in which they now live. There can be no doubt that the current world and the current political and economic structures are very much changed and entirely different and alien from those with which our elderly citizens had learned to confront, deal with, and operate with in their earlier lives.

The WCCAA would like to take this opportunity to offer a few ideas on behalf of our elderly citizens which we are respectfully requesting the Senate Special Committee on Aging to give careful consideration in your future deliberations on the design of programs and upon the appropriations and expenditures of funding targeted to the needs of the elderly. Others have offered or will offer testimony today from a wide spectrum of vantage points. We will limit our comments to essentially three areas of need for our elderly citizens—housing, transportation, and legal services.

Housing: During the conduct of our winterization/weatherization program geared toward energy conservation and thus home heating cost reductions for low income and elderly citizens, our agency has become increasingly aware of the inhumane and dangerous conditions in which some of our elderly citizens and homeowners are forced to exist. Homes that were once the pride and joy of a growing family are now full of hazardous situations and many are identified as containing major housing code deficiencies. In 1975, according to Sioux City's housing assistance plan, there were 4,642 low-income households in substandard housing; 32 percent of these were elderly citizens. From July 1973 through December 31, 1975, the Sioux City Housing Inspection Office has in their random housing code inspections encountered major housing code deficiencies in over 400 homes of senior citizens in Sioux City alone. We expect this type of experience to be representative of the housing situation throughout other towns and the rural areas of Woodbury County.

Subsistence level fixed incomes and the spiraling building costs have worked in combination to severely limit the capabilities of many senior citizens to maintain and to repair their family home. We are recommending the development of a program of home maintenance and home rehabilitation targeted to the

elderly homeowners. At the present time, the Woodbury County Community Action Agency has on file an approved, extremely small, pilot project application with SIMPCO's area agency on aging; but the funding has been held up by the Iowa Commission on Aging. This program calls for a meager $8,850 in Older Americans Act title III funds for materials and essential building improvement contracts targeted for 10 homes owned by elderly citizens in Woodbury County. We have also submitted a similar application for fiscal year 1977 funding in the requested amount of $75,912 to repair and to rehabilitate an estimated 35 elderly homes. This program would be targeted to the structural and building hazards such as dangerous steps and sidewalks, deteriorating plumbing systems, crumbling foundations, faulty heating systems, hazardous electrical systems, as well as insulation, weather stripping, roofing, and physical appearance/structural protective features. The results of this program would have two significant impacts: (1) the elderly owners would enjoy a much improved and safer living condition through the minimization of crippling accidents, much improved comfort and cost, and the avoidance of unnecessary premature institutionalization; and (2) the deteriorating housing in our towns and countrysides would be preserved for a much longer life; we would, in effect, be protecting two valuable American resources—our elderly citizens and our supply of safe, sanitary, and decent housing.

Funding Difficulties in Housing Programs

However, at the present funding levels and under the present match requirements, the housing maintenance rehabilitation programs targeted for the elderly citizens are extremely difficult to fund and to develop. With the competition for scarce funding, our area agency on aging cannot afford to allocate sufficient funds to relatively expensive rehabilitation programs. Secondly, local agencies such as ourselves find it extremely restrictive to generate 10 percent, 25 percent, and 40 percent matching funds. I am suggesting that the Senate special committee give consideration to a revision of the match requirement of title III to exempt this type of program or to develop a separate funding mechanism earmarked for the dual purpose of protecting both our elderly homeowners and our scarce housing resource.

Legal aid: Our neighborhood centers and our outreach staff members as well as other portions of our agency staff continually encounter senior citizens who are intimidated by the current maze of governmental agencies and regulations as well as by the complicated alien economic environment, both of which represent distinct problems to our senior citizens. Not being as well versed as some of the younger citizens in the exercise of their rights of citizenship, the elderly often suffer the pains of abusive and unresponsive governmental bureaucracy and often exploited by the various elements of our economic environment. Effective legal aid services and/or paralegal assistance could be very helpful and productive to the senior citizens in exercising the rights of citizenship through education in the utilization of the judicial system, the exercise of consumer rights, advocacy or ombudsmanship services with respect to governmental agencies in many other areas of supportive assistance. The elderly are fully cognizant of and often infuriated by seemingly unfair treatment but also are unsure of who, what, or how to seek remediation; instead they often seethe in their anger and just throw up their hands in disgust with a world which they helped to create but which has now changed so much and so rapidly as to have left them largely undereducated and largely defenseless.

Recent congressional action in appropriating additional funding for the Legal Services Corp. is one small step toward improvement of the valuable legal aid services *if* the Legal Services Corp. is required to expand the geographic coverage of its service. Two other suggestions for improvement of legal aid service availability would be to increase the Older Americans Act funding and to include legal aid and paralegal assistance in the mandated elements of state and area agency on aging plans and programming.

Transportation: The enhancement of mobility for senior citizens must be pursued. Our elderly citizens, for physical, psychological, and financial reasons, find themselves increasingly unable to utilize the most usual mode of transportation in America—the private automobile—and thereby become increasingly remote from essential medical services, desirable nutritional resources or services, and the essential business and professional communities. This distance from or inaccessibility to reliable, serviceable transportation also minimizes access

to valuable social and recreational contacts which contribute so much to a fuller life for our elderly citizens. Urban situated elderly citizens are not as adversely affected by this need for transportation *if* they can accommodate themselves to the rigid fixed routes and to relatively inaccessible equipment or can afford the relatively expensive paratransit cab facilities. For the urban elderly, even the local existence of the mass transportation and paratransit operations does not represent solutions to the needs to travel for essential medical, nutritional, business/professional, social, or recreational needs. If the urban situated elderly cannot avail themselves of available mass transit/paratransit operations, the transportation problems of the rural elderly are astronomical. The facts of low-density population and relatively long distances contribute to make rural oriented transportation virtually nonexistent. Elderly, both in the urban and rural environments, are forced into a relatively empty life existing without access to means of fulfilling basic human needs or are forced to become increasingly dependent upon family, friends, neighbors, etc., to assist them. Forced dependency is extremely distasteful to the proud elderly citizen of this area.

Transportation for Elderly Still Inadequate

In this area, Ida County, Cherokee County, Woodbury County, and Monona County have initiated efforts to overcome some of the transportation inaccessibility faced by the elderly; but much more needs to be done. The State of Iowa, local county boards of supervisors, the area agency on aging, and others, have all contributed to the initiation of rural transportation systems targeted primarily for the elderly in each of the above counties. However, Cherokee County has but one vehicle for a large rural county; Ida County has recently acquired one vehicle to serve the entire Ida County. Woodbury County has had until recently only one vehicle to service the transportation needs of an area encompassing over 17,000 persons over 60 years of age, 5,000 of which are economically disadvantaged. Monona County just recently acquired the availability of one vehicle for a county which contains 2,000 elderly citizens, half of which are below governmental poverty standards.

WCCAA has currently in the offices of the Federal Highway Administration in Washington, D.C., an application for a rural highway public transportation demonstration program of a 2-year pilot project nature with the goal of establishing a comprehensive, integrated transportation system of a regional nature. If funded, the rural transportation program would allow the region to demonstrate to ourselves, to the local communities, and to the Federal Government what can and must be done to enhance the mobility of our senior citizens.

The problems of mobility and transportation service for our senior citizens has not received enough attention and enough funding in the past. Present funding by the Older Americans Act, title III, is about to terminate because of unreasonable expectations that any project initiated by the Older Americans Act funding mechanism should be self-supporting after 3 years. Where has public mass transportation in heavily populated centers become self-sufficient? The elderly could also benefit much more by door-to-door or demand-response systems, but these services are extremely costly to perform because of the time, the mileage factors, and the capital equipment needs to cover a large scarcely populated rural area. Even the rural highway public transportation demonstration program which includes 100 percent funding for capital equipment and partial funding for operational expenses contains a requirement that the project be self-sufficient after 2 years. The local political communities could absorb the costs of these services, but they cannot be expected to do so entirely alone as they would have to rely upon property taxation (which would increase the burden upon the elderly homeowner) or upon other relatively scarce resources. It should be increasingly apparent to Congress and to the administration that units of local government are not fat with underutilized financial resources. Congress and the administration are going to have to realize that rural public transportation operational subsidies are going to be essential to the future expansion of and continuation of rural public transportation systems; Federal rural public transit operational subsidies are going to have to become part and parcel of our national transportation program.

WCCAA welcomes the opportunity to be of service to our elderly citizens and to contribute what resources we can mobilize toward the goals of helping our older Americans lead a much more productive and much fuller life for a longer period of time. We sincerely hope that our comments here today will have

contributed, even in some small way, to the improvement of that golden age life.

Senator CLARK. Thank you very much.

One more statement and then we will close.

STATEMENT OF MARY C. COLLETTI, YOUR, INC., WEBSTER CITY, IOWA

Ms. COLLETTI. I am Mary Colletti and I work for the community action agency. I am the new projects developer; I am also the public relations officer. I would just like to thank the people in Washington for their insight and foresight as related to public relations in CAA work. I have lots of gripes, but the one thing I am happy about is that they are recognizing it is very important to have a public relations program for the community action agencies. Since last year when we started, our public relations program has increased two times and are serving approximately 150 clients per month. We are now serving almost 400 a month just because the word is out. Now I wish we could have enough funds to be able to support our programs and have a little more administration for such things.

Senator CLARK. Thank you.

I think we are going to have one last statement here.

STATEMENT OF MYRTLE SIEVERTIEU, IDA GROVE, IOWA

Mrs. SIEVERTIEU. I am Mrs. Myrtle Sievertieu. I would like to bring something forward that I have been talking about for 7 years—ever since I moved from the farm to Ida Grove. My biggest problem, and it is a big problem for a lot of other people, is that I have seen my elderly neighbors over 65 years old—we put in applications sometimes to Grace Montgomery at our center where we are expected to get help with our yard work and snow shoveling in the wintertime. It is absolutely impossible to get dependable help to shovel our walks and porches and get us out of the house, after a heavy snowfall especially. After a very light snowfall maybe we can get a neighbor boy or someone to shovel and sweep, or maybe it is something that we can do ourselves.

When we have a heavy snowfall and we really need help, there is no one available. I have called Grace Montgomery on various occasions. I have been fairly successful in getting help to mow the yard or to rake leaves, but when it comes to shoveling snow it is just an impossible situation. School children can't come until the afternoon. They promise you faithfully that after school they will come and clean your walk, but when there is a heavy snowfall it just lays there and lays there until you go out and dig it off yourself. By that time it is an icy, impossible mess to clean off.

We have some wonderful facilities in this town and I am very proud of my town. I will back it 100 percent in every way I can, but when it comes to helping the elderly people clean their sidewalks in the wintertime, it is no good.

Senator CLARK. Thank you.

Mrs. SIEVERTIEU. I hate to say it, but I wish we could get some dependable snow shoveling here in the wintertime.

Thank you.

Senator CLARK. Thank you very much. It is hard to imagine snow in weather like this.

We are going to close now. I wonder if Congressman Bedell might have any further comments.

Representative BEDELL. I just want to thank you and the staff again for coming out here to Ida Grove.

Senator CLARK. Thank you.

With that we close our hearings. Thank you very much for coming.

[Whereupon, at 4:32 p.m., the hearing was recessed.]

APPENDIXES

Appendix 1

LETTERS SUBMITTED BY THEODORE E. MURPHY [1]

ITEM 1. LETTER FROM THEODORE E. MURPHY TO L. D. ELWELL, ASSISTANT ADMINISTRATOR, MULTIPLE FAMILY HOUSING, FmHA, WASHINGTON, D.C., DATED APRIL 14, 1976

DEAR MR. ELWELL: You may recall that I visited with you at the Northwest Iowa Community Conference sponsored by Representative Berk Bedell, and on November 21, 1975, wrote a letter to you regarding rent supplements under section 8.

The 12 housing units for the elderly with limited incomes was completed on January 15, 1976, and was completely occupied in less than 1 week. It appears to be operating very satisfactorily.

Now our housing corporation group have requested FmHA to finance the development of 20 additional units. Our housing survey of Ida Grove of October 1975, and the list of applicants we already have for the additional units, indicates there will be no problem in filling up the units as soon as available.

Again we have the problem I mentioned in my conversation with you in October 1975 and in my letter of November 21, 1975, "We need assistance under section for rent supplements for a number of our prospective tenants."

In your reply to my letter to your office, you indicated there was much work being done about this matter with HUD and FmHA holding meetings and that a satisfactory solution could be worked out by March 1976.

We are much concerned and I would welcome a letter from your office bringing us up to date on this matter. Our board holds monthly meetings and I would like to present your reply to them.

Representative Bedell and his wife will be visiting in my home on April 24 and I will include this subject in our conversations.

Yours respectfully,

THEODORE E. MURPHY.

ITEM 2. LETTER FROM L. D. ELWELL TO THEODORE MURPHY, DATED MAY 12, 1976

DEAR MAYOR MURPHY: This will reply to your letter concerning the present status of the rental assistance payment program for low-income prospective tenants.

Our letter of December 2, 1975, indicated that we were working on the tandem approach of utilizing the Department of Housing and Urban Development's (HUD) section 8 and the Farmers Home Administration's (FmHA) section 515 rural rental loan authorization.

The FmHA and HUD representatives have been working together to develop a memorandum of understanding which proposes to eliminate the processing of dual applications to both HUD and FmHA to obtain section 8 rental assistance payments on new construction to be financed by FmHA. It is contemplated that FmHA will handle the complete application and processing on all new construction projects financed by FmHA section 515 loans. As the situation now exists, FmHA can consider your loan application for a section 515 loan to be operated

[1] See statement, p. 205.

under plan II with interest credits the same as your previous project; however, when the proposed memorandum of understanding between HUD and FmHA is reached, there would be a possibility that the proposed project could be developed utilizing the tandem approach which may provide the rental assistance payment program you require to meet the needs of the low-income families in your community.

We suggest you contact our Iowa State director, Mr. Robert R. Pim, room 873, Federal Building, 210 Walnut, Des Moines, Iowa 50309, telephone 515–284–4121, who will be glad to keep you informed of changes within our rural rental housing program.

Sincerely,

L. D. ELWELL.

ITEM 3. LETTER FROM THEODORE E. MURPHY TO ROBERT R. PIM, IOWA STATE DIRECTOR, FARMERS HOME ADMINISTRATION, DES MOINES, IOWA, DATED AUGUST 6, 1976

DEAR MR. PIM: I am enclosing a copy of a letter I received from Mr. L. D. Elwell some months ago, relative to the rental assistance payment program.

In January 1976 the Ida Grove Low-Rent Housing Corp. completed 12 units of one- and two-bedroom apartments. They were filled within a week. No rental assistance was available from HUD or FmHA, so four of our tenants had to receive rental assistance from relatives.

Now we have been approved for 24 one bedroom units and we expect to have a letting on August 31. We know from the applicants we have on file that a number of them will need the rental assistance payment program for low-income tenants.

We have contacted HUD a number of times through the Siouxland Interstate Metropolitan Planning Council (SIMPCO) and the latest information is that we cannot qualify for low-rent assistance under section 8. If we are to receive any assistance for the low-income elderly in the Ida Grove area it will have to be through Farmers Home Administration program, so we urge you to give the fullest consideration to this matter.

If at all possible we would like to have a reply from your office before August 17 because on that date Senator Clark and his staff will hold a meeting in Ida Grove relative to the problems of elderly people, especially in the fields of housing and transportation.

Sincerely,

THEODORE E. MURPHY.

ITEM 4. LETTER FROM ROBERT R. PIM TO THEODORE MURPHY, DATED AUGUST 10, 1976

DEAR MAYOR MURPHY: In response to your inquiry dated August 6, 1976, it is our understanding that the memorandum of understanding which was referred to in Mr. Elwell's letter of May 12 has been signed by both agencies, and the implementation of the understanding now is contingent on both agencies issuing operating instructions to their field offices. As of this time we have not received any such instructions, and therefore do not have rent subsidy assistance available except as it is currently available through Housing and Urban Development section 8 program.

We anticipate that this program should be operational sometime in the near future, and our county offices will be informed as soon as it is available.

If you have any further questions, please feel free to contact us.

Sincerely,

R. R. PIM.

Appendix 2

AID CENTER REPORT, SUBMITTED BY JEAN SANDMAN [1]

AID CENTER: SURVEY OF NEEDS OF RURAL SENIOR CITIZENS IN RURAL AREAS OF NORTHWEST IOWA

The form, "Survey of Needs of Rural Senior Citizens" was given to 119 rural residents, age 60 or older, who were attending congregate meals in the towns of Cherokee, Onawa, and LeMars, and visting the Siouxland Senior Center in Sioux City.

Service categories in the survey, as well as individual service items, were adapted from the United Way of America Service Identification System (UWASIS).

Participants were requested to check service items they felt important to senior citizens, indicating either "needed," "adequate," "available," or a degree of need. Participants were encouraged to make written comments on felt needs and to note other concerns of rural older citizens. These comments are attached to a summary of survey results. No copies of the survey were signed.

From answers recorded on the survey, one can conclude rural seniors feel their greatest needs are in the areas of income maintenance, housing, transportation, and health.

Income maintenance.—Of those completing the survey, 51 percent indicated they needed increased coverage in medicare and 49 percent expressed a need for larger social security allotments. An additional 20 percent requested more coverage in survivor's insurance as well as 20 percent expressed need for emergency financial assistance service.

Housing services.—Low to moderate cost housing was checked as a need by 54 percent of the respondents while 14 percent indicated a need for assistance in housing search. Public housing units were seen as a need by 22 percent and rent supplements by 21 percent.

Low-cost transportation for older persons.—Fifty percent of persons completing the survey saw transportation within the home community as a need. Transportation to neighboring communities was indicated "needed" by 32 percent and to special functions and events by 37 percent.

Health.—Health care ranks high as a concern of older citizens. Twenty-four percent requested more public health nursing, 18 percent called for community clinics, 28 percent asked for home health care, and 24 percent indicated adequate nursing home facilities are needed. Physicians were checked as needed by 47 percent and 30 percent asked for rehabilitation for persons afflicted by crippling diseases.

Other priorities.—Other priorities include 31 percent who stated legal aid is a need, 25 percent who checked opportunities for free or inexpensive clothing as a need, and 27 percent who marked jobs for older persons as a need.

Sidelights.—One item of interest to the respondents was congregate meals which commanded a 60 percent response. Twenty-eight percent indicated more sites are needed, 4 percent requested cheaper meals, and 34 percent stated congregate meals are adequate.

Interest of senior citizens in community problems became evident through the questionnaire with 24 percent expressing need for drug and alcohol prevention and treatment and 25 percent marking a need for pollution and litter control.

Conclusions.—The survey was made as a sampling of needs of rural senior citizens in the Siouxland area. Though an unscientific and inconclusive study, the survey indicates that older persons in northwest Iowa are aware of their needs and quite ready to express their opinions. Planning for older citizens re-

[1] See statement, p. 212.

quires their involvement and a respect for their expression of needs, solutions, and methods.

(119 persons interviewed in Woodbury, Monona, Plymouth, and Cherokee Counties, in the State of Iowa)

Question: What do you feel is most needed as a service for *persons aged 60 and over* in your northwest Iowa community—a need that presently is not met?
Question: Check one or more categories which apply. *Star* those items which you feel are priority needs.

1. Employment services for persons 60 years and older:

Help in finding a job: 18—15% needed; 3—2% available.
Training for jobs: 13—11% needed; 1—5% available.
Jobs for older persons: 32—27% needed; 3—2% available.

2. Income maintenance services:

Health insurance (Medicare): 61—51% more coverage; 11—9% adequate.
Social Security: 59—49% larger allotments; 12—10% adequate.
Survivor's insurance: 24—20% more coverage; 6—5% adequate.
SSI (Supplementary Income): 15—13% more persons covered; 8—7% adequate.
Emergency financial assistance: 24—20% needed; 6—5% adequate.
Special benefits for persons aged 72 and older: 48—40% needed; 8—7% adequate.

3. Consumer protection and safety services:

Consumer Education, classes or individual: 7—6% needed; 6—5% available.
Merchandise quality control: 22—18% needed; 3—2% adequate.
Service to handle consumer complaints: 21—18% needed; 5—4% adequate.

4. Food and nutrition services:

Food stamp program: 10—8% more persons eligible; 18—15% adequate.
Congregate meals: 33—28% more sites needed; 5—4% cheaper meals; 34—28% adequate.
Meals on wheels: 18—15% needed in area; 7—6% cheaper meals; 17—14% adequate.

5. Clothing and apparel services: Opportunities for free or inexpensive clothing 30—25% needed; 16—13% adequate.

6. Housing services:

Low to moderate-cost housing: 64—54% needed; 3—2% available.
Assistance in housing search: 17—14% needed; 3—2% available.
Rent supplements: 25—21% needed; 3—2% available.
Public housing units: 26—22% needed; 2—1% available.

7. Low-cost transportation for older persons:

Within the home community: 60—50% needed; 9—8% adequate.
To neighboring communities: 38—32% needed; 9—8% adequate.
To special functions and events: 44—37% needed; 8—7% adequate.

8. Protection, justice, and safety:

Free or low-cost legal aid: 37—31% needed; 2—1% available.
Adequate police and fire protection: 24—20% needed; 11—9% available.
Public disaster services: 14—12% needed; 8—7% available.

9. Environmental protection:

Pollution—littering control: 30—25% needed; 4—3% adequate.
Environmental conservation: 2—1% needed; 5—4% adequate.
Historical conservation—buildings, etc.: 11—9% needed; 6—5% adequate.

10. Community health:

Communicable disease control: 17—14% needed; 8—7% adequate.
Public health nursing: 29—24% needed; 9—8% adequate.
Public health sanitation: 12—10% needed; 9—8% adequate.
Health education: 10—8% needed; 8—7% adequate.
Community clinics: 21—18% needed; 4—3% adequate.
Home health care: 33—28% needed; 4—3% adequate.
Adequate nursing home facilities: 29—24% needed; 7—6% adequate.

11. Medical care services:
Hospitals: 16—13% needed; 14—12% adequate.
Emergency care: 23—19% needed; 8—7% adequate.
Physicians: 56—47% needed; 6—5% adequate.

12. Mental health and mental retardation:
Psychiatric clinics: 6—5% needed; 7—6% available.
Alcoholism prevention and treatment: 12—10% needed; 10—8% available.
Drug abuse prevention and treatment: 17—14% needed; 2—1% available.
Services, treatment and care of mentally retarded: 14—12% needed; 6—5% adequate.

13. Rehabilitation:
(For stroke patients, crippling diseases): 36—30% needed; 2—1% available.

14. Optimal personal and social adjustment services:
Chore service: 10—8% needed; 5—4% adequate.
Homemaker service: 15—13% needed; 7—6% adequate.
Friendly visiting: 19—16% needed; 7—6% adequate.
Recreation—social groups/senior centers: 18—15% needed; 9—8% adequate.
Cultural opportunities: 4—3% needed; 7—6% adequate.
Spiritual services: 6—5% needed; 10—8% adequate.
Equal opportunity, civil rights: 6—5% needed; 10—8% adequate.

(Cherokee County—48 respondents)

Income maintenance:
1. Right for persons to marry without losing pension.
2. Persons can get married without losing pension.
3. Cheaper rates—hospitals and doctors.
4. Right to give your children property while you're living without gift tax.
5. Trouble getting medicare—takes forever.
6. Pension for war widows should not be cut when social security is increased. These widows sometimes have minimum social security and it is difficult for them to make both ends meet.
7. Stop cutting pensions of widows or veterans of WWI every time social security raises. Instead they need a raise.

Food and nutrition:
1. Need better meals (congregate).
2. Need better meals (congregate).
3. Deep investigation of present set-up. Make it a State law that all names of persons on welfare and those getting food stamps and those getting ADC be published monthly. Taxpayers have a right to know where their money is being spent and who is getting it (food stamp program).
4. Inequitable, unfair (food stamp program).
5. Not always fair (food stamp program).

Housing:
1. Need low-rent housing by HUD.
2. Public housing units—better built buildings.

Transportation:
1. Cab service needed in Cherokee.
2. We have excellent minibus service.

Personal and social adjustment: More service is needed to supply entertainment to those in nursing homes.

(Plymouth County—34 respondents)

Income maintenance:
1. We need a larger estate tax exemption.
2. We need a larger estate tax exemption.
3. Lower rates on dental and eye care.
4. There should be an overhaul of the inheritance tax. It is too severe for the little guy.
5. There should be an overhaul of the inheritance tax. It is too severe for the little guy.
6. Insurance for those who pick up old people in their own cars.

Food and nutrition:

1. Too much is spent and too many are not eligible (food stamp program).
2. No more persons eligible (food stamp program).
3. Overdone (food stamp program).

Housing:

1. Needed bad (low to moderate cost housing).
2. Bad. We need this (low to moderate cost housing).

Transportation:

1. County wide transportation needed.
2. Transfer rate for a minibus.

(Monona County—30 respondents)

Income maintenance: Raise the $60,000 deductible in inheritance tax.

Food and nutrition:

1. A place to meet (congregate meals).
2. Need new meeting place (congregate meals).
3. We need a place to meet of our own where there is no stairs to go up and down.

Transportation: Ride to doctors, et cetera.

Personal and social adjustment: More good fishing areas for older people.

(Woodbury County—7 respondents)

Transportation: Low-cost transportation for older persons—badly needed.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form reads as follows:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing in Ida Grove, Iowa, on August 17, 1976, on "The Nation's Rural Elderly," I would have said:

The following replies were received:

MARTHA AMENT, MARCUS, IOWA

We in Cherokee County need more help in transportation. We have only one 10-passenger bus for the whole county. No other public transportation is available in the county, and that includes the city of Cherokee—plus eight other towns.

Why penalize the low-income persons when the social security benefits are raised a small percentage? All other help or supplementary income is cut back until their gain is nil.

I certainly enjoyed the meeting at Ida Grove. I have worked with the elderly for many years as volunteer, and 5 years with OEO. I can understand their problems.

MAY ANDERSON, SIOUX CITY, IOWA

I would have inquired concerning the funding of home-delivered meals under other than title VII as compared to nutrition funding under title VII.

GEORGE W. KENNEDY, IDA GROVE, IOWA

I would like to know what is being done about national health care for the population as a whole.

I speak of population as a whole, although I am a senior citizen. I think some other groups of different ages are as important as mine.

BETTY MAGUIRE, IDA GROVE, IOWA

I am a public health nurse who has functioned entirely on a county-fund payment for 2 years. Our budget has been protected this past year because it was above the 9-percent level. We really could use some sharing money to support our local health agency. There has been talk in other counties of dropping or cutting the service. I hope you can appreciate this disservice to the elderly. I can function as a nurse and earn a living without the employment. But will the elderly be helped and stay as healthy without the public nurses' services? Please try to get some tax dollar money designated to help support county-funded nurses. I don't feel the nurses that help should have to be hassled by local politics.

MARIE RABE, ONAWA, IOWA

Here in Onawa there is a lack of doctors. We do have three, but two of them are past 60 years old. All the surrounding towns depend on these doctors: Turin, Moorhead, Soldier, Ute, Little Sioux, Pisgah, Whiting, Solix, Sloan, and Blencoe—to name a few towns without a doctor. What we need is younger doctors to fill in and finally take the place of the ones we now have.

Transportation is another problem to older citizens.

To get any repair job done—even a fallen tree off the electrical wires in Onawa took several calls to the city. The tree had fallen on my roof during a storm. It took more than 2 weeks before anyone came to even look.

To get a senior citizen center in Onawa has been worse than pulling teeth. Until we even get the city council to realize that we definitely need a center—we were pushed out of the former multipurpose center over a year ago. Now we have our congregate meal program in the Methodist Church. We certainly are handicapped. Why?

JANE ROLOFF, AMES, IOWA

The North Central Regional Center for Rural Development located at Iowa State University is involved in a project to summarize and synthesize information and research concerning the rural elderly. We would appreciate a copy of the hearing as soon as it is available.

MARK K. SUZUMOTO, REMSEN, IOWA

In essence, what all the speakers asked for were more options, although there was talk of housing as the primary need, health care, and title XX programs as tantamount needs. What the government is or should be attempting is a housing program that would provide for everyday needs as well as the unexpected needs. The system is only as good as its weakest link—the government can provide adequate I & R service and dial-a-ride programs, but if inadequate income prevents the aging from owning a telephone, the programs become feathers in some bureaucrat's hat and nothing more.

The Older Americans Act in its entirety is exceptional legislation. Why are the programs administrated so strangely? The budget appropriators have the compassion of social darwinists, waiting through financial attrition for the "least fit" to fall by the wayside. Goodloe said some hundred years ago an appropriate phrase for today, "Millions for defense but not one cent for tribute." The "millions" should be changed to $104.5 billions, and the "tribute" interpreted as programs created to show our Nation's gratitude to those who helped build it.

To believe that our industrial-military complex will bow down its head "in tribute" to our Nation's aging is a pipe dream. What is perhaps a feasible national plan is to place a focus on education at all levels and in all segments of society (age, income, urban, rural). We must educate to restore the dignity of growing old—the "Pepsi generation" mentality of today is the perpetrator of many subtle crimes against the aging; it makes growing old kin to growing ugly. If we do not begin to educate our young about aging today we will continue toward further segregating our people by age and the financial burden will continue to grow. We need to create options for the elderly by trying to make their environment less hostile until this horrendous task is accomplished. I suggest that the government take a wholistic approach by adequately funding and implementing all titles under the Older Americans Act.

BEULAH E. WEBB, SIOUX CITY, IOWA

At present, everything is geared to youth.

Not too far into the future northwest Iowa will have more senior centers.

Revenue sharing has been distributed in various projects, but Sioux City seniors have not been able to receive one dime.

Since the hearing on August 17, we have been in the dark. The money for training never got to the grassroots, where the need is, but reaches workers, more personnel in homemaker services, et cetera. Yet, I know that money has been allocated. I regret to say that the majority of the elderly do not know anything concerning what region they are in or how many States are in their region. Please try, in your own way, to reach the people. My time is running out. I am 81 years of age with 50 years of service to my community. It is sad when a few people exploit the ones who need the services for their own selfishness. Thanks for coming. You and your staff were most gracious.

THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 3—GRETNA, NEBR.

AUGUST 17, 1976

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The Nation's Rural Elderly:
Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove. Iowa, August 17, 1976.
Part 5. Sioux Falls. S. Dak., August 18, 1976.
Part 6. Rockford. Iowa. August 18, 1976.
Part 7. Denver, Colo., March 23, 1977.

(Additional hearings anticipated but not scheduled at time of this printing)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

THE NATION'S RURAL ELDERLY

TUESDAY, AUGUST 17, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Gretna, Nebr.

The committee met at 10 a.m., pursuant to notice, in the Municipal Building, 202 North McKenna, Gretna, Nebr., Hon. Dick Clark presiding.

Present: Senator Clark and Representative John McCollister.

Also present: William E. Oriol, staff director; Kathleen M. Deignan, professional staff member; David Harf, legislative assistant to Senator Clark; John Guy Miller, minority staff director; and Alison Case, assistant clerk.

OPENING STATEMENT BY SENATOR DICK CLARK, PRESIDING

Senator CLARK. Good morning. It is good to be with you in Gretna for this official hearing of the U.S. Senate Special Committee on Aging. We have several scheduled witnesses and then we will try to hear from people in the audience. A stenographer will record all that is said, and we will issue a printed transcript of the proceedings.

Our subject at this and five other hearings this week is "The Nation's Rural Elderly." In other words, we are emphasizing in these hearings the specific problems that people have in rural areas. We know that many of the programs are designed, in fact, for metropolitan areas. The metropolitan areas certainly need programs for the elderly as well; but the particular emphasis of these hearings will be on the problems faced by people who live in small towns, by people who live in the countryside, and what we can do to help them.

I first suggested these hearings a little more than a year ago to Senator Frank Church, who is the chairman of the Senate Special Committee on Aging, and he agreed. We held some meetings, in fact, last April in Washington, and now we are holding them here in the Midwest so we could come out to talk to people who are affected by the Federal programs that have been instituted. I want to make my statement very brief, and call on Congressman McCollister for a statement as well, and then we will have the witnesses. I want to make three or four major points before we start with these hearings.

First of all, the prime objective of these hearings is to determine the responsiveness and the practical help provided to the rural elderly by such programs as the Older Americans Act, medicare, public housing, transportation assistance—how and in what way people in small towns can ride minibuses and other kinds of buses.

Second, there is a real need for this evaluation because, in our view, we failed to do what we said we were going to do in the 1971 White House Conference on Aging. We have not yet arrived at a national policy on aging, particularly on rural areas and/or rural issues. A part of the lag has been caused, I think, by the lack of leadership that we have had in Government in these programs. Another part has been caused by economic uncertainties related to inflation and unemployment. Nationally about 8 million people, or about 28 percent of all the people over 60 years old, live in rural areas—communities like this one and smaller communities—but in some States the percentage of older people who live in rural areas rises to 50 percent or more.

For example, here in the State of Nebraska about 45 percent of all people over 60 years old live in small towns or live in rural areas. In Iowa, we have almost exactly the same percentage—almost half the people over 60 years old live in rural areas, and yet much more than half the total population lives in metropolitan areas. There are major differences among the States and even though each of our hearings has a rural theme, we find that there are special circumstances in each locale that call for close inspection.

Here in Nebraska we will be especially concerned about the delivery of services to the widely scattered rural elderly and the effects of the increasing isolation of the elderly in small towns and communities as they leave the farms and as many younger workers leave to take jobs in other areas. We will be hearing from a number of individuals from all across the State of Nebraska who have confronted some of these problems firsthand.

Another issue on which I hope we can have some discussion today is the financial ability of rural county governments to help pay for services funded by the Older Americans Act, as well as other programs of the Federal Government meant to serve the elderly. I think we often find that in many rural areas local governments are very much in support of services, but find the financial burden imposed on them in meeting the matching requirements for participation in Federal programs particularly difficult.

Finally, I would like to say that in the Older Americans Act program and in all the others, the rural elderly must feel that no one is dictating to them. The progress that we are making in aging is due in no small part to the initiatives and determination of older persons who are making things happen. The Federal share of their effort, if one is needed, ought to be part of the solution, and not part of the problem.

Now I would like to ask Congressman McCollister if he has a statement.

STATEMENT OF HON. JOHN Y. McCOLLISTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Representative McCollister. Senator Clark, thank you. Thank you for two reasons: Thank you for coming to Nebraska where a large proportion of our population is in the senior citizen category and thus have a very special meaning to us, and because so many of our senior citizens do live in rural communities; and to thank you for in-

vit'ng me, a member of the other body, to participate in these deliberations today. I am grateful, too, for your generous invitation.

I think the policy of the Federal Government toward the rural elderly can only be characterized as one of benign neglect. The Federal Government has a great number of programs for elderly people in our metropolitan centers, but as I go around this State I discover that there are very few programs that are able to be delivered to the people in our smaller rural communities. Thus, these Senate hearings today can serve as a real basis for beginning to formulate policy that will change that neglect of so many of our rural senior citizens.

I think we need many programs designed to address those in rural communities—stronger nutrition programs and transportation programs. I understand in Council Bluffs this afternoon you have some hearings addressed to that subject, as well as other places around Iowa. There are a great many problems that are affecting rural senior citizens.

I say, again, I am grateful to you for your being here and for your invitation to allow me to participate. I am going to be very brief because I think the real meat of what happens here today comes from our panels and from those who will be participating.

Thank you.

Senator CLARK. Thank you very much, Congressman.

Now we are going to hear from a group of persons who are very well qualified to speak on this subject. I think we are going to go in the order in which they are printed here. First, Norman Magnusson, who is chairman of the board of governors, eastern Nebraska Human Services Agency; then we are going to hear from Evelyn Runyon, ombudsman, eastern Nebraska Office on Aging in Omaha; then Pete Lakers of Columbus, Nebr.; Glen Soukup, executive director, Nebraska Commission on Aging in Lincoln; and Marge Stine, director of Senior Citizens Industries, Inc., in Grand Island, Nebr.

I think we have asked the panelists, if they have an opening statement, to limit their remarks to about 5 minutes, and then we are just going to have discussion back and forth for a while. This panel then will probably end about 5 minutes till 11.

So you proceed in any way you think appropriate, Mr. Magnusson.

STATEMENT OF NORMAN A. MAGNUSSON, BELLEVUE, NEBR., CHAIRMAN, BOARD OF GOVERNORS, EASTERN NEBRASKA HUMAN SERVICES AGENCY

Mr. MAGNUSSON. Senator, first I want to sincerely thank you and your staff. It is very heartening to us in the Midwest to know that we have people in Congress and the Senate who are interested enough in our local problems to come and meet with us on our own grounds. So welcome to Sarpy County, and this is from all the citizens of Sarpy County. We are very happy to have you here.

I think I am known to most of you. In case somebody doesn't know who I am, I am Norman Magnusson. I am on the Sarpy Board of County Commissioners and I serve on several other boards throughout the community. I am also chairman of the Eastern Nebraska Human Services Agency Governing Board.

I am testifying today in regard to the needs and wants, or at least as I regard them, of our senior citizens in the rural area. I will start by saying that some people in the East cannot understand we people in the Midwest. We are a different type of people. We are proud of our heritage, we are proud of what we have accomplished, and we like our home—this is where we like to be.

In Sarpy County I think the board is doing a pretty good job, as far as funds go, of what we are doing for senior citizens. At the present time we have homemaker services, specialized transportation services—that is the one that, as far as I am concerned, has been a dismal failure. It is one of the higher cost ones, but it is one of the most needed. There will be some people speaking a little bit more on that. I just wanted to get in what my concerns are.

Administrative Costs Erode Funds

I am chairman of the MAPA. In case you don't know what MAPA is, it stands for Metropolitan Area Planning Agency, of the Urban Affairs Committee. Lately we have been getting all kinds of requests for grants in transportation for the elderly from various organizations. At our last meeting I requested that we hold a meeting so we can try to coordinate these services under one head. I don't like to see money going for administration when it should be going for services.

The way the transportation system is fragmented at the present time, this is what we are doing. We are spending money for administration that should be going for furnishing buses or transportation for you people to get to your doctors, to get to your church, to get to any place you want to go in the community. If it is necessary, I will try to get legislation introduced at the next session of the unicameral to take care of that, at least in the State of Nebraska, and hopefully we can get some legislation passed in Congress that will make it national instead of just one State.

We have the ombudsman service where, if you feel you have a complaint, you can go to one of the youngest ladies that I know of in spirit, not in years. She is one of my favorite people. We will hear from her later.

Information and referral services, recreation services, foster grandparents and, beginning in September, the senior companion program, retired senior volunteer program, family services, counseling services, health maintenance clinics: These are other areas that, due to the cooperation of our visiting nursing association, I cannot speak highly enough of. They have done wonders in Sarpy County since we have had them.

All of our nutrition sites—we do have a health maintenance clinic at the present time and this is not just for senior citizens. We, at one time, thought just of senior citizens but, realizing the need for this service for everybody, opened it to everybody. I hope you use it, because the service is there.

Then there are some special needs such as medical services. The older residents have difficulty in maintaining their health due to the difficulty to get periodic medical services. We hope that these health maintenance clinics that are on nutrition sites can overcome part of

that problem. If we can't, write me or call me up. We will see what we can do about it.

Transportation—I spoke about that. This is the most serious thing that we have. A lot of you have your own cars, I know, but there are also many that do not. I think you are entitled to some of the things in life that you can't get unless you can get there. I am very prone to go to church myself. The fact is, when my minister is gone, there are several other churches around and I fill them up. So church is important to me, and I hope it is to you. I hope that we can one day give you transportation so that you can go to the church of your choice on Sunday.

Legal services is another program that we so far have not been able to get off the ground.

We talk about isolation and people in rural areas, or about our children moving away. Mine have been gone for a good many years. Friends are dying off. I am afraid to look at the obituary column any more, I might find my own name there some morning. I don't have the philosophy that some people do. I don't believe in a rural area with high-rise apartments or housing for senior citizens. I still have the old kind of philosophy, "Be it ever so humble, there's no place like home." As far as I am concerned, I think that the broad effort should be made to keep you people in your own homes as much as possible and also to see that the home is taken care of, that it is kept up so it is a decent place to live, and that you have transportation to go from that home to the various activities that are already outlined.

Visiting Nurse Program Economical

Now I know this is a departure from what some people believe in. One reason we got visiting nurses is so that we could keep people out of rest homes, nursing homes, and hospitals. Last year alone the home nursing program saved Sarpy County taxpayers about $170,000—at a total cost to the county of a little over $60,000—by having the nurses go to your home, visit with you, take care of you there, and keeping you out of these costly hospital rooms and nursing homes. The most important part of all this program is that it keeps you home with your loved ones where you belong.

You are an independent people, and you should be. You should be proud of your heritage and proud of what you have accomplished in this great country of ours. It is people like you who have made this country what it is today, and the younger generation growing up can learn a great deal from you—if they just will. I think it is wrong to put your talents on the shelf and say there is no place in society for you.

Limited county revenues—yes, our revenues are limited by statute. We have a statutory limit of 14.28 mills. This is as high as the county board can go. Fortunately, we have a board in Sarpy County that feels human services are important, and I will tell you how important they think they are. The total request we had this year would have called for a budget of a little over 17 mills. We have whittled it down to 14.28. Did we whittle down human services? No, we did not, We added $5,000 to the visiting nurses budget. Senior citizens was a little over $7,000 last year; this year it is a little over $36,000.

I am told I am running over my time. I could talk all day long. Folks, this is the way I feel. This is what I think we should be doing for you.

At this time it gives me a great deal of pleasure to introduce this young lady I spoke about, Evelyn Runyon, who knows a bit more about your problems than I do, because she is your ombudsman—she is the one that takes your complaints.

Evelyn.

STATEMENT OF EVELYN RUNYON, OMBUDSMAN, EASTERN NEBRASKA OFFICE ON AGING, OMAHA, NEBR.

Mrs. RUNYON. Thank you very much, Mr. Magnusson.

Senator Clark, and all of you, my 78 years have been spent mostly in rural areas, although part of the time I have had to be an urbanite, so I see both sides working in Omaha as I have as ombudsman and hearing from people who have moved into a city to get the conveniences they need as older people. Also, I have made visits to many sites the Eastern Nebraska Office on Aging has in the rural area. I think that probably the best thing I can say is that Mr. Magnusson has just about covered everything that I wanted to cover. I do feel sure of one thing, and that is that the services that an urban agency such as the Eastern Nebraska Office on Aging can offer are altogether appropriate and applicable to those in the rural areas.

RURAL URBAN CITIZENS DIFFER IN FEELINGS

I am thinking particularly, however, that those services must be offered in an entirely different way, perhaps, than we offer them to those in the city. Rural citizens are a little different than urban people in feelings about each other; they have had green spaces between neighbors, and this is very important. This is always pointed up to me when I am called in to help someone who has moved from a rural area into a high-rise in the city.

It is a terrible adjustment because rural people are used to space and friendly neighbors and used to living in a different way than people in a city who live close together and scarcely know their neighbors. I think one of the greatest gifts that a person can have is to have grown up in a rural area. There must be a definite understanding of the mores of the rural area if our services are to be effective.

Health care and nutrition, of course, are prime needs that rural areas have, and Mr. Magnusson has told you about the health maintenance sites. I would like to see those transported into rural areas. I am thinking particularly of a visit I made sometime ago to Valley where I was asked to have some of the nurses come out and do diabetic and glaucoma tests, as well as other uncomplicated laboratory tests that are so needed.

This brings me to something that I thought of yesterday: a man in the little town of Waterloo, very close to here, I think—it is certainly close to Valley—came home from the hospital. He lives alone and the closest relative he has is a niece. He needs a homemaker; he needs hot meals; he needs everything that we have to offer. Fortunately, we were able to supply most all of his needs.

The whole thing back of all of this is the need for transportation. We must in some way find a way to either transport those from rural areas to the services or transport our services to them. This is something that I think will be a problem for people like Mr. Magnusson and other officials who have to know how to put budgets to work.

One of the truest things that I know of is that we want to keep rural people in their own homes, and this means also a handyman service. I think that is very possible in most all communities because there we will find older, skilled craftsmen who can help.

I don't want to run over my time. I could talk until 3 this afternoon, but let me stop here and introduce to you a man who probably is one of Nebraska's greatest humanitarians. I say this because he has been helping people from the Boy Scouts, the Girl Scouts, all the way through to senior citizens. The programs that he has been able to start in Platte County are really just overwhelming. It is an honor, and certainly it is a privilege, for me to introduce Mr. Pete Lakers from Columbus.

Mr. Lakers.

STATEMENT OF PETE LAKERS, COLUMBUS, NEBR.

Mr. LAKERS. Thank you very much.

Senator Clark, Congressman McCollister, and friends, I want to devote my time to the business that is most important. I might say to start with we have all the State problems, and we are trying to solve them. I do want to say something about the handyman service. It is not going full force, but yesterday we got a permanent chairman who is retired from the employment service, and that service is this—for some people, it is a hobby—for instance, one man repairs electric irons at a cheaper cost than what is the regular cost at the service center.

Last summer my wife had a heart attack—she is an invalid, but does very well for herself because her attitude for life is the same as mine. We needed someone, other than the person we had, to take care of our house. Through the handyman service we were able to get a younger person who comes to our house 4 hours a day and she eats with us, the same as we had for 2 months, which is a great deal of help. This girl was in nurses' training.

There is another instance that I can recall where the person needed the service, because of her husband. This was a young lady who came to her house to make supper, stay all night, make breakfast in the morning, and handle her work. We can expand this service in many different fields.

I also want to mention one other thing. Last Tuesday morning at 7 o'clock—we have what we call the helping hand, of different organization representatives, and we discuss the problems and work to solve them. This meets every month and we have accomplished a great deal in that group. Also, every Tuesday, and now every Wednesday, we serve a TV dinner for 60 cents with something to drink, and usually somebody brings a cake.

Well, I covered some high spots here. There are many others that we have. The reason that we are so successful is because we have 341 members in our association of retired people and we follow the old

theory of the Boy Scouts—do a good turn daily, and help your neighbor.

Thank you.

[An additional statement of Mr. Lakers was subsequently received, and follows:]

ADDITIONAL STATEMENT OF PETE W. LAKERS

In addition to what I said at the hearing in Gretna, Nebr., I would like to mention what is available through the American Association of Retired People, which was started 3 years ago here and, as of now, has a membership of 341. We have a handyman program and a halfway house program. We also have other programs in cooperation with our technical college. We had 226 participants in lifetime learning courses as follows: metric system, laymans law, cards-for-fun, printing, defensive driving, mechanics for women, and physical fitness. The courses were for 6 to 20 hours and cost from $6 to $20, enough to defray expenses.

We have bus trips to shows almost weekly; to Omaha and Lincoln at a discount. Also longer tours.

We have groups of four people calling each other four times a day to see if things are all right.

We have a monthly meeting, with an average attendance of 55. We motivate each other and help each other.

Priorities for services are: (1) transportation—we have some, we need more; (2) meals-on-wheels—we should have it in other towns; and (3) handymen or chore people.

We also have complete social security payments at 65.

We are trying to do what we can for senior citizens, but with increased costs, our problems are the same as other counties. Together we must all get more involved and work together.

Senator CLARK. Thank you.

We are going to hear next from Glen Soukup, who is the executive director of the Nebraska Commission on Aging in Lincoln.

STATEMENT OF GLEN SOUKUP, EXECUTIVE DIRECTOR, NEBRASKA COMMISSION ON AGING, LINCOLN, NEBR.

Mr. SOUKUP. Thank you, Dick.

I have heard it called the curse of all old farmers—they always move to town. Curse or not, the trend is obvious. Only the urban areas of Lincoln, Omaha, and south Sioux City have a smaller percentage of elderly residents than the countryside.

But when a farm family retires from the farm, they try to remain as close to the farm life as they can. Generally speaking, the smaller the community, the higher the concentration of elderly citizens. Based on 1970 census figures, only 9 percent of the population of our urban areas are elderly. That percentage almost doubles for communities of 2,500 to 10,000. By the time you reach towns of 1,000 to 2,500, you can anticipate about one-quarter of the population to be 65 or older.

The small rural hamlets don't even show up on the census figures, yet this is where the greatest percentage of elderly reside. These crossroad communities have become retirement centers for yesterday's farmers. They dot the map in out-of-the-way places—communities of 200 or less—with most of the residents on social security.

These could be Nebraska's retirement utopias—the basis of Nebraska's well-known legacy of longevity. In the past 15 months I have signed certificates honoring 138 centenarians. Enough of these men and women have been farm people to convince me that it is the rural way of life that is the basis of their longevity.

But I said these communities could be Nebraska's retirement utopias. Often these small towns are many miles from the nearest doctor and emergency aid. The residents live in constant jeopardy. Even the simplest consumer needs—a grocery store or library—may be in the next town 20 miles to the north. Without adequate public transportation, many are forced to rely on neighbors or their own driving skills—or simply stay home.

Not all the rural communities are slowly fading away. Much has been written about the "rediscovery of rural America." This rediscovery might be viewed more realistically as a flight from the cities. Eager for country living, many city workers commute to nearby rural hamlets "for the kids" or for their own peace of mind.

These migrating workers often maintain their finances in the city while increasing the demand for services in the rural communities. Seniors in these "bedroom communities" often find themselves faced with crushing special assessments for public works improvements.

Federal Programs Discriminatory

Rural areas lack the resources to provide necessary transportation, health, community development, and social services. Far from redressing this lack of resources, Federal programs discriminate against rural areas. Rural counties have a disproportionate share of the Nation's poor, aged, and unskilled. Yet a 1970 Government survey of 242 Federal programs revealed that only 27 percent of Federal outlays reach rural areas.

Rural America has three-fifths of the Nation's bad housing, but gets only one-fifth of all Federal housing subsidies. Rural America is served by just 12 percent of the Nation's doctors and 8 percent of its nurses. Rural counties are home for about one-half of the Nation's poor, yet the efforts of these communities to seek solutions to these problems have been frustrated by spiraling costs, economic recession, and requirements mandated by Federal and State programs.

Federal funding formulas have been heavily weighted in favor of the highly visible urban areas. The rural aged are poor and isolated—out of sight and out of mind.

A good case in point might be title IX of the Older Americans Act which provides employment opportunities for seniors. When a rider was attached to the President's swine flu vaccine bill that provided increased funding for title IX, hopes were raised that such senior employment programs as the handyman service could be extended to more rural areas. Of course, the lion's share of the funding ultimately went to the urban areas.

There are certain diseconomies in providing services to rural areas that have held back the development of needed programs. Without the social services, rural citizens have relied upon themselves and each other. But the world is changing. New problems, such as the crisis in the cost of fuel, have made it increasingly unrealistic to expect that the self-sufficiency of rural people can continue to meet these growing needs.

Much remains to be done. Through the use of paramedical personnel and visiting nurses, medical services can be provided to areas that have gone without. We need to expand volunteer opportunities. We must

stay up to date on technological breakthroughs—such as improved methods of insulating homes, and we must rediscover old methods with promise, such as windpower, if we are to meet the growing needs with our limited resources.

There are a great many skilled and capable seniors living in rural Nebraska. It is frustrating indeed that so many of these competent workers are unemployed while so many crying needs exist in the country. Elderly residents could be doing much to help improve facilities and services in their communities. For example, there are 120 older workers employed under the federally funded green thumb program in Nebraska working on community improvement programs that would otherwise go undone. Despite the fact that green thumb can serve only a small portion of the State, the program always has substantially more applicants than it can hire. This demonstrates that rural elderly people will seek out the programs that help them to help themselves if they are given half a chance.

Rural America has been last in line for too long. We must begin to extend opportunities to the elderly in both the cities and the country. Probably the most important single step we can take is to promote an enlightened awareness of the rural elderly and their needs.

Sitting next to me is a woman who has done much to promote this enlightened awareness in the Grand Island area of the State, and I am going to now let her tell it like it is on the local level.

I would like to present Marge Stine.

STATEMENT OF MARJORIE G. STINE, DIRECTOR, SENIOR CITIZEN INDUSTRIES, INC., GRAND ISLAND, NEBR.

Mrs. Stine. When I was asked to explain how we got our program started in the rural area, it is a very serious thing. How did we get the older people involved? We were under the OEO—Office of Economic Opportunity. We then went to the grassroots level and talked to the people themselves through intensive outreach. We started with five participants—that, you can imagine—and these five participants went into the areas and helped the people find out what their greatest need was. Their greatest need was additional income. They felt additional income was their greatest need.

At this meeting of these five participants, we asked them how they felt they could supplement their income. The only way they could see it at that time was to start selling their handmade crafts, so we drew on all the resources in the community. We held periodic craft and white elephant sales by some of the stores, some of the county officials, State officials, several of the service clubs, and then we had what we called a flea market that helped raise money for a small store. The store was established and we incorporated as a nonprofit organization under the name of Senior Citizens Industries, Inc. We then applied for delegate agency status from the Office of Economic Opportunity and applied for title III funds.

After the retail outlet was established, the Senior Citizens Industries, Inc., board of directors applied for a foster grandparents program. Through this funded program, 50 or 60 seniors were able to supplement their income by working 4 or 5 days a week, several hours a day, working with disadvantaged children.

With participation increasing, need was evident for the means of transporting seniors to and from activities, doctors, getting their groceries, and so forth. Through the advisory councils and the incorporated board of directors, Hall County applied to the Nebraska Commission on Aging for the handi-buses. At the present time both buses are running at peak capacity in all counties.

We then applied for a nutrition grant which we received through title VII. We are serving many meals per day at several sites, two of which are in the very rural area. This was funded for all counties by the Nebraska Commission on Aging. Through the combined efforts of the church, a meals-on-wheels program was developed serving 25 to 35 meals per day to homebound individuals.

Senior Centers Essential

At one time most of our activities centered in the Grand Island area. We have had a very difficult time getting the very rural elderly involved. We tried the news media through human interest stories, et cetera, to no avail. Outreach was sent out from the Grand Island area. It seemed everything failed. We then decided to take the programs to the rural community towns. We hired a part-time community aide from each town with the idea of developing an informational center for each area. The community became involved by providing space in churches, fire halls, town halls, et cetera. The centers became a focal point for all activities. The seniors were able to get information regarding services available to them in the community.

The seniors feel most comfortable with their own peer group and seem to develop a good rapport with the community aides. Even the most timid and withdrawn individuals become involved in one or more of the activities.

We at the rural level have found the senior center concept as a vehicle to get the local residents involved, for the simple reason the elderly have an opportunity to pitch in and help other individuals in need. By the same token, they have a feeling of dignity and pride in their own activities they themselves have helped to develop.

I came from a town by the name of Surprise, and it is a surprise, believe you me. It has a population of about 79, I think, at the present time. My mother still resides there. It is a tragic situation. Three-fourths, I would say—maybe 90 percent—of those older people have no means of transportation. The doctors' facilities are not within 23 miles of this area and they have to depend on their children or, if the children are gone, the neighbors to get to the services in the health-related field or even to buy some of the groceries that they need. This is a very unpleasant situation. I do think when we develop centers in the rural areas the community gets involved, we have information and the old people know where to go to get help.

Thank you.

Senator Clark. Thank you.

I want to thank the entire panel. I think they did a good job of reflecting the fact that the elderly people in rural communities have very wide ranging, different, and unique kinds of problems. That obviously is one of the concerns about trying to apply the Federal

system so that it does have some ability to adjust, be flexible, and to fit the specific needs of small communities.

I just have a couple of questions, and perhaps the Congressman does.

Since you still have the microphone over there by you, Marge—one of the most impressive achievements of your efforts in Grand Island is the enlistment, I think, of about 140 persons in the retired senior volunteer program, and I am just wondering, very briefly, what kinds of things they did for the community and how did you get that many people involved?

Mrs. STINE. I wrote the original RSVP program, but before it was written, we went to the volunteer sites and explained to the community what these volunteers provide. Then we went to the advisory council and explained how much the people could gain by volunteering. In the rural areas at this time we did not have transportation. Transportation was provided. This gives the older people a chance to get out and get involved in the community. I think this is one of our greatest things, that we have transportation whether we do get out or not. We have, I think, over 163 members at the present time.

Senator CLARK. Over 163 now?

Mrs. STINE. Yes.

Senator CLARK. You don't think there is any secret in how you do it, you just go out and recruit them?

Mrs. STINE. Yes; but I think actually it is getting the older people involved. I don't know. It seems like we like to help our fellowmen, and I think it is one of the secrets that if they are helping someone, you don't have much problem in getting volunteers.

Senator CLARK. Let me ask Glen Soukup a question.

As I understand it, at one time you were involved as a director of the community action program—a CAP program. Now in Winterset when we opened these hearings yesterday afternoon just south of Des Moines, we heard about a well-run cooperative effort between the community action agency on the one hand and the area agency on aging on the other, but sometimes we hear of conflicts between the two. What has been your own experience and what would you recommend in terms of the Federal Government trying to create an atmosphere of cooperation as contrasted to some of the problems that we seem to have between the community action agency on the one hand and area agencies on aging on the other? What has been your experience and what would you recommend for us to consider to try to improve that?

COOPERATION SOMETIMES LACKING

Mr. SOUKUP. Well, in my experience, there is cooperation and lack of cooperation. In my own experience years ago, of course, we had a demonstration grant from AoA which was one of the original three pilots that resulted in the title VII feeding program, so I can say our cooperation was very good.

There have been problems recently between the community action programs and the area agencies on the local level because of disputes that go back a long way. The area agencies on aging came in after the CAP agencies were there and there seemed to be some problems.

What can you do at the Federal level? Anything in the way of enforced coordination that you can do and that we can do, of course, is going to help alleviate this problem in Nebraska. We are working on that very thing right now.

We just completed a companion study with an agency on the State level which deals with community action programs going into what the problems are and looking at possible solutions to them. We are in the finalization stage of this report at the present time. I guess we all know we have very limited resources and we have to do everything we can to get these resources used in the most effective way at the local and State levels. I believe that is what the people at the local level are interested in doing; however, there are problems involved.

Senator CLARK. Thank you.

Congressman McCollister.

Representative MCCOLLISTER. Thank you, Senator.

I have two questions, but first an announcement that is, I think, very apropos to what the panel has been talking about.

Late yesterday afternoon we received word that a grant we had been working on for Douglas and Sarpy Counties of $100,000 has been made to provide a senior companion program for the elderly. Basically what it involves is the employment of 60 seniors at the minimum-wage rate, but it is nontaxable, and it also has, in addition, transportation and other services as part of it to provide some companionship for senior citizens—rural citizens in Douglas and Sarpy Countries—that I think is going to be very, very helpful. As I heard your comments, I was struck by how very different the need is of rural communities compared with the urban communities who have, to date, received the bulk of the funds.

LOCAL CONTROL OF FUNDS

Now the first question. Recognizing that difference in need, and speaking of the Federal role in these programs, it is my belief and rural communities, in the sense that we know it in urban communities, of Federal guidelines, and Federal strings attached to it, in order that each community or each rural agency may tailor their priorities to fit their need.

I will give you an example. It occurs to me that housing in most rural communities in particular are better served with a minimum is not the same thing at all. The programs of which you have spoken—maintenance and handyman services, visiting nurses—those are the things that you need in order to help the elderly maintain the highest degree of independence possible in their own community. Yet if the Federal Government sets the guideline, it seems to me, that you are likely to have mandated a priority of funds that is going to be somewhat different. Do you agree with me that there should be a maximum of local determination of how Federal funds are to be used in tailoring a program for the rural level? Any disagreement?

Mr. MAGNUSSON. No disagreement whatever, John. Speaking as a local government representative, this is one big problem with Federal funding. They don't realize the local problems like we people do. I think if we got it with less strings attached we could do a much better job.

Representative McCollister. You mentioned in your discussion on transportation that you regretted that so much of the Federal funds were used for administrative purposes at the expense of the money being directed to the actual services to be provided to the beneficiary recipients. It seems to me that it gives you a maximum of independence in the use of those funds that is helpful in reducing the administrative costs not only at the Federal level, but at the local level as well.

The question on transportation to which you referred—you said you hoped it could be consolidated and that evidently a number of different efforts, each requiring its own administrative costs, now go forward, and you are hoping that there could be some kind of combination of those transportation services. Could you elaborate a little bit to give me a little better idea of what you mean? How is it done now?

Transportation Pool Practical

Mr. Magnusson. Now there are a number of organizations who are performing services for the elderly. Each organization is requesting buses through the Nebraska Highway Department on funding that has been in effect for 2 years. Too often these buses are only used for an hour or two a day. If we had a common transportation department or a central transportation department, all of these buses could be pooled on a central dispatch and when they were not being used for the one agency, then they would go into the pool to be used by another agency who has the need.

Representative McCollister. Are you talking about multicounty, or within a county? MAPA as the coordinating agency?

Mr. Magnusson. No; multicounty, because our senior citizens are multicounty. Two counties, Douglas and Sarpy, are the only two so far that have used it. Washington County is showing a great deal of interest and we are working with them. We hope we get the other two counties in region 6 to realize what they are doing or not doing for senior citizens.

So I think it should be central transportation agencies, such as MAPA, or somebody who has the knowhow of transportation. I am not a transportation man. There is no one on the Government Board that is a transportation expert. So it should come under the heading of somebody who is knowledgeable about transportation and knows what can and can't be done.

Representative McCollister. These counties, of course, have a history—even back 6, 8, or 10 years ago—of coordinated effort. I refer, I guess, to the meeting of the tricounty watershed board, Encore, MAPA—I don't know how many others. All have demonstrated that the capacity and the attitude of these counties is to work together. I would hope that you could come together in some fashion to provide this coordinated effort.

Mr. Magnusson. It just proves what county government can do; we can pool our resources at much less administrative cost and the public can get the job done.

Representative McCollister. Thank you.

Thank you, Senator.

Senator Clark. Thank you very much.

We want to thank the panel for some excellent testimony. It has been very helpful to us.

The next panel is Dorothy Switzer, host of the Grand Generation, editor of "The Dorothy Switzer Report," and a member of the Nebraska Commission on Aging; Helen Storms, Lizzie Springer, and Henry Knape.

Following this panel we will be hearing from Richard D. Heft, who is chairman of the Harlan County Board in Alma, Nebr., and Hans Jensen, legislative committee chairman of the Nebraska Senior Citizens Council in Aurora, Nebr.

We are going to start now with Dorothy Switzer, member of the Nebraska Commission on Aging.

I might ask each of you, because of the time problem, to try to limit your opening statement to 5 minutes; then we will have more time for discussion.

STATEMENT OF DOROTHY SWITZER, HOST, THE GRAND GENERATION; EDITOR, "THE DOROTHY SWITZER REPORT"; AND MEMBER OF THE NEBRASKA COMMISSION ON AGING, LINCOLN, NEBR.

Mrs. SWITZER. Thank you.

The Grand Generation is a program which appears on the Nebraska Educational Television Network supported, in part, financially by the Nebraska Commission on Aging. It has just completed its third year and in October will begin its fourth year. It is a program designed for older Nebraskans, and we are very happy to always be of service. We have a toll-free telephone line known as the hot line on which people may call us with their problems. I am basing my testimony today largely on the letters and the telephone calls we have received—they number in the thousands now.

On each of the weekly Grand Generation programs on the Nebraska Educational Network in the months of October through June, I present an information report, "The Dorothy Switzer Report," on subjects thought to be of interest and importance to older Nebraskans. The information reports are compiled and distributed by mail twice a month to a mailing list of more than 1 thousand individuals, groups, and agencies. As many elderly Nebraskans do not have access to television, the printed report is intended primarily for them. The report is also used in numerous ways by senior citizen centers and by appropriate public and private agencies concerned with needs and problems of the aging.

My testimony, based on the kinds of inquiries that come to the Grand Generation, emphasizes very strongly the fact that the elderly in Nebraska and the rural elderly, in particular, wish to remain independent in their own homes as long as possible to avoid having to be institutionalized. They need exactly the same kinds of supportive services which, happily, are now being received by many of the urban elderly. The rural elderly urgently need access to health delivery systems and to home health care and physical therapy. They need homemaker and handyman services, congregate hot meals and, in some cases, meals-on-wheels. They also need opportunities for recreation and socialization.

Hospitals and clinics, physicians, dentists, audiologists, speech pathologists, and oculists are few and far apart in many areas in the far-flung State of Nebraska. Thus, the rural elderly need transportation in order to procure such services. They also need transportation to transact essential business, to do shopping, to attend church, to maintain social contacts, to keep active in the community, and to remain in touch with the world. Incidentally, many of them look enviously at those rows of schoolbuses parked in school parking lots for very many hours of the day when it seems to the elderly that those buses could be used to take them to places they need to go.

It was hoped at first that the Federal transportation demonstration project might help solve our problems. We all rejoiced when one of these proposed projects was notified that its application had been accepted. However, 14 months have elapsed and the application is still involved in the review process. It is now awaiting equipment specifications. No money has been received and there is no promise of action before January 1977. Similarly, application for three buses for three Nebraska cities under the Federal national transportation section 16(b)(2) have long been bogged down in equipment specifications hassles.

Post Office a Necessity

I have been asked to testify about the deep concern of the rural elderly who live in communities that are threatened by loss of small-town post offices. Such towns usually have no banks or credit unions, and they have few or no sources of general merchandise. Being largely without transportation, the rural elderly must, per force, shop by mail and must pay for their purchases by postal mail orders. If, for example, their eyeglasses, dentures, or hearing aids need repair, these must be sent and returned by mail. Because they are without legal or even paralegal services in their communities, they must often send important documents and business papers by registered or certified mail. How are they even to purchase stamps when their post offices are closed? As small communities decline, the elderly tend to become increasingly isolated, and this becomes even more acute when they have no post office. Small town post offices serve major information and referral functions, and they serve social functions, as well.

Granted that small town post offices may operate at a loss and that in many cases the postmastership is a political sinecure, there are economies which could be effected—such as decreasing the hours and days of service—without depriving the rural elderly of their greatest source of service and satisfaction.

If I may take a moment to be personal, I may tell you that my mother lived in her farm home until her death at age 82. She kept up correspondence with a host of friends of all ages, and arrival of the mail was the high point of each day. Also, one of my aunts who lived alone on her farm until her death at the same age, 82, maintained a worldwide correspondence. Both women belonged to regional and national flower clubs which, through the mail service, gave them an avid interest in life to the very last.

The rural elderly are in urgent need of legal or even paralegal assistance, such as is available in metropolitan areas of the State through

legal aid societies. Many of the appeals addressed to the Grand Generation program relate to this need.

A higher proportion of the rural than the urban elderly own their own homes, although most of these homes are exceedingly modest and often in need of repair. In small towns the tax base has been seriously eroded as local businesses have closed when population declined, thus taxes are onerous. Others will speak to a reverse trend in some "bedroom" communities, but this inevitably requires expensive extension of services. Thus, a problem of deep concern to the rural elderly, which might seem to be of local or statewide nature, is one of which the Senate Special Committee on Aging should be cognizant—it is the matter of special assessments for such things as street paving districts and water and sewer improvements. In order to pay such special assessments, the elderly are often faced with having to sell the home, acquired through a lifetime of sacrifice and thrift, in which they had hoped to live out their days.

Others will speak to the subject of the disastrous effect of ever-rising costs for fuel, electricity, telephone service, and other utilities—to say nothing of astronomical medical costs.

Another thing I would like to say is that inflation has created the most overriding problems for the rural elderly—the very people who have the least opportunity to find employment by which to supplement their limited incomes. Restrictions on earnings by social security recipients are unfair, but the lack of jobs in rural Nebraska is even more devastating. It is not lack of work. There is work which should be done throughout the State, as well as throughout the Nation, which has myriads of unmet needs.

Thousands of our rural elderly have talents and skills which should be put to use—often, indeed, to serve the needs of other less physically able older people. Elderly rural Nebraskans survived the years of drought and depression, bank failure, and crop failure. They are notoriously long-lived and self-reliant, and they do not wish to be relegated to the rocking chair or the whittler's bench. Under present circumstances, however, too many of the rural elderly—totally against their will or desire—constitute an enormous wasted human resource.

[An additional statement of Mrs. Switzer was subsequently received, and follows:]

ADDITIONAL STATEMENT OF DOROTHY SWITZER

In many of the small towns of Nebraska there are relatively few young or middle-aged families, and therefore few young people who can be employed to mow lawns, shovel walks, and do other chores and errands for older residents. In the surrounding farm areas there are often, however, sizable groups of farm boys and girls enrolled in 4–H Clubs and in Future Farmers and Future Homemakers of America. Leaders of such groups are interested in community service projects in which the members can engage, and frequently their cooperation can be enlisted to serve the needs of the rural elderly. This is a source of help for older Nebraskans which is largely overlooked. Services of the young people need not be entirely unpaid, as frequently the older people can afford to pay a reasonable amount for services rendered.

Possibilities of involvement of rural youth with the rural elderly are virtually unlimited. Youth with garden projects often have a surplus of produce which can be shared with older people who are unable to garden; those enrolled in cooking and baking clubs who are trying to perfect their skills may share some of their products with the elderly; young men in farm construction projects

often have building skills which can be contributed to help older people keep their homes in repair.

In Council Bluffs, in Senator Dick Clark's home State of Iowa, a youth handyperson program in Cass and Pottawatamie Counties provides homeowners over age 60 with free small home repair jobs. The young people are willing to work without pay because they find it spiritually rewarding; others, whose grandparents have died, just like being close to older people, it is said. Many of the elderly people have so much pride that they do not want to have something done for them for nothing, hence they reward the young workers with cookies, milk, and ice cream—and with their friendship.

There is evidence that when communities are made aware of the needs of the rural elderly, awakened concern leads to innovative and creative ways to meet such needs. For example, in Bellevue a concerned woman became aware that older people had difficulty in getting to the grocery store. She enlisted the cooperation of church groups which supply a bus and driver and a volunteer escort to take elderly residents on a weekly shopping trip. This has served not only a practical purpose, but has provided socialization opportunities for many who had previously been isolated at home for weeks at a time.

Senator CLARK. Very well said.

Now we are going to hear from Helen Storms from Western, Nebr.

STATEMENT OF HELEN STORMS, WESTERN, NEBR.

Miss STORMS. Thank you, Senator.

Senator CLARK. Western is a town, isn't it?

Miss STORMS. That is right.

Senator CLARK. Not just western, but Western with a capital W.

Miss STORMS. That is right. Western is a town of 340 people at the present time.

I wish to speak as a senior citizen and as a member of the rural community. I am truly a member of a rural community in that, on both sides, my grandmothers homesteaded within 7 miles of where the town of Western is at the present time. I have lived all my life, you might say, in Western, except for 42 years of teaching. I moved in and out, but Western has always been my home.

I would like to bring up something a little personal in some of my remarks, and I hope you will forgive me for that. In years past we had three doctors. We had a dentist, we had a registered nurse—we had two or three. They were not called practical nurses then, but they took the place of practical nurses. We had two trains a day and we were pretty well served. Today we have no doctor, no dentist, no RN. We are 18 or 19 miles away from any of those services, and that has very decidedly changed the life of the people that live in our rural community.

I would say that probably 50 percent in our town are retired. Just going up and down the street in my own mind the other day, I counted 50 people who live alone. I counted another 50 who, husband and wife, are still together but have practically no relatives within the town, which makes quite a difference.

TRANSPORTATION TOP PRIORITY

Then in 1971 there was a survey made in our country as to needs of the older citizen, and the first preference was transportation. So with the help of the community action and our county agent, who was very active in that program at the time, we established a minibus.

Well, there were lots of trials and tribulations in getting the minibus off to a good start, but we still have the minibus that we think is working very well. We serve six towns—two towns in other counties. They have doctors and hospitals in their towns. We run our bus 3 days a week—2 days we go to Lincoln and on alternate Tuesdays we go to either Fairbury or Beatrice.

Then we have a program of special tours, because it is my feeling that for some of these senior citizens a trip, purely recreational, is good therapy and perhaps does as much as a trip to the doctor. We ask them where they would like to go or if there are programs they would like to attend. For instance, we go to Abilene, Kans., almost every summer, they love to go down there. In the fall we go to Nebraska City to the apple orchards. They love that because they are always treated to a good drink of apple cider.

It has been up and down financially, but we think we are off to a pretty good start. The other day I got on the telephone and decided to make another survey of our town, which is not hard to do when you have a town of only 340 people. I asked them what their major concern was. Well, I found that they were really very satisfied with our transportation setup. They thought that was very nice. Their second preference was some kind of health service to come in.

The next preference was the handyman service, and I certainly could go along with that. It is very difficult in our small towns to get people to come to do odd jobs. Maybe you live alone and can't get out and do them all yourself. It is just a little simple thing of mowing the lawn. It is very difficult to find people. They say, "Well, how about the Boy Scouts?" Well, we don't have a Boy Scout organization. We have Cub Scouts, but they aren't old enough to do that.

It is impossible for me to trim my rose bushes because the boy mowing the lawn takes them down every time. So a handyman service is something that is very important.

Senator CLARK. Thank you very much for an excellent statement.

We are going to hear next from Lizzie Springer from Macy.

STATEMENT OF LIZZIE SPRINGER, MACY, NEBR.

Mrs. SPRINGER. Thank you.

Senator CLARK. How big is Macy?

Mrs. SPRINGER. Macy is an incorporated little town of about 300.

Senator CLARK. About 300. I feel right at home here. I am from a big city. I was raised in a town of 490. Now I find that both our communities are smaller.

Will you tell us about Macy?

Mrs. SWITZER. She lives on a farm.

Mrs. SPRINGER. Macy is practically all Indian people. There are very few non-Indians left. We have a senior citizen center which we all go to 5 days a week to eat dinner. They have come out to us and take us back, which is good, but the transportation is very poor for us to go shopping for groceries because just 14 people can go in this panel van. Then when we want to go shopping, our coordinator says we have to have more than one go—"Just one? We cannot take you." The nearest good place for shopping is Sioux City. We like to go

there because there are always bargains in the grocery stores, but we have to wait until we have more than one to go. So transportation is poor that way.

If we want to go see the doctor, the transportation is good for that. There is a van that comes out to us when we set a date for them to come.

About our housing. I live out in the country; I am a widow and I live all alone. My children and grandchildren have grown up and left me, so I live alone. Not only me, there are other senior citizens living alone—men and women.

I have pity for one man. He is a blind Indian and he lives out in the country. I get in this panel truck when they go out to him and a lot of times I have helped to lead him to the truck. I don't think anybody goes out there to see this man. We have meal service there, but I don't think they go out to see him.

There are a lot of gardens that the senior citizens fall back to. There is a lady that lives alone and her sons have a bad habit of drinking. They bother her, and we just can't do anything about that.

About our telephones—we have our telephones installed, but we have had a difficult time getting them. We even signed a petition with the non-Indians to get the phones and when the non-Indians got their phones in we didn't get ours until about 2 years after.

Senator CLARK. Why is that?

Mrs. SPRINGER. I don't know. That is what I would like to know.

Mrs. SWITZER. It took action by the Nebraska Commission on Aging and some other concerned citizens to bring it about.

Senator CLARK. You have phones now?

Mrs. SPRINGER. We have phones now. Before then we had real problems. I was sick one time and I had to walk down to the road to a farmer to take me to the hospital at that time before we had the phones. Many people have been doing it.

I don't live in fear now. I have my own phone. The rest of them with seven families have their phones now—some of them are senior citizens.

Then I don't know if I should say this. Our panel is——

Senator CLARK. Your panel is your minibus?

Mrs. SPRINGER. Yes, the minibus. It is pretty well worn out and I told our supervisor, Mr. Mayer, about it. He said that we had to go and talk to our tribal council, that they had charge of that. We have not gone to the council yet. I think maybe next week some of us senior citizens will go and talk to them to see if they can get anything else. It is very unhandy to get in and get out. There are a lot of things that different ones talk about here that we have not got.

Senator CLARK. I want to come back after we hear from Henry Knape and ask you some questions about some of those specific areas, if I may.

Mr. Knape is from Alma, Nebr. You may proceed in any way you wish.

STATEMENT OF HENRY J. KNAPE, ALMA, NEBR.

Mr. KNAPE. I will give you just a little history of our town and surrounding area. We have a population of 1,450 and we have a senior citizen center. It is progressing, in my belief, very successfully. We

are like everybody else. We have our problems and we serve five other towns around us. We have four meals a week—Mondays, Tuesdays, Thursdays, and Fridays. We serve one meal a week over at Orleans, Nebr., because they haven't any restaurants there and we are going to let them serve on Sunday so that senior citizens can be served with a hot meal on Sunday. They come over the other four times and a lot of them have participated in the meals and activities of our community. I will just give you a little rundown on the towns, the population, and the districts.

Ragan is 19 miles away from Alma and it has a population of 60, with no stores. Republican City has a population of 173 and it is 8 miles. Stamford has a population of 200 and it is 17 miles. Oxford has a population of 150 and it is 14 miles.

We have one minibus. I am just like all the rest of them—that minibus is one of the most important things in the senior citizens community to me, because it helps bring the elderly into town and it helps take them to the doctors. Besides these towns we serve, we have a phone. They go up there once a week. The bus holds eight, and they take these eight people out—different ones, of course, on different weeks—for a ride in the country.

When people get old they like to see where they live and see how things progress. Our big trouble is transportation. While we have the minibus to these other towns, we have emergencies lots of times and they have to get a person to a doctor. Then we have volunteers—we have no volunteer service. My wife is 76 and she volunteers to take these people to the doctors lots of times. I was thinking, if we could get another minibus to fill in while this one minibus is out, we could get volunteer drivers, I am sure, to run it in cases of emergencies. Then when that minibus was not busy, we could take that on a trip. Like the lady said here a while ago, take it down to the Eisenhower Museum.

My main concern is that we have to take people to a specialist lots of times. We had one this week. Well, the bus could not go because it was out of town and they wanted to go to Kearney to a specialist. If we had another minibus, that would have filled the gap.

Representative McCollister. How far is it to Kearney?

Mr. Knape. Forty-five miles. You know, when you take a bus out of town and serve these other towns it is quite a chore. I am like most of them, I think the No. 1 priority is transportation.

Chore Service Program

No. 2, as the lady said a little while ago—I am just rehearsing some of the things they have gone over—that is chore service programs. I think the chore service program is one of the most important things. We have elderly around in the small towns. They have that handyman for putting in storm windows, painting, odd jobs done, like mowing their yards. It is awfully hard to get somebody to do chore services, because most of us down there are elderly. There are just a lot of elderly there.

Of course we have the reservoir. We have people from Hastings come there to retire because it is a nice place to fish, and you know how that is. If people have someplace that they enjoy more than others, they move there. That is why I moved down, too, as far as that goes.

I think my time is just about up, so I better just leave it that way. I am very glad that I had the privilege of talking to you.

Senator CLARK. Well, I wish we had more time to visit, but let me try to keep my questions brief. As you know, if we are going to successfully fight inflation in this country, we have to limit our spending.

Mr. KNAPE. That is right.

Senator CLARK. So the question is, which of these programs is the highest priority? Which ones do we need to be putting more funds in? Which ones can we eliminate, and so forth? You have said, for example, that in your judgment you support much of what has been said here before—that transportation is a very high priority. Now, would you put a high priority on the nutrition program, on the hot meals program, and why? How high and why?

Mr. KNAPE. We have that and I think it is one of the most wonderful programs there is because there are a lot of elderly women and an awfully lot of elderly men that need a good hot meal. I didn't stress that as much as I should have, but I think that is No. 1, really. Then I think transportation is No. 2, and I think chore service would be No. 3. That is the way I would grade them.

Representative MCCOLLISTER. Did you say nutrition is No. 1?

Mr. KNAPE. Yes. I think nutrition would be No. 1—see that the elderly get a good meal as many times as you can. Yes, I would put that No. 1, I would put transportation No. 2, then I would put chore service No. 3. I would like to see chore service so you would have somebody that would do these jobs that are needed to be done for the elderly, because they like to stay in their own homes. This has been brought up before.

NUTRITION PROGRAM 5 DAYS A WEEK

Senator CLARK. Now let me ask Lizzie a question. What about nutrition programs at Macy? I don't know how many programs you have or if that is the same. Do you have a hot meals program there?

Mrs. SPRINGER. Yes.

Senator CLARK. Is that each day, once a week, or how does that work?

Mrs. SPRINGER. One a day at noon, 5 days a week.

Senator CLARK. Is there good participation in that? Do people go?

Mrs. SPRINGER. Yes. They have trays they take out to some who are unable to come in—27 trays every day, to take care of those people.

Senator CLARK. I see. Twenty-seven trays a day are taken out to elderly people to their homes.

Mrs. SPRINGER. Yes, to their homes.

Senator CLARK. The other thing I wanted to ask you about was health care. Suppose you get sick? Where do you go? How far away is it? How do you get there? In other words, what kind of health care do you have available?

Mrs. SPRINGER. We have a hospital there about 9 miles north of Macy and they have a panel car. They have a clinic right in Macy, and that car takes us over there.

Senator CLARK. Is the food good, in your judgment?

Mrs. SPRINGER. Yes, it is good.

Another thing, too, Senator, I want to tell. Some of the senior citizens that are old are in homes now—about four or five of them—and

they don't like it there, but their families can't take care of them at home. The hospital keeps them just a certain length of time and they are discharged—they have to go home. They don't want to go to these nursing homes, they just don't want to.

Senator CLARK. Let me ask you just one other question. You mentioned, when you were speaking earlier, about housing. What is the condition of housing in Macy? How would you describe that?

Mrs. SPRINGER. There are five homes for the elderly in Macy, and they are out in the country. We didn't ask for them to move there; I don't want to move out there. I have my own home, and I would rather stay there. My sister is about 75 and her home is very poor. They told us last week that they were going to try to have more housing for the elderly out in the country, but that may be just something they are talking about. This month they are going to have a meeting.

Senator CLARK. About housing?

Mrs. SPRINGER. Yes. There is a way to help us elderly out. If we could get housing, we sure would appreciate it.

Senator CLARK. Well, it is a very basic need. It is as important as food.

Thank you very much.

Dorothy, I wanted to ask you a question. We have been talking here about the most basic needs and you have mentioned several of them here very clearly, but do you think that the highest priority in rural areas is nutrition? Is it health care? Is it employment? Is it transportation? Can you evaluate those?

PRIORITIES VARY LOCALLY

Mrs. SWITZER. Well, it varies, of course, in various parts of the State. These people who are fortunate enough, as Mr. Knape is, to have transportation in their community, even if it is not quite adequate, and nutrition and various other things, are lucky. There are vast areas in the State in which there are no nutrition projects, no kind of transportation, public or otherwise, and there are vast areas in which there is no opportunity for employment.

Small towns have declined, the businesses have gone out of business. There is little opportunity for the retired farmer, who moves into town and finds a special assessment for a paving district doing devastating things to his taxes, to, in any way, earn any money to supplement his income.

So, I think it is very difficult to spot any one thing as the most needed, because it varies greatly by the area of the State and circumstances. I suppose that at every meeting I have attended, and I have attended many of them in area agencies on aging, senior citizens council meetings, and things of that kind, transportation does loom the largest.

The nutrition programs are appreciated more after they have had them, but until they have, they don't realize what they are missing. I think I would have to say transportation is most important.

Another very great need, however, is for legal assistance or paralegal assistance, comparable to what the elderly in the metropolitan areas are able to receive through the Legal Aid Society.

Senator CLARK. That is a good point. It has not been mentioned before in these hearings.

Mrs. SWITZER. It is urgent. Many of the questions which have come to us at the Grand Generation relate to this subject.

Senator CLARK. Let me ask you this, and then maybe Congressman McCollister will have questions.

You said that in your town—that is, in Western—you have what you consider to be, at least, adequate transportation now, but what about health care? Now, you said you needed that. My question really is—I think you said Western is a town of 300.

Miss STORMS. Three hundred forty.

Senator CLARK. What kind of health center could you support, that would be useful and helpful to you, and yet practical enough to do the job? I am particularly interested in writing legislation, and I would be interested in any suggestions that you have.

Miss STORMS. I think if we have somebody—I don't know just what term we should use, perhaps a visiting nurse or something like that—who could take blood pressure, and things of that sort. I have a neighbor who, once every 3 months, goes to Lincoln and has her blood pressure checked. It takes about 5 minutes. The nurse takes her blood pressure and tells her whether to take those pills, something that easily could be done at home. If she cannot get her appointment on the day that the bus goes, then she has to scrounge around and see who she can find to take her.

Senator CLARK. A registered nurse?

Miss STORMS. A registered nurse perhaps could handle a good many of those problems.

Senator CLARK. Suppose you had a place there for distribution of prescription drugs, would that be helpful?

Miss STORMS. Well, yes. I would say that a third of our people that ride the bus go for medicines.

Senator CLARK. Very well.

Congressman.

Representative MCCOLLISTER. Thank you, Senator.

I have been sitting here listening to the testimony and remembering almost half a century ago when the needs of the elderly were the same, yet our ability to administer to those needs was quite different. I suppose that many of us in this room can remember our great-grandmothers and our grandmothers living with us and we were able then to provide for their care. In the meantime, in half a century, our small towns have dried up, our society has become so mobile that numbers of senior citizens have been increased because of the fortunate increase in our longevity, yet our ability to minister to the needs of the elderly has steadily, over half a century, gone down.

THE CHURCHES' ROLE

Now my question to you is, since the family is no longer as wel, able, because of the wide dispersion over all the country—what other institutions in these communities are still able to address themselves to the community? For example, I was wondering if Western has active churches who address themselves to the needs of the elderly in providing some of these services and some of these needs—particularly I was thinking of the socialization need, the need to remain a part of the community.

I was thinking of the hot meals program. Is that a characteristic of smaller communities—that the churches minister to their congregation of senior citizens?

Miss STORMS. Well, in many of these small towns, like ours, for instance, we do not have a resident minister. The idea of the parish among the churches—our minister in Western—the one that ministers to our church—lives in Wilber 18 miles away. We have three active churches in our town and not a single resident minister.

Representative MCCOLLISTER. But there are three congregations?

Miss STORMS. Yes, there are several congregations, and they are all small, needless to say.

Representative MCCOLLISTER. I assume that their membership is on the upper side of 50 as well.

Miss STORMS. Yes. I think the largest church in our town has a membership of 167.

Representative MCCOLLISTER. Well, as we try to devise or invent systems to provide for needed services for the elderly, we think of all the institutions who used to do it and who now cannot, and what we must do to fill that gap. There is the community, there is the State government, there is the Federal Government, and I suspect that the farther away we get from the community, the less personal interest, the less efficiency, and the greater cost. So whatever we can do to devise systems to support local effort, the better off we are. Thus, what I have obtained from you and the previous panel's testimony is to whatever extent this becomes a Federal program, to do whatever we can to use it as a stimulus to make the local communities more self-sufficient. Do you all agree with that?

Miss STORMS. Yes.

Mr. SOUKUP. Yes.

Mrs. SWITZER. It has happened in many communities in Nebraska. I wish that Art Nebelsick from Crete were here, because the churches in Crete were responsible for organizing a program for the elderly and from that has developed the senior center, and all kinds of activities. There has not been a cent of Federal or State money put in it and they have one of the best programs in the State. There are other towns which have acted to solve their problems. Neligh organized a senior citizen program through the churches because it was felt there was great need for it. The Commission on Aging has recently granted a small amount to a center which was organized in much the same way at West Point. Many of the senior centers in the State have developed through the concern of church people who have initiated the kinds of activities that later developed into a larger program.

Representative MCCOLLISTER. We are grateful for your contribution.

Mrs. SWITZER. Thank you.

Miss STORMS. In our town, by far the majority of the members of the church are senior citizens.

Representative MCCOLLISTER. What town is 18 miles away—Wilber?

Miss STORMS. Yes. Wilber is 18 miles away.

Representative MCCOLLISTER. Any possibility of that church in Wilber adopting the congregation in Western to aid that congregation?

Miss STORMS. I kind of doubt it.

Mrs. SWITZER. It can happen though.

Miss STORMS. Yes, it can.

Mrs. SWITZER. In Crete, the rural churches cooperate just as much as the churches in the town.

Miss STORMS. They have some very active church members in Crete who really have pushed it. We have no nutrition program in Western or in the smaller towns. We have one town of 120, one of 160.

Representative MCCOLLISTER. Thank you.

Senator CLARK. Thank you very much.

We thank you as a panel. It has been very, very helpful to us.

Mrs. SWITZER. We appreciate the opportunity.

Senator CLARK. We have two more witnesses, and they may both come up at this time. Richard D. Heft, chairman of the Harlan County Board in Alma, and Hans Jensen, legislative committee chairman of the Nebraska Senior Citizens Council in Aurora, Nebr.

I might say as the witnesses come up that the flowers on each of the tables come from the Gretna 60-Plus Club whose representative, I think, is here. Would she stand, please.

I understand that one representative may want to make a brief statement. Am I correct about that?

Mrs. DIETZE. Yes.

Senator CLARK. Please come up to the table.

We are going to hear now from Richard Heft, chairman of the Harlan County Board. We have about 20 minutes and we have three witnesses, so we will try to divide the time evenly.

Mr. Heft, please proceed in any way you think appropriate.

STATEMENT OF RICHARD D. HEFT, CHAIRMAN, HARLAN COUNTY BOARD, ALMA, NEBR.

Mr. HEFT. Senator Clark, Representative McCollister, my name is Richard Heft, and I am from Alma, Nebr.

When Glen Soukup called me up and wanted me to speak, he went out so far that you cannot even find it from here, you have to go out someplace else. You can't get here from there.

Anyway, when he asked me to speak, I really didn't know what he wanted me to speak about, but he said I would have about 5 minutes to talk. I said, "Well, that should not be any problem because my wife says I talk so slow, it will take me 5 minutes to say what I have to say and then by the time I tell a little story my 5 minutes will be up." So I will tell you a short little story.

There was an elderly gentleman that liked his spirits, and he went into this bar and ordered a drink of whiskey. He told the bartender to put in three drops of water. So the next time the same little gentleman came in and ordered his drink, and he said, "Bartender, just put in two drops of water." And the third night he came in again, and by this time the bartender's curiosity was quite aroused, and he said, "The first time you said you wanted three drops of water in your drink, the second night you wanted two, and tonight you want one. Why?"

He said, "Well, us elderly gentlemen can still hold our whiskey, but we can't hold our water." [Laughter.]

Tax Limitation Effects

Anyway, being the chairman of the Harlan County Board, our biggest concern with the elderly is taxation. For just a small county—we have less than 5,000 population in all the county, which covers about 25 square miles. When I first went on the board about 4 years ago they appointed me to the service for the aging, and I thought it was a very worthwhile project. We had no service for the aging at that particular time.

When I went on the board, the first thing I did was to get a survey of what the people in Harlan County wanted first, and it was transportation; second was job chore, and third was a civic center. Well, I am glad to say we have all those, plus several more now. We have a nutrition program along with it. We have the medical lady that comes in and takes blood pressure at least once a month, and we hope to expand a lot further on that.

Anyway, back to taxation. Our county tax valuation is only $30 million, so 1 million brings in only $30,000. By the time you get it all divided between the 14.28 which the State requires you to have, and by the time you take care of all your services, you don't have anything left. Last year the person who represents the counties said there were 31 counties that had reached their mill levy and that there will be over 30 more that will reach it this year. So I am telling the counties that don't have the service for the aging—if they don't get the tax relief, there is no way that they will be able to handle it.

Revenue sharing, I understand, has been up before and I think that should probably continue. Before, you could not use any Federal moneys, but I think that is going to be changed to where you can use some of that revenue sharing, too, for some Federal programs. Right now we have only about 0.21 of 1 mill toward service of the aging, because it only brings in about $8,000, and Federal aid from it started off as 90–10.

Well, the predicament in Harlan County on the service for the aging came to us. Our No. 1 problem was transportation, so they said, "Well, you go on a 90–10 for the first year." When we got down to it, it came down 75–25. So we have been in it for 1 year and 9 months, and the Federal Government has come out now and said, "We are not funding any more money for transportation in Nebraska; we have it cut off."

So the State has come out and said, "Well, we will continue it at a 50–50 grant. If we had known this to start off with, there is no way in the world that our county could have gone into transportation. We have it now and we have it on the tax rolls, so there is no way that they can take it away from us. The people in our county definitely want transportation, but it makes it all for the bad when they cut it off. They guarantee you at least 3 years, and we have 1 year and 9 months.

The panel that was here before me fairly well covered every aspect of all the programs and I don't think that I need to repeat any more on that, so I will turn it over, then, to this gentleman here.

Senator Clark. Thank you very much.

We are going to hear now from Hans Jensen who is legislative committee chairman, Nebraska Senior Citizens Council, in Aurora, Nebr.

STATEMENT OF HANS O. JENSEN, LEGISLATIVE COMMITTEE CHAIRMAN, NEBRASKA SENIOR CITIZENS COUNCIL, AURORA, NEBR.

Mr. JENSEN. Senator Clark, Congressman McCollister, I am the lobbyist for the senior citizens in Nebraska without any pay. I am glad to do that for them and they probably get as much services as they pay for. However, I served 6 years in the legislature and I am glad that I have the time, and I enjoy being involved. This is one way of being involved, it gives me an opportunity to keep abreast of these things and it also gives me an opportunity to be of service to my fellow man. The world has been good to me and I would like to be of help to the people that made it possible.

One of the peculiarities about the elderly is that they have the tendency to make do. They will sit back and suffer injustices and shortages without really saying much about it.

I attended a meeting in Omaha one time and I will tell you of a little incident. We sat there and listened to the elderly testify and discuss their problems with the mayor. Along about 3:30 in the afternoon some old lady got up and led the group in singing "God Bless America." It almost brought tears to my eyes because the elderly are just as grateful, even though they have as much need as any group, or perhaps more so.

Let me just briefly cite some of the things that I put together.

MEDICARE FORMS COMPLICATED

Most elderly are confused and baffled by the forms connected with the medicare program which they are requested to fill out upon receipt of medical services and care. Oftentimes, words used are medical terms not understood by lay people. Medicare usually pays approximately 80 percent of the bill and other insurance companies are called on to pay the balance. This gives the elderly no end of trouble and concern to understand and to use. It is my opinion that oftentimes medicare is not used because of the problems it brings about.

Language used by medicare to describe action taken should be simplified and amounts covered by medicare either should be increased or charges for medical services reduced so it could all be covered by medicare. It is my opinion that the present policy used is so troublesome that it is limiting the use of medical services which the elderly need.

I am also a representative of the Damascus Farmers Union and I am doing all sorts of lobbying work for them in Nebraska for the same reason. I would like to mention something they prepared for me that I think is of interest to you. Just a brief remark about the Green Thumb program. The National Farmers Union sponsors this program in 28 States, Puerto Rico, and the District of Columbia. There are only

120 older people working under the program in Nebraska to date in 14 communities. There are 49,000 elderly eligible for the Green Thumb program in Nebraska, according to the latest census figures. Therefore, special interest should be placed on enhancing a program of this nature, a program that uses the skills of elderly and part-time work for improving the homes in which they live. It is the kind of program that gives older people the opportunity to earn a better living in our affluent State, rather than being destitute or on public assistance. I might add here, too, that as long as these elderly people feel that they have a purpose in life, they can look forward to tomorrow. I tell you, this makes life a lot easier for them to live.

Senator CLARK. Thank you very, very much.

Let me just ask you one question.

You identified yourself, Hans, at the beginning by saying that you were a lobbyist for the elderly and that you tried to speak for their interests. One of the impressions that I have in watching elderly clubs, associations, groups, and councils form is that much of the reason that the Congress, the administration, the State legislatures, the county boards of supervisors, and so forth, have responded, to some degree at any rate, to the problems of the elderly is that the elderly have themselves become organized. They have become a strong force and have, in fact, called these people in and talked with them. They have been effectively organized and are an effective voice for their own use and their own needs. Do you tend to share that view?

Mr. JENSEN. Indeed I do, and I am going to quote you on it, too.

Senator CLARK. Good. There are a lot of people who think that lobbyists are bad people or that they are bad names—and certainly they can be—but in a democracy I don't see how you can work effectively otherwise. I don't see how you can really have your own point of view represented, whether you are elderly or young, farmers or businessmen, or anybody else, without being effectively organized. I think until the last 10 years, the fact is that elderly people had not been well organized for that kind of effort. I think in the last 10 years they have, and I think it is reflected in the kind of legislation and the kinds of administrative actions that have occurred as a result of that.

Mr. JENSEN. They have the political moxie, if they just use it.

Senator CLARK. That is right.

Mr. McCollister.

Representative MCCOLLISTER. We are short on time. I yield.

Senator CLARK. Please identify yourself.

STATEMENT OF EVA DIETZE, SENIOR NUTRITION PROGRAM, 60-CLUB, GRETNA, NEBR.

Mrs. DIETZE. I am Eva Dietze.

Senator CLARK. You are here as a representative of the 60-plus club here in town.

Mrs. DIETZE. Yes.

Senator Clark and Congressman McCollister, my name is Eva Dietze and I am speaking for the senior nutrition program in Gretna, known as the Gretna 60-Plus Club, who have signed this statement. We feel that the special problem the senior citizen faces living in a rural

area is transportation. A person living in a rural or farm area who cannot continue to drive because of poor eyesight or other health problems is forced to move into town. The rural town also being without transportation forces the senior to be dependent on others to drive him to the eye doctor or to have glasses fitted—to the dentist, podiatrist, et cetera, all of which are located in the metropolitan area.

Now in the area of health care we feel that the nursing home should be required to have a registered nurse on duty 24 hours a day and a reliable resident doctor, or one that would be on call at least 24 hours a day. The nursing home should be required to have large outside areas, fenced in, where the patients can be wheeled outside for fresh air. The area should be large enough for the ambulant patients to walk around. Windbreaks of trees and shrubbery should surround this outside area. We recommend a State inspection, under Federal regulations, of nursing homes, including an inspection of the rooms, perhaps four times a year. We recommend higher and stricter standards to run a nursing home.

We feel there should be more information and education in the area of preventive health care, not only for seniors, but for every American citizen. That is, enlightening people on how to prevent illnesses and take care of their bodies before they are sick. We feel there should be more exposure and tighter controls on the chemicals and additives and the colorings and dyes that are in the foods we are eating, and steps should be taken to eliminate these additives in our foods.

Thank you.

[The written statement of Mrs. Dietze included 41 signatures. Retained in committee files.]

Senator CLARK. Thank you for a very excellent statement.

I was handed a note that there are two additional statements. Although we don't have time to actually read them, I would like for them to be included. I will distribute forms and you may send them back. They will be made a part of the official record.[1] They simply invite you to comment on any phase of discussion that we have had today, and read as follows:

Dear Senator Clark: If there had been time for everyone to speak at the hearing in Gretna, Nebr., on August 17, 1976, concerning "The Nation's Rural Elderly," I would have said:

Please feel free to fill these out and bring them to us.

I would like to call on these two people very briefly, and Congressman McCollister and I will speak about 30 seconds, then we will close the program.

If you will please keep your seats, we can have some order. I would like to call on Margaret McMullen, who is president of the State Association of Community Action Agencies.

STATEMENT OF MARGARET A. McMULLEN, EXECUTIVE DIRECTOR, MID-NEBRASKA COMMUNITY ACTION PROGRAM, INC., KEARNEY, NEBR.

Mrs. MCMULLEN. Senator and Congressman, I know you are under a tight time frame here, so I will try to make this very brief.

[1] See appendix 3, p. 196.

As the Senator noted, I am president of the association that includes all of the community action agencies in the State. Our association includes nine agencies total; seven of these are multicounty rural agencies, the other two are metropolitan agencies that also serve some limited rural area around the metropolitan centers. I believe Mr. George Woods, our State director, will be submitting some more written testimony to you before September 15, so I am just briefly going to touch upon a few things here.

As you perhaps know, the community action agencies were leaders in most areas in the development of senior citizen programs and services throughout the State. CAP agencies were established back in 1965 and the early part of 1966; CAP programs have developed over the years since then including transportation, nutrition, telephone reassurance, social and recreational activities through senior service centers, health services and clinics and, most recently, our winterization program.

Incidentally, you may be interested in knowing that in the past 2 years—or a little less—the CAP's have winterized approximately 2,550 homes, and 75 percent of these—or 1,800—were homes of elderly persons living on fixed or limited incomes.

All of these services that I have mentioned are still, in many cases, being operated by community action agencies. Other service agencies in more recent months have entered the field of providing services. This, in particular, includes the area agencies on aging. I believe Mr. Soukup spoke just briefly about some duplication and, perhaps, problems regarding this type of thing earlier. I would have to support this statement, but I hope that the CAP's and the AAA's are on their way to working out these problems and will coordinate efforts in the future. In fact, the State CAP association will be making some recommendations to the Commission on Aging at their meeting in September and, hopefully, this will help resolve some of those problems.

I think the CAP's are unique in many respects. They have capabilities that are not available or are not used by any other human service providers. One of these that I think is particularly important is the efficiency of the CAP's. By law our administrative costs cannot exceed 15 percent, and the most recent reports from throughout the State indicate that our administrative costs are approximately 11 percent at this time. I also think we have a unique capability of mobilizing volunteers. An example is in southeast Nebraska—the Humboldt area. The CAP down there has a nutrition program that only costs them about $1.35 a meal because they are using all volunteer labor. I think one can see the obvious saving here.

Another plus which I think the CAP's have is that they have combined other State and Federal moneys, such as Department of Labor funds, title XX moneys from the department of social services, and others, thus stretching the dollar so we can serve more people.

I could probably go on and on about our unique capabilities, but I know of the tightness of your time frame and that everyone is anxious to close the session here. I would like to thank you for your time. Mr. Woods will be submitting some more written testimony.

Senator CLARK. Good. We will be very happy to have that testimony and it will be made a part of the record as if given here. Any other comments that you would like to make, submit them as well.

I know Mr. John Buck of Creighton University has a statement, and again I would ask him and others here who have statements—because two or three other people approached me as we came in this morning, and others called ahead—if they would be kind enough to give us their statements in writing, they will be included in the record.

This is John Buck.

If you could just summarize your statement in about 20 or 30 seconds and then give us your written statement, it will be included in the record in full.

STATEMENT OF JOHN BUCK, CREIGHTON INSTITUTE FOR BUSINESS, LAW, AND SOCIAL RESEARCH, OMAHA, NEBR.

Mr. BUCK. I am John Buck and I am an advocate of legal services for the elderly. I do have a longer speech that I could give. The need for legal services has not really been brought out, with the exception of Mr. Magnusson's and Dorothy Switzer's comments. The first reason the agency in area 10 in Iowa found that persons were not utilizing assistance as offered by their legal services program was that the elderly persons were found to not realize they had a problem requiring legal assistance.

A second point is the National Senior Citizens Law Center has determined that approximately 90 percent of the legal questions that the elderly have can be answered without the assistance of an attorney; for example, by a paralegal person. There are retired attorneys who do belong to RSVP and who do volunteer their services.

In Nebraska, the only place that the elderly persons can presently get the assistance of an attorney, without having to pay $40, $50, or $60 per hour, are the three legal aide offices in Omaha, Lincoln, and Scottsbluff. Therein lies the problem that was mentioned about transportation needs. For example, the rural elderly don't have access to transportation to Omaha. But Omaha Legal Aid requires that legal assistance be given directly in the office—the elderly cannot call up and ask questions. They have to go into the office physically, which presents a great problem for them.

I work with Creighton University and we suggest, as a possible solution to this problem, the establishment of a legal information center for rural elderly which would operate with a WATS line, which is a toll-free telephone that anyone in the State of Nebraska could call. The center could provide answers to legal questions when a lawyer's services are not needed and where the presence of the elderly person would not be necessary. Second, it could provide case research for the attorney servicing the elderly which would then, hopefully, lower the cost of the legal services.

I am being cut off now, but Lizzie Springer brought up an excellent example where such a center could be very useful which she could have called the legal information center that we suggest. Perhaps we could have gotten the ball rolling to get her the assistance that she needed and she would not have needed to wait 2 years for a telephone.

I thank you.

Senator CLARK. Thank you.

We will make your full statement a part of the record.

[The prepared statement of Mr. Buck follows]:

PREPARED STATEMENT OF JOHN BUCK

First of all, thank you for the invitation to attend this meeting about the special needs of the rural elderly. It is most encouraging that the Senate is continuing its interest in the problems of the elderly and specifically in relation to those living in rural areas. Older Americans live "needing" adequate income, housing, health care, nutrition, and employment much more acutely than do younger people. There exists a vast array of laws which have been designed to, and in most instances do, assist the elderly to be better able to live independently within this society, but these laws are too numerous and usually too technical for a layman (especially an older person) to be able to understand. The particular area, in relation to the Older Americans Act of 1975, which I would briefly like to address is the problem which the elderly have in obtaining legal assistance, especially in rural America.

Elderly persons most often live on fixed incomes; the source of which could be social security, supplemental security income, pensions, or possibly their life savings. No matter what the source, however, these incomes are usually fixed, and less than that to which the elderly were accustomed to in their working years. They are particularly susceptible to the effects of inflation, but generally do not qualify for legal aid.

As Senator Tunney stated last year, "Unfortunately, few elderly can afford the $40, $50, or even $60 per hour fee charged by the average lawyer. Thus, they fall through the cracks of the legal system: Too rich for legal aid; too poor for a lawyer." Senator Cranston added that "The situation of the nondestitute elderly with respect to legal representation may be even more acute than that of the elderly poor. The former have too much income or resources to qualify for free legal service and yet often cannot afford to hire a private attorney." In many instances, even where attorneys are available, they may not be able to provide adequate services—often they do not have the time or resources available to keep up-to-date on the rapidly changing laws which affect older Americans' lives. This is especially a problem in rural areas, since these lawyers rarely have access to complete law libraries, and do not specialize in law affecting the elderly.

In a survey performed by the Area X Agency on Aging, the reasons for the area's elderly not seeking the assistances offered by legal services were: "(1) Not realizing that they have a problem requiring the assistance of an attorney; (2) confused or frustrated about legal affairs; (3) lack of aggressiveness; and (4) can't afford legal services." In addition, the National Senior Citizen's Law Center has estimated that approximately 90 percent of the legal questions which elderly persons have could be taken care of by the provision of legal information without direct legal representation from a lawyer. With these facts in mind, and a stated purpose of the Older Americans Act being to provide "legal and other counseling services," it seems that solutions to some of these problems should be forthcoming. Before these solutions are determined, careful consideration should be given to the long neglected problems of the rural elderly. A review of the 11 model projects funded last year (designed to promote the betterment of legal services for the elderly) reveals none with the select purpose of serving rural elderly.

The rural environment multiplies the difficulties the elderly have in procuring legal assistance. First, accessibility of private lawyers is lowered and these rural attorneys lack the necessary resources for case research. Since the legal questions of the elderly deal with such a vast number of laws, and rural attorneys would usually not have a caseload sufficient to warrant becoming an expert in the field of elderly law, the assistance which these attorneys can provide may often be limited. In Nebraska, elderly persons (over age 60) comprise the third highest percentage of population of all the States. The only legal assistance presently available to elderly citizens stems from the urban legal aid offices in Omaha, Lincoln, and Scottsbluff. These offices are usually inundated with requests from low-income persons, elderly, and nonelderly alike. In Omaha, legal aid requires that the requester of service must physically come into the office, which may often be impossible for confined elderly. In addition, what of the elderly who live too far from the legal aid offices, and what of those who are too rich for legal aid, but too poor for a lawyer? How can these older Americans receive the assistance they need to live independently in this society?

We would propose, as a possible solution to these law-related problems of the rural elderly, the establishment of a legal information center for rural

elderly, which would essentially provide service to three groups, with the end purpose to serve the needs of older rural Americans. The center would provide research to lawyers serving the elderly, would train social service personnel about the law affecting the elderly, and would directly answer some of the elderlys' legal questions in instances where the direct assistance of an attorney was not required. The center could provide information about the family farm, inheritance, consumer fraud, or tax laws and could refer elderly to such existing social services such as the small claims court. Since such a center could operate in each State, drawing on the law schools and other resources located therein, it should be designed so that, if a model is successful, it could be easily replicated by other "rural" States. We hope to propose establishing such a center in Nebraska to the Administration on Aging, and while it is not presently known whether or not it will ever be funded, it is evident that the rural elderly need legal assistance of the type that model urban programs do not and cannot provide. Any effort to promote the provision of legal services to rural elderly (such as the Older American Act of 1975) should be strongly supported by all concerned parties, and we encourage such efforts.

Senator CLARK. This room is going to be used at 12 noon for a congregate meals program, so we have to break up at this point.

I do want to call on Congressman McCollister.

Representative MCCOLLISTER. Senator, the only comment I want to make is to commend you for the organization of these 2 hours and 5 minutes that has produced, I think, a record that ought to be very useful to the Congress in determining the priorities of legislation. It has been an excellent job and I commend the Senator from Iowa for coming to Nebraska to hear from our citizens.

Thank you.

Senator CLARK. Thank you very much.

I think we have received a lot of valuable information. If I could try to summarize it in about 8 or 10 sentences, it seems to me that what we have learned here is that we have unique needs in rural areas, yet, in fact, particularly in the area of transportation, we have even greater needs than we have in metropolitan areas.

We have heard about the value here of the nutrition program—hot meals. We have heard a great deal about the need for extended health care into some of the smaller communities. We mentioned Western, but really there obviously are other communities as well across this State and across the country that are badly in need of additional health services. We have heard about the problem of housing in rural areas. We have heard just now about the need for additional legal services.

So the demands are many and I would be hopeful that coming out of this hearing and other hearings that are being held in other parts of the country we can design some programs now that are uniquely beneficial in helping to solve the problems of people who live in rural America.

We thank you very much for coming.

Mr. SOUKUP. We would like to say thank you to Senator Clark and Congressman McCollister for being here with us.

Senator CLARK. Thank you. This hearing is now recessed.

[Whereupon, at 12:13 p.m., the hearing was recessed.]

APPENDIXES

Appendix 1

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM EDWIN L. CORDING, OFFICE OF COUNTY COMMISSIONERS, HEBRON, NEBR.; TO SENATOR DICK CLARK, DATED AUGUST 10, 1976

DEAR SENATOR CLARK: I am the chairman of the Blue Rivers Agency on Aging which comprises Gage, Jefferson, and Thayer Counties in Nebraska, and a commitment to Richardson County for a nutrition program which is to start soon.

In the first three named counties we started with a transportation program: two buses, now a third has been added, and all are running at full capacity and as per schedule. We had some difficulty with funding. After being in operation 2 years we were informed by the Commission on Aging that the third year's funding would not be available. This problem has been worked out, however. The main problem now is in local funding as all three counties are at the mill-levy limit as allowed by the Nebraska statutes.

In Thayer County, of which I am a member of the county board, we cut 0.60 mill from our road and bridge levy last year to come under the 14.28 levy limit. This, of course, is the last one that should be cut since we need our roads and bridges updated so desperately.

Our elderly problem for the up-coming winter will be the terrific cost of fuel to keep warm which takes a large part of their welfare income and leaves very little to subsist on.

Our agency on aging sends us a monthly report of expenses and work done in the various departments. I only wish the community action programs would do the same.

I may not be able to get to the meeting at Gretna, but I am sure our director, Fred Holtz, will be there and could answer any questions you may have. Willard Gumar may also be there from our board.

I am enclosing a levy sheet[1] from Thayer County for your review if you like.

Sincerely yours,

EDWIN L. CORDING.

ITEM 2. LETTER FROM DELBERT L. NIEMEIER, STATE DIRECTOR, GREEN THUMB, INC., LINCOLN, NEBR.; TO KATHLEEN DEIGNAN, STAFF MEMBER, SPECIAL COMMITTEE ON AGING, DATED AUGUST 10, 1976

DEAR MS. DEIGNAN: Enclosed are some statistical facts and figures about the people who are enrolled in the Green Thumb project here in Nebraska.

In 1975 the estimated number of people eligible for Green Thumb in Nebraska was 49,783 persons. At that time only 107 Green Thumb positions were available. This is only 0.215 percent of the total available.

In 1975 the estimated number of people eligible for Green Thumb in the 14 counties in Nebraska where Green Thumb operates was 15,976 persons. Again only 107 positions for part-time work were available, or only 0.6 percent of the total available older work force.

In June 1976 in Nebraska, the total enrollment in the Green Thumb project was 118 people. Their average age was 70 years and 1 month. Their average

[1] Retained in committee files.

education was 8.7 years and their average income was $1,577—most of which was their social security benefits.

Nine people were enrolled between 55 and 59 years old; 51 people enrolled were between 60 and 69 years old; and 58 people enrolled were between 70 and 80 years old.

The oldest Green Thumber is 89 years old. Actually four people enrolled are over 80 years old and working hard every day earning a better living.

Eighteen people are handicapped (loss of an eye, progressive arthritis, recuperating from a stroke or heart attack, etc.) and 13 people who are enrolled are veterans of World Wars I and II.

On July 21, 1976, we held a training meeting in Syracuse, Nebr. Part of the time was spent in a question-and-answer period devoted to the needs and problems of the elderly living in rural Nebraska. Listed are some of those discussed:

(1) Need of public low-cost transportation from rural areas to county seats, and occasionally to Lincoln, the State capitol.

(2) Need more opportunities to work at least part-time to earn a better living and not be on public welfare.

(3) Lower taxes on private property (their homes).

(4) Better health care, including dental care, and more free medical examinations.

(5) Lower utility costs for the elderly.

(6) More low-rent housing available for the older people.

(7) Social security should not be counted as income. The social security benefits are something that each older person has earned through their productive years and they are just now able to draw on these earnings after age 62 or 65.

(8) Need more winterization work done on their homes to help save on energy and on heating costs.

The Green Thumbers also believed that the maximum income guidelines should be much higher than they now are. These are the guidelines that these older people need to meet in order to qualify for programs that the Congress has enacted for their well-being.

All the Green Thumbers present believed that an older person should be assisted by whatever means possible so that they could live in their own homes as long as physically possible.

They were very grateful that they were given an opportunity to express their needs to you and the Special Committee on Aging. We enjoyed your visit to our office and we also thank you for this opportunity for "in-put."

Please contact us if you have any questions.

Sincerely,

DELBERT L. NIEMEIER.

ITEM 3. LETTER FROM FRED HOLTZ, DIRECTOR, BLUE RIVERS AREA AGENCY ON AGING, GAGE, JEFFERSON, AND THAYER COUNTIES, NEBR., TO SENATOR DICK CLARK, DATED AUGUST 13, 1976

DEAR SENATOR CLARK: I would like to address the problem of rising costs of energy and utilities faced by retired persons, especially low-income senior citizens.

Numerous complaints and comments in the fall of 1975 prompted this agency to do limited investigation into propane pricing practices. Information was hard to document and almost impossible to receive concerning wholesale prices of this fuel; however, we were able to establish that wholesale propane prices did not change through the fall and winter of 1975–76. Retail prices did fluctuate greatly with each individual dealer. Some raised prices by as much as 5 cents per gallon in the heating season and, as usual, the small user suffers the greatest increase. Volume users are and were offered up to 2 cents discount per gallon. We also found that elderly are paying 1 percent interest per month on bills not paid in 30 days. Some pay interest all summer for the past year's heating bills.

Our investigation also found that numerous persons on small incomes cannot heat their homes comfortably. Most were paying from $80 to over $125 per month for heating fuel and receiving from $147 to $178 per month social security, and unable to build any kind of reserve to fall back on. I am speaking of only

heating cost. This person still has lights, water, phone, and other utilities. We found senior citizens trying to survive on less than $30 per month after fixed utility bills were met.

Surely something (maybe a fuel stamp program) must be done to assist the senior citizens living in rural areas. They have no choice but to lock in or use this type of heating fuel, and are completely at the mercy of our energy crunch and pricing practices of local propane dealers.

I definitely feel that this problem should be investigated and addressed by Federal agencies with the thought to some type of assistance for needy low-income senior citizens.

Thank you for the chance to comment on this problem.

Sincerely,

FRED HOLTZ.

ITEM 4. LETTER FROM EVERETT W. GREEN, SECRETARY, NEBRASKA PUBLIC SERVICE COMMISSION, LINCOLN, NEBR.; TO SENATOR DICK CLARK, DATED AUGUST 31, 1976

DEAR SENATOR CLARK: This is in reference to your August 4, 1976, letter asking various State agencies for comments on what has been done by the State agency to serve the elderly with transportation subsidies and other services.

This is to advise that this commission recently assisted the Nebraska Legislature in drawing up a bill, which was subsequently passed, to exempt the transportation of the elderly from the jurisdiction of this commission.

This would be the action of any consequence for us to report.

Sincerely yours,

EVERETT W. GREEN.

ITEM 5. LETTER FROM NEBRASKA STATE SENATOR ROBERT L. CLARK, SIDNEY, NEBR.; TO SENATOR DICK CLARK, DATED SEPTEMBER 8, 1976

DEAR SENATOR CLARK: This is in reply to your letter of August 4, 1976, in which you have asked for suggestions concerning improvement of rural telephone service.

The Telecommunications Subcommittee of the Nebraska Legislature has conducted public hearings in Nebraska communities relative to rural telephone systems. The committee was instructed by the members of the 84th legislature to:

(a) Identify the unique problems and characteristics of rural telephone systems which inhibit the provision of quality service;

(b) Propose alternative solutions to the problems identified;

(c) Develop and analyze information about the size of the telephone exchanges in rural areas, and the effect of such geographic and population size upon service;

(d) To gather whatever additional information is necessary to make an assessment of the situation.

In your letter you stated that your Committee on Aging was conducting a series of hearings on "The Nation's Rural Elderly." It should be pointed out that our Nebraska Study Committee did not direct its attention specifically to the problem of the elderly, but to the problems of rural telephone systems in Nebraska.

The findings of the committee:

(1) Nearly all of Nebraska's rural homes presently have phone service.

(a) Approximately 60 percent are being served with buried cable facilities.

(b) Nearly 56 percent are being served on either 1-, 2-, or 4-party facilities, at the customer's option.

(c) Multiparty lines (eight-party service) are presently scheduled for elimination by 1982, with a few scattered projects remaining until 1984.

(2) Rural customers have submitted testimony asking for wider toll-free calling areas. The telephone companies in Nebraska, operating under rules of the Nebraska Public Service Commission, provide EAS when 65 percent of the telephone customers request such service and agree to pay the higher basic rate that is applicable to the enlarged calling area. At the request of the Nebraska Public Service Commission, the telephone industry has submitted to the com-

mission several proposals that will hopefully meet with a more favorable customer acceptance. In these proposals, charges would be applied only to those customers that would benefit from the expanded service.

(3) The costs of providing and maintaining telephone service in rural and sparsely populated areas are extremely high and will continue to be subsidized by the total rate structure of the State.

(4) The present policies of the Federal Communications Commission, which encourage competition in the most lucrative area of the telecommunications industry, will almost certainly reduce revenues for Nebraska telephone companies. Under FCC sponsorship, specialized common carriers are skimming the cream by serving the more profitable intercity market, while ignoring less populated areas. The results can only be higher telehpone costs for all customers, but particularly for those in rural areas.

Our committee will not have final recommendations for our legislature by the September 15 date which you suggested. It is my belief at this time, however, the final recommendations will be similar to the following:

(1) Consider enacting legislation that would encourage telephone companies to advance their plant modernization schedules.

(2) Review the action of the Public Service Commission on extended area service (EAS) requests and orders.

(3) Explore the possibility of legislation or a resolution supporting the Consumer Communications Act of 1976.

(4) Continue monitoring the activities of Nebraska telephone companies regarding rural service improvement programs.

If I can be of further service to you, please feel free to contact me.

Sincerely,

Senator ROBERT L. CLARK.

Appendix 2

INTERAGENCY MEMORANDUM FROM EVELYN RUNYON [1] TO LAWRIE ROBERTSON, EASTERN NEBRASKA HUMAN SERVICES AGENCY, DATED JULY 23, 1976

SERVICES TO RURAL COMMUNITIES

You have asked for my thoughts on services for the rural elderly. Most of my 78 years have been spent in small communities, though I have been an urbanite for some time. However, I have maintained close association with persons living in small towns, villages, and on farms. As ombudsman for ENOA, I am, and have, worked with the elderly who have always lived in the city and many who have come to the city from rural areas to seek the services and conveniences of the city.

It is my strong conviction that the same services offered through the area agency to our urban elderly are as needed and are as altogether appropriate and adequate for older persons in small towns, villages, and on farms. The need for transportation, health care, nutrition, companionship, and social life may be even more urgent in some locations and in numerous cases than for the urban elderly. All of the services we at ENOA offer could be taken to those in our rural areas. We can meet the needs effectively with competent, understanding staff.

In fact, there is no organization better prepared and equipped than the area agency on aging to fill and coordinate services to respond to the needs of the elderly located in rural areas. But, I feel, as I indicated, that this rural service provision will take a special approach. For the mores in rural living are vastly different from those in urban living. There is a defensiveness to be overcome, for the rural resident is most apt to be suspicious of the person from the city. This is partly because our myths have included the one that the city dweller looks on the small town citizen and the farmer as unsophisticated and uninformed. And, too, because living with space and free association possible in small communities, and living close to the soil on farms, gives a different perspective on life that the more or less impersonal and close association in city living does not afford.

The offering of services from the area agency must be accompanied by an understanding of the psychology of rural living and with a compassion born of understanding and sensitivity to the mental and emotional characteristics of the rural citizen. Any hint or semblance of welfare or patronizing should be totally lacking. It is imperative that there be empathy, if the necessary degree of rapport is established. In my opinion, in most all rural areas there would be very little, if any, difficulty in recruiting volunteers as aides in all of the programs. There does remain a residue of neighborliness that makes volunteering for many almost second nature and carries with it a badge of honor.

It can be noted that with the almost total dependence on the automobile for transportation, the handicaps that may come to the rural elderly tend to isolate many of them. This is even more so than if they lived in the city where some public transportation is available. Many women did not learn to drive, and after the death of their husbands, lose a taken-for-granted mobility; many, both men and women, have had to sell their cars because of financial need, as well, and many have physical disabilities that make driving a car impossible. Gone are the days when the family's horse and buggy provided safe transportation for those suffering handicaps, financial or physical, that most often come in later life. We tend to accept the myth of "unquestioned neighborly help" to the elderly and a rugged self-sufficiency in both the small communities and on the farm. In print, media, and television scripts this myth is perpetuated, but does not bear out what the truth is now, only as historical qualities.

[1] See statement, p. 160.

Health care, at best, is limited in rural areas. Often it is meager, if not nonexistent. For many physicians today have migrated to the city since competence beyond first aid demands the laboratories, technicians, and modern technology supplied by metropolitan hospitals. House calls by a physician are practically eliminated. Thus, with distances greater and mobility limited, rural citizens most often neglect to see a physician and do not receive preventive care.

Time was when a physician knew practically everyone in his community and his concerns for them was that of a benevolent neighbor. That too, has become a myth. Even the midwife has been replaced by a licensed practical nurse, but most small communities do not have the services of LPN's on a regular basis. A mobile unit for health service staffed with trained personnel and equipped to take blood pressures, make diabetic and other uncomplicated tests, eye and hearing examinations so as to recommend medical care when necessary could fill the vacuum in health services in the rural areas.

If food sites could be assured with added portal-to-portal transportation, then this type of facility could be utilized if necessary in lieu of a mobile van to fill the existing and growing need for health care. This also implies, of course, a health maintenance staff is available for a nutrition site.

We are apt to assume that persons in small towns, villages, and on farms raise their own food and are therefore adequately fed. This too, falls in the category of myth. The mother used to be able to can sufficient vegetables and fruit for the winter and the family together took care of the garden. Yet in reality, often the elderly are alone and these chores not possible. Cooking becomes a difficult task for the majority of elderly persons and nutritious, balanced meals are rarely on the table. Often, because the older person alone is apt to have no appetite, and/or no knowledge of the body's need, or of the harmful effects of certain food he or she may be getting in a daily diet, malnutrition often occurs. Statistics bear out the fact that nutrition sites with the carefully planned meals for the elderly, served in attractive settings and with the inherent sociability encourages and provides proper nutrition.

Nutrition sites can and do fill many needs of the elderly beyond a balanced hot meal at noon. The social activities and companionship are vital to keep the elderly active and with the feeling of belonging. The sites make it possible to reach many of the community's elderly with informational and inspirational programs on health maintenance, safety, and financial affairs. Many need knowledge of regulations in social security, taxes, homestead exemptions, and filing the necessary forms, to mention only a few matters of special interest and value to the older citizen in the rural areas. Games, recreational programs, dancing, trips, and warm congeniality that comes from eating, listening, and playing together all imply portal-to-portal transportation for many site participants.

My experience as ombudsman has brought me face to face with the lack of coordination in many valuable and needed services offered to the elderly. This is not limited just to AoA programs, but the entire spectrum of community services that eventually will be needed for a great segment of our elderly citizens, rural as well as urban. I have the distinct conviction that many programs have been designed without thinking to the long-range implications—the peripheral outcomes are often ignored. Health maintenance, nutrition (through balanced meals), social life, and the feeling of belonging are all interrelated and all dependent upon adequate transportation, and flexibly responsive programing adapted to meet the special needs of any particular group of elderly served by the AAA—whether they be rural or urban.

The Role of the Ombudsman

The role of the ombudsman is a complex one for it must deal with all conditions of human needs and characteristics. It demands careful, accurate investigation, compassionate human understanding, and must call upon certain administrative skills in resolving problems and in handling unjustified complaints.

The ombudsman is called upon to investigate any concerns of senior citizens for essentially any unresolved concern is basically a complaint that needs to be solved.

This office has investigated concerns relating to customer-vendor differences, legal situations, housing, social security misunderstanding, insurance difficulty, fear for personal safety, housing, or human associations, critical situations inci-

dental to illness as well as many referrals to other human service agencies to name some of the areas that become cases to be handled in this office.

In short, any human concern, whether personal, confidential, or impersonal, could ask for the services of the ombudsman. Often the caller only needs someone with patience and understanding to talk to for loneliness is so often the primary or triggering factor in concerns or complaints.

It is also the duty of the ombudsman to discuss with the administration possible improvement of services in the agency from insights gleaned through the investigation necessary to resolve the concerns or complaints.

EVELYN RUNYON.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing on "The Nation's Rural Elderly," in Gretna, Nebr., on August 17, 1976, I would have said:

The following replies were received:

RUTH C. BLANKENSHIP, OMAHA, NEBR.

The hearing in Gretna, Nebr. was very worthwhile. It brought out the real needs of our rural elderly.

The testimony has given us some real guidelines.

You are to be congratulated in bringing this hearing to rural Nebraska.

HELEN M. BROWN, GRETNA, NEBR.

In Gretna, we now have delivery of mail in town. However, the Federal law says that mail is not to be delivered to anyone closer than one-quarter mile from the post office. Most of our elderly people—at least a number of them (I counted 40)—live in this area. That means they have to walk to the post office. This is also true in other towns near here. Can't something be done about this?

JOCIELL BULL, WAYNE, NEBR.

The needs of the rural elderly are the following in the line of necessity: (1) Transportation; (2) Nutrition; (3) Home nursing; and (4) Homemaker—chore service.

These should be available for all the elderly—no matter what their income is. We find in our area that those in the poverty level are better provided for than those who have a dollar or two above the poverty line!

We also feel that more services should be provided under medicare, such as: eye surgery, hearing-aids, dental work, etc.

We want to keep them in their homes as long as possible, because they enjoy being in the neighborhoods where all aged persons live. They do not want to be put on a shelf, and many do not use a rocking chair. They have knowledge and wisdom, and they want to share it with others. Let us meet their needs so they can remain in their homes as long as possible.

HELEN C. HENGEVELD, BLAIR, NEBR.

I felt this was a very worthwhile program and I was glad to attend.

ELMER F. LANGE, LINCOLN, NEBR.

ACTION has a deep concern for the rural elderly and is conducting, in rural areas. programs that are for those 60 and over. These programs are in communities with a population range of 800 and up. These programs are also operated on minimum funds, but with specific emphasis on keeping the elderly active.

ACTION elderly programs consist of retired senior volunteer programs (RSVP), foster grandparent programs (FG), and senior companion programs (SCP).

BILLIE F. LOGAN, OMAHA, NEBR.

First of all, Senator, I would like to thank you very much for your advocacy for the elderly. They are certainly a forgotten group but, thanks to individuals like you, things are beginning to look up for them. I manage 11 elderly high-rises in Omaha, exclusively for the elderly, and am aware of and a strong advocate of their needs. This has been a problem for the elderly in that when a little illness overcomes them and they need some time for recuperation, there is no intermediate-type living for them; it is either self-sufficiency or a nursing home. The homemaker service that they are able to receive has been one of the most important services for the urban elderly, and helps them maintain their independent living.

There are many services now available, and the little individual in the urban areas, as well as the rural elderly, have a difficult time learning of the services. It would seem that those agencies rendering the services would have a greater responsibility to an outreach program that would encompass all. The little elderly persons still remaining in their homes, living out among the residents of the urban city, can be more easily forgotten than those who have the capacity to learn of the programs. Then there are the SRO's, single-room occupants, living in the urban core of the great cities who are strictly loners and give no encouragement whatsoever to agencies and their services. It is a tremendous task—and much needed—to take and give a helping hand to our elderly of the Nation. These are individuals who have sacrificed time and again for their country. They suffered during the days of the depression, pulled themselves up by the bootstrap, and sacrificed again for their country—many to the extent of giving a loving son, daughter, or husband to World War II. During all these years they attempted to put some little something away in savings so they could care for their old age and not be a burden to their families or country, but inflation took care of that and left many without a penny. Their pride continued on and many still refuse assistance, thinking it is charity.

Talk about the "Grand Ole Generation," we should all certainly be proud. Still in the limited incomes, they continue to ask what they can do for their country. We all owe our elderly much more than we could ever hope to repay. There are so many things our legislature could do in helping them with their ability to live in dignity. Such things as limiting them to earnings and affecting their social security. They are forced into retirement, put on a limited or fixed income, and forced to remain there. Also, those who receive veterans' pensions are penalized by their social security increases, for social security is counted as income in computing the amount of VA received, so consequently when they receive a raise in social security, they receive a deduction in VA—fair?

The recent Federal programs of Senior Companion and Green Thumb are the greatest thus far. They permit the elderly to help one another, receive payment, and are not penalized on their other incomes. In the urban areas this takes the pressure off somewhat, for at least now they can afford a little transportation—public that is—and get around. As so many spokesman at the meeting said, "I could go on and on." It is rewarding to see so many persons interested in the elderly and I certainly feel with national politicians as yourself so interested, the elderly have a great fighter in their corner. Thank you very much, Senator.

LAVERN PLAMBECK, OMAHA, NEBR.

I believe that transportation is one of the big problems for the senior people; they also need a better health care program. The hearing was very interesting. Thanks, Senator Clark, for taking time out for this type of program.

LUCILLE PRATER, RULO, NEBR.

How would one go about handling local transportation for the rural elderly? And how would the financial end be taken care of, such as who would be in charge of maintenance and other expenses? Many need the service and are on limited income.

RUTH ANN RAILSBACK, HUMBOLDT, NEBR.

As public information officer for Southeast Nebraska Community Action Agency, I would like to inform you of the services we are making possible for the senior citizens in our area. We operate in the four-county area in the extreme southeast corner of Nebraska with winterization and nutrition services offered in the two counties to the north.

Nutrition: Seven congregate meal sites, also offering home delivered meals, plus some of the small towns with cafes prepare home delivered meals. Two more meal sites are in the process of being started.

Transportation: Regular monthly bus trips within each county from the small towns into the county seat or larger towns. This provides access to medical services, grocery, etc. Portal-to-portal services within the area for special medical needs, congregate meals sites, etc.

Winterization: Service is available in the 6-county area with over 150 homes being served and the large majority of these belong to senior citizens.

Health services: Blood pressure clinics are held at five multipurpose centers on a regular monthly basis and other clinics are held as needed, with volunteer nurses and aides conducting the clinics. Diabetes Clinics are held. Home health aides call on the elderly in their homes for nonprofessional health care. At present time, we are helping sponsor a demonstration county health project in Nemaha County with the cooperation of many agencies. This will serve all ages, with many being senior citizens.

Recreation: Recreation and educational field trips, crafts, card playing, socialization, etc., at the five multipurpose centers; senior citizen clubs in most all of the small communities which meet regularly; telephone reassurance; we helped the senior citizens form AARP chapters in each of the four counties.

Used clothing: The multipurpose centers provide used clothing for all ages, including senior citizens, some of which are used for quilting materials.

Sell food stamps: In one of the counties our outreach workers sell food stamps in every town, large and small, some of the clients being seniors.

Outreach and referral: This is a large job done by our outreach workers, keeping the senior citizens aware of the programs they are eligible to participate in.

We are proud of the services that we do offer, but fully realize that the elderly in our area still have many needs that are not being met. We need handibus service in the five counties not having one; we need chore service, handyman service, and some kind of legal service. We also need multicounty bus service. We must also admit that we need to continue and enlarge the services that we are now providing.

HENRY D. SMITH, LINCOLN, NEBR.

It seemed there were three primary concerns echoing throughout the hearing. These were: (1) transportation, (2) home health services, and (3) nutrition (meals prepared for the elderly). Most all of the speakers described these as basic needs, at least in one respect or another. I think you will also agree that throughout the hearing it was apparent there is a desire to remain independent and in the home as long as possible. It was also brought out that, coupled with the nutrition and home health services, should be health education services to teach methods of disease and disabling prevention.

The three concerns are closely related. As an example, certain needs for transportation services might be alleviated, such as to a physician, if home health services were available. Also, nutrition should consist of more than just availability of meals; nutritional quality of meals is indeed vital.

As "health" is our primary concern, we would encourage your support of home health services. Health services are a basic need for all of us, especially the elderly. Nutrition and transportation could be coupled into this or at least serve a complementary relationship.

The State department of health has placed a high priority the past several years on assisting (consultative and finanically) communities in developing their own community health services. This includes home health care and prevention through health education. Such services are furnished to everyone in need of such services, though the elderly have certainly a high rate of utilization. Since 1972, six rural counties have established such a program for a population of 80,000 persons. (Urban areas of Omaha, Lincoln, Grand Island, and Scottsbluff have had established programs for quite some time. Our emphasis has been on the rural counties.)

Fifty-one counties do not have home health services available for an approximately 600,000 population. These are rural counties with a high elderly population. The State department of health does not presently have the resources to furnish such services in this magnitude.

We heard at the hearing that counties are having a problem in providing services due to the 14.28 mill tax limit. So, even with our assistance, many counties seem unable to alleviate this problem and furnish this much-needed service for their people in need, especially the elderly.

The committee hearing was excellent. Views and needs as expressed by the witnesses certainly stress that action is needed.

Again, we encourage your support and offer our services in any way we can be or assistance to you in this endeavor.

DOROTHY TREMEL, OMAHA, NEBR.

I am a firm believer in helping people to help themselves. The agencies, and especially churches and synagogues, could do more to dispense needed services to older people. Is there any way for Federal dollars to be given in the form of small grants to initiate programs as an incentive for especially churches to get involved?

We spoke at the hearing about coordination of transportation services. There must be some way of using the expertise of MAT in Omaha, and yet let local churches, agencies, and hospitals be the spokesmen for the elderly who need transportation. Without this in-between, the system is so impersonal and hard to get that all older people experience is frustration.

MARIE WADDELL, PAWNEE CITY, NEBR.

I am a resident of Pawnee City, Nebr., in Pawnee County. We have 166 widows 65 to 90 years of age; 275 couples, widowers or bachelors 65 and over. There are 5 small towns with from 12 to 50 senior citizens in the county.

We have two doctors and one dentist in the county.

We have no transportation in the county but the Seneca bus. What has to be done in our county to get a minibus? We have low-rent housing, but it is five to eight blocks from groceries, bank, and doctors.

We are 45 to 80 miles from eye doctors or other specialists, and from 20 to 80 miles from bus, train, or plane service.

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THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 2—OTTUMWA, IOWA

AUGUST 16, 1976

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The Nation's Rural Elderly:
Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove, Iowa, August 17, 1976.
Part 5. Sioux Falls, S. Dak., August 18, 1976.
Part 6. Rockford, Iowa, August 18, 1976.
Part 7. Denver, Colo., March 23, 1977.
(Additional hearings anticipated but not scheduled at time of this printing)

CONTENTS

THE NATION'S RURAL ELDERLY

MONDAY, AUGUST 16, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Ottumwa, Iowa.

The committee met at 2:10 p.m., pursuant to notice, in the Indian Hills Community Center, Ottumwa, Iowa, Hon. Dick Clark presiding.

Present: Senator Dick Clark.

Also present: Deborah K. Kilmer, professional staff member; David Harf, legislative assistant to Senator Clark; Margaret S. Fayé, minority professional staff member; and Donna M. Gluck, resource assistant.

OPENING STATEMENT BY SENATOR DICK CLARK, PRESIDING

Senator CLARK. The meeting will please come to order.

There is a larger crowd than we thought would be here and I know that the machine makes a little noise, so it may be difficult for some of you to hear. We are trying to get a microphone for the witnesses, and I will try to speak up as best I can. If we can get a microphone, that will be helpful.

I have 3- or 4-minute statement that I want to make at the beginning about the nature of the hearing.

We have two panels this afternoon, and while I am doing that perhaps the first panel could come on up to the table. The first is a panel on transportation. Edward S. McMillin, the State legislative council, American Association of Retired Persons, Inc., here in Ottumwa; Dr. Albert Burrows, professor of sociology at Penn College in Oskaloosa, and a member of the State Advisory Committee on Aging; and Ben Grismore, from Corydon. If they will come right on up here, we will start the hearing.

I want to say at the outset that I am particularly happy to be here in Ottumwa for this meeting which is an official hearing of the U.S. Senate Committee on Aging. The hearing will probably be over at about 4 o'clock. We will have the two panels, and following those we will give people an opportunity to make statements or ask questions up until 4 o'clock.

As you see on my left, a stenographer will record everything that is being said and we will issue a printed transcript of these proceedings. If you want a copy of what has been said here today, please leave your name and address with anybody here at the center and indicate that you want a copy of the printed hearings and we will be happy to supply those.

Six Hearings Being Held

Our subject at the six hearings that we are holding in the State of Iowa and outside the State—we are holding some of these hearings in Nebraska and South Dakota, as well as Iowa—is "The Nation's Rural Elderly." We are interested principally in programs as they affect rural areas, and by "rural areas," I simply mean communities the size of Ottumwa and smaller, with particular reference to the smallest communities.

So that is what we are emphasizing, not simply problems of the elderly, but problems of the rural elderly and what unique kinds of problems people face as they grow older in the small towns.

I suggested that such hearings be held about 1 year ago because it is my judgment that we cannot hope to know what is happening in rural America if we simply stay in Washington. That is why we are coming out to smaller communities in various parts of the country.

The chairman of this committee, Senator Frank Church of Idaho, agreed with this suggestion and so we are holding these hearings in Iowa, Nebraska, and South Dakota.

I want to keep my own statement brief because we want to emphasize the questions, particularly, on transportation, and our second panel is going to be talking more specifically about employment programs.

Let me sum up a few points that I think ought to be made. One of the prime objectives of these hearings is to determine the responsiveness and practical help that is provided to the rural elderly by programs such as the Older Americans Act, the medicare programs, and the housing programs.

I remember visiting some of the housing programs here in Ottumwa some time ago—transportation assistance, programs of that kind, the multipurpose centers such as this. These are the Federal programs that are in existence and we would like to have your reaction as to whether they are working or whether they are not working—what we ought to be doing differently, and what we are doing right. That is really the purpose of the hearing.

There is a real need for this kind of evaluation, I think, because we failed to do what we said we were going to do in the 1971 White House Conference on Aging. We set some very good goals, but we are a long way yet from reaching them.

We have not yet arrived at a national policy on aging, particularly as it regards rural issues. Part of the lag has been caused by a lack of leadership, I think, both in the executive branch and in the Congress.

The fact is that we still have a great number of elderly people—about 8 million, to be exact, which is more than one-quarter of our entire population—60 years and older who are from rural areas. In some States, I might say, that percentage is much higher—as high as 50 percent. Here in Iowa it is about 45 percent.

Transportation: The Key

So there are major needs in rural America and we are going to be talking here in Ottumwa today—listening, I should say—first about transportation.

Now it does not stretch anyone's imagination to realize that in rural areas transportation is particularly important. It does not really matter much what the Federal, State, or local government provides if it is not accessible to anybody.

What good is health care if you cannot get to it? What good is any service if it is not accessible? Transportation is really a key to the problems of rural services. For many elderly without an automobile or bus, there is no way to cash their retirement checks; no way to see doctors; no way to pick up prescription drugs; and no way to go to and from the grocery store. And yet, we are told by experts that even though rural areas depend more on an effective transportation system than urban areas, rural residents are losing access to any kind of system faster than other areas. In the past 15 years, nearly 150 bus companies have gone out of business in cities with less than 25,000 people.

So what do our rural elderly do? If they do not have family or friends to drive them for necessary appointments and errands, they simply stay home—stay home and become more and more isolated, unhealthy, and literally homebound.

The Ottumwa area has been more fortunate than some other areas of the country because of the 10-county bus program you have operating for the elderly. With support from the State office on aging and other agencies, there is one bus operating in each county to serve the needs of the elderly residents. But is this sufficient? Are individuals able to get direct, door-to-door service? Are schedules convenient for the riders' needs? We hope to explore these questions today.

Our other topic of focus today will be employment programs for the older worker. The employment situation for younger workers has improved recently, but the jobless rate for the older worker is still too low. The number of unemployed persons 55 or older has actually increased lately despite our modest economic recovery.

The second panel today will discuss several special employment programs for older workers that exist in this area. We will hear how such programs assist the older person in supplementing his or her small retirement check. I am sure we will also hear how employment opportunities for the older worker are vital means for keeping the person active and productive. This is a virtue that most elderly desire above all else—to feel needed. I am sure our witnesses will convey this point.

Finally, I'd like to say that in the Older Americans Act programs, and in all the others, the rural elderly must feel that no one is dictating to them. The progress we are making in aging is due in no small part to the initiatives and determination of older persons who are making things happen. The Federal share of their effort, if one is needed, ought to be part of the solution and not part of the problem.

This first panel, again, is made up of Ed McMillin, State legislative council, American Association of Retired Persons, Inc., Ottumwa; Dr. Albert Burrows, professor of sociology at Penn College, and a member of the State Advisory Committee on Aging; and also Ben Grismore of Corydon.

They are going to be talking, I think, in that order. Then we are going to have questions for the record and then our second panel.

So Ed McMillin, would you wish to start? I apologize for the fact we don't have a microphone. I know that it is a little noisy, so the louder you can speak, the better.

PANEL ON TRANSPORTATION PROGRAMS

STATEMENT OF EDWARD S. McMILLIN, STATE LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, INC., OTTUMWA, IOWA

Mr. McMillin. Thank you for the opportunity, Senator Clark, to testify before the Special Committee on Aging on "The Nation's Rural Elderly."

I guess, Senator, this area is about as rural as any area in Iowa. Statistics tell us that, per capita, we have probably more older persons than anywhere in the State of Iowa.

My many years as a public servant—18 years as Wapello County auditor—put me in touch with a great number of older persons who, through the years, expressed many of the same concerns they are expressing today.

As I retired and became one of those older-person statistics, I found the elderly of this area of Iowa are still vocalizing many of those same concerns I heard as county auditor: a need to be useful, to have adequate transportation available, and needs related to nutrition and health.

One of the key concerns, Senator, is the lack of adequate transportation in this rural area of southern Iowa. My association with the American Association of Retired Persons and my work with the area agency on aging program has placed me in direct contact with a number of older persons who are grateful for a mass transit system in Ottumwa, Iowa, even though cost and accessibility does not often meet the need.

They are also appreciative of the area agency on aging minibus program that is a source of transportation within the 10 counties of area XV.

As good as the area agency on aging transportation is, Senator, there are still a number of older persons living out in the rural areas who have extreme difficulty in getting from their homes to a doctor, a dentist, or a pharmacy, all of which may be located in a county seat town miles away.

Many of our older persons, Senator, must rely on friends, neighbors, and family, if they have any, to provide this kind of needed service.

Many Are Isolated

In addition, there are hundreds of older persons who are simply isolated from people due to a lack of transportation. There are people who have lost all contact and, as a result, begin to deteriorate mentally and physically.

AARP does provide personal, door-to-door service for a number of older persons, but the need goes well beyond AARP's ability to respond.

There is a need to bring together existing transportation potential in the area—to coordinate what is being done and to expand service beyond what is being done now.

We feel we have the capacity to expand and enrich the lives of older persons in this area of southern Iowa.

We do have organizations with the interest and the expertise to provide some kind of comprehensive transportation program for older and handicapped persons in Wapello County and all of area XV—organizations, such as the American Association of Retired Persons and area XV Agency on Aging advisory groups, both of whom have been instrumental in making suggestions and devoting time and energy to improving the lot of older persons.

Southern Iowa Economic Development Association (SIEDA), the community action agency serving this southern Iowa area, has, in my opinion, the planning and operation capacity to do something about transportation.

Area XV regional planning commission, along with the cities and counties, have that kind of expertise. These groups and organizations are planning together, Senator, to solve this serious problem, but it all takes money—money from Federal and State areas. It will also take technical assistance from Federal and State sources in a concentrated effort at solving the problem.

I understand much is being done now, and many people in this area are laboring long and hard, but more effort, cooperation, and funding has to be available if we are to be successful.

I believe this area of Iowa can establish the first workable rural transportation model in the country; we have that capacity, but we need a prolonged and concentrated commitment by government to assist us in the effort.

The problem has taken years to develop and, in my opinion, will not be quickly solved. Many of us may not be around to enjoy the success we feel will come, but surely it can and will happen.

With all the technical know-how we possess, Senator, we must have the capacity to structure a transportation system in rural America that will move an older person 14 miles to an area where needed services are available.

Surely we can collectively bridge the gap from Blakesburg, Iowa, to Ottumwa, Iowa, from Batavia to Fairfield, from Moulton to Centerville, from Deep River to Sigourney—it's a matter of a few road miles, Senator, certainly far less than the 240,000 miles to the surface of the Moon. We managed, during a war for survival, to solve massive transportation problems, Senator. Can we do less for the survival and well-being of the Nation's older persons?

Thank you for the opportunity to speak, Senator Clark.

[Additional material submitted by Mr. McMillin follows:]

TRANSPORTATION

MAJOR EVENTS AND ACTIVITIES IN AREA XV

The regional planning commission has received preliminary approval on a demonstration project for $250,000 to be spent over the next 2 years. Mr. Bruce Bullamore has initiated an advisory group to give input for the final application for this comprehensive rural system.

Area XV Agency on Aging, soon to come under the Southern Iowa Economic Development Association umbrella for programs to serve Area XV, is submitting a proposal for Urban Mass Transportation Administration funds under section 16(b)(2). Funds will be used to replace equipment currently being operated as

well as offering an additional service for the handicapped via special equipment in Wapello County.

South central Iowa community action program is applying for funds to provide transportation to handicapped people in Wayne, Monroe, and Lucas Counties. These funds would also come through section 16(b)(2).

MAJOR EVENTS AND ACTIVITIES IN WAPELLO COUNTY

An agreement has been reached with the Ottumwa Transit Authority by the Area XV Agency on Aging allowing the agency's bus to operate 3 to 4 hours daily inside Ottumwa's city limits. Service is aimed primarily toward those individuals who, for one reason or another, cannot utilize the city bus.

Ottumwa Transit Authority will be eligible to apply for a portion of the $2 million appropriated last session by the State legislature.

One application will be accepted also for the rural operation. It is hoped that this money will be spent in a fashion acceptable to the legislators so they can see their way clear to reallocate funds to the Department of Transportation for future use to provide or help provide comprehensive transportation services in Iowa.

MAJOR NEED IN TRANSPORTATION

When a system has updated its equipment, there is a need for operating assistance. In many grant applications the emphasis is on capital outlays, rather than operating expenses. That is one major point that needs attention, mainly because in rural Iowa the strain of operating a system cannot be met by local support totally.

STATISTICAL DATA, BASED ON QUARTER ENDING JUNE 30, 1976

	Area XV	Wapello County
Trips, total	19.093.00	1.752.00
Miles, total	55.160.00	6.320.00
Income, total	7.728.69	1.087.47
Cost, total	31.196.43	3.448.30
Cost per trip (area average)	1.97	1.98
Cost per mile (area average)	.61	.54
Income per trip (area average)	3.44	.63
Income per mile (area average)	.14	.17

Senator CLARK. Thank you very much. I liked your statement that if we are capable of reaching the Moon, we ought to be capable of solving the transportation problem to get back and forth to the communities of this area.

I will have some other questions, but I think we will go ahead and hear the other panelists first.

Next we are going to hear from Professor Burrows. Please proceed in any way you think appropriate.

STATEMENT OF DR. ALBERT BURROWS, PROFESSOR OF SOCIOLOGY, PENN COLLEGE, OSKALOOSA, IOWA, AND MEMBER, STATE ADVISORY COMMITTEE ON AGING

Dr. BURROWS. I want to get back from the Moon to this area. As he said, we are probably one of the two or three States with the most aging, and in this particular area probably more than anywhere else in the State. I was just checking. It takes four of our largest metropolitan counties—Woodbury, Polk, Black Hawk, and Linn.

Between 17 and 18 percent of our people are 60 or above, so we are more than twice as urban as these other metropolitan counties. That makes a big difference because that means we are scattered out over a lot of the countryside.

Before I say some other things, I wanted to say that I have not been a college teacher all my life. I am not teaching at Penn now. All these definitions, when we talk about aging—I am a little sensitive on that. I have already beat the projectors by 10 or 15 years. As far as I know, you start aging the minute you are a day old, or you could even start the minute you are conceived, so we are all aging.

I am always hearing them talk about terminal illness. After all, we are all on kind of terminal stay here. Just what do you mean by terminal, and what do you mean by aging?

In any case, we have a problem and, roughly, we think we know what it is. The transportation in Mahaska County—the county seat is Oskaloosa. We have one bus, I guess, as every other county has one bus, and we do the best we can with one bus. We have hours from 8 to 5, and they are not long enough. Particularly the later hours—folks can't get their shopping done or can't get through with the doctor, or whatnot.

So we need longer hours. If our minibus takes a load to the State fair next week, then there is no bus in the county. We ought to have another bus. We ought to have another driver or more hours for part-time drivers.

Additional Funds Needed

Of course, that takes money. So, Senator Clark, we always need more money. Today some folks think there is something happening important in Kansas City. I think the only thing important is happening here.

In any case, I lived through the thirties and the New Deal.

This middle-aged lady had finally gotten her husband to church one day, and so after church she was introducing him to the deacon of the church, newly elected. She was saying, "John, this is the new deacon"—this was in the New Deal days. He was hard of hearing.

"What?"

"The new deacon."

"What?"

"This is Mr. Jones, the new deacon."

He said, "New dealer?"

She said, "He is a son of a bishop."

"Oh," he said, "they all are." [Laughter.]

I come from Missouri, and Missouri has the Ozarks. I come from another part of the State, so don't call me an Ozarkan.

In any case, they tell the story of the old farmer who is old—I don't know what "old" is, but to me it has to be 80 or so.

Anyhow, this old farmer kind of quit his farming, but he had an old trick mule. The folks from the city—Springfield and other cities—would come out and pay a quarter to have the trick mule perform. The old man got sick—I think it was this pig flu that is supposed to be going around.

The folks would come to the door and say, "I want to see the trick mule." She got tired, so she went out and put a sign on the road gate that said, "The old jackass is sick. You can't see the trick mule until he gets better."

I didn't get those just in order, but, anyhow, it is real good. [Laughter.]

We are interested in this area—area 10—10 counties here, as rural as you find them. We do need, Senator, all the support we can get now.

I notice in one of your comments to the Senate or somewhere that the Senator knows about all these things we need already. I am sure that in this particular area we appreciate what Senator Clark does and his interest, and I think we are very fortunate to have him down in Washington.

So you know, they say, "Ask not for whom the bell tolls, it tolls for you." You know, the bells will toll for all of us. One way or another, and we have got to get the best we can out of life while we are at it.

In my teaching career, I think I learned that folks want about four things. They want security—we will make that two things. One of them is material security—that means money, housing, food—material security. And they want emotional and psychological security, probably. I don't want to leave a question mark after this, but I say "probably" easier.

At least you can know better when they are lacking in material security, but when they are lacking in psychological security or emotional security, I think what is the matter with a lot of older folks is that they don't have the emotional security.

Educational Campaign Needed

One thing that I think, Senator, that someone at Washington ought to do is to put on a campaign such as they had following World War II, I guess it was. I know the legion promoted a lot of movies, and I think others did, showing the folks back home how to treat the attitude they should have toward these crippled soldiers that came back. They had had their training and had gotten them in the proper emotional attitude toward their own missing leg or a couple of arms or something, but to tell the folks back home what attitude to have toward them.

I think they did a pretty good job getting us back home to know what attitude we should have toward these wounded, crippled ex-soldiers, but I don't think the people back home know how to react toward the aged. I don't believe they do.

I think we probably need some propaganda or education there. Incidentally, propaganda does not have to be truth.

The New Testament Apostle Paul—it was hardly ever said that Paul was the propagandist for Jesus Christ. You sell good goods as well as bad goods.

Ordinarily we think with propaganda you are selling bad goods.

We need a campaign, I think, to educate folks back home who are not as old yet as they are going to be, to know how to react toward the aging. Transportation is one of the things. I started to say we need material security. We need psychological and emotional security, and we need new experience to go to the Moon, or something.

I am not one of any of these folks to start there, but in any case we need to do something new.

In prisons they say that the worst thing that the prisoners have is boredom, just plain boredom—the same old thing every day. I think that may be true of the aged, too, to a great extent.

We need opportunity for new experience. We don't have buses enough in our county or, I guess, any other county to give the aged opportunities to go to the State fair or over to Mount Pleasant, the old reunion, or to go up to some other corner of the State and see the beauty of Arnold's Park, or something. We need more new experience.

We all talk about dignity these days. They talk about dying with dignity. I don't know how you would die with dignity, but from my point of view it would be doing it pretty fast when you get at it. [Laughter.]

In any case, we want dignity.

You know, it is pretty hard for a person who has been put on the shelf economically, because they are kind of economically minded in this country. When a fellow is put on the shelf economically, why somehow he is put on the shelf in general. He is no good for anything if he cannot do the job he has always done.

It has not worried me. I have other things that I can get into. We need one way or another of keeping dignity.

Economic Independence

So the fourth thing we need is favorable recognition. Here is the person who amounts to something in his own right. Some folks think that automobiles are tied up with economic shortages. I tell students on labor if everybody would have a job at an adequate salary, there would not be any labor disputes and that sort of thing.

So if we are independent economically—and I am thinking of transportation now—we can have some of the dignity that we want.

I want to close because I think I can sort of feel the Senator looking across here at me. [Laughter.]

We do appreciate the interest that Senator Dick Clark has in us and we are happy to be connected with this program.

Thank you.

Senator Clark. Thank you.

I did have a couple of things by way of introduction that I wanted to say of the witnesses, and I might just read those before I introduce Ben Grismore.

Mr. McMillin on my left, as I understand it, is retired and has resided, I think, in Ottumwa for about 20 years. He is on the State legislative council, as I said, for the American Association of Retired Persons—the largest, I believe I am safe in saying, organization of retired persons in the United States.

I had the privilege of speaking at their national convention a year ago in Kansas City, if I remember right. I know he has also done a good deal in tax assistance and counseling for older people.

Albert Burrows, whom you just heard, has a doctorate, and is, I think—are you still teaching economics and sociology out at Penn?

Dr. Burrows. Off and on. Mostly off.

Senator Clark. Dr. Burrows said that he didn't consider anybody old until they were at least 80. Now I notice on his biographical sketch that he is 84. [Laughter.]

He taught at Northern Michigan University for 25 years prior to coming here. He is on the State Advisory Committee on Aging and

has worked with the area agency on aging in providing transportation services, so he knows his subject.

Lastly with this panel I want you to meet Ben Grismore, who has lived in this area most of his life and is particularly interested in the transportation system. He helped with its implementation, helped to develop the first plan for a transportation system in his home county, which is over at Wayne County, and I know is very active in a number of things over there.

So, Ben, you may proceed.

STATEMENT OF BEN GRISMORE, CORYDON, IOWA

Mr. GRISMORE. Senator Clark, other dignitaries, and guests—I would like to say first, Senator, they are going to be hard for me to follow. The only way to half way keep up with them is to start out with Mars.

Senator CLARK. With Mars, yes.

Mr. GRISMORE. I will get ahead of them some way.

I, too, concur with what they have said and I would like to say that I appreciate very much this opportunity of being able to express my views, even though they may not have much value on the subject of senior citizen transportation.

It was my privilege to be able to observe this program from the very beginning. How this came about was because I think, back in 1972, give or take a year, seven or eight counties in Iowa were being considered for a model county. Well, during that time we were being interviewed a lot from agencies like the Office of Planning and Programing to see if our needs would merit this project and, of course, we are competing with seven or eight other counties.

Along in September in that same year we got that distinction from the Governor, and he did admit this was a model county.

The first thing we did was set up committees, like on HEW, community development, natural resources, and so forth, to study the needs of our county, and then they would be reported to see what would be feasible with this particular program. There were 25 or 30 people on each of these committees and they were enthusiastic in the beginning, and stayed that way. They would bring in the needs to be compiled on what they thought.

It didn't take very long to begin to see in our county, the rural county end of area 15, that the need was there for elderly people. After that need began to be compiled, then naturally committees began to get anxious to have something happen because they wanted a county that was going to be active.

TRANSPORTATION GRANT SOUGHT

We got this message through Bob Case who, at that time, was the director of rural urban development under OPB. We said, "Bob, we need a sign. We need something to happen." He said, "You are going to get it. Just in a few days we are going to get a grant, and in this grant you will be able to purchase a senior citizens bus." He said, "Now, this will be the first bus of this kind in the Nation."

That is where the Senator brought out the ground floor plan, and so in a few days this happened. We got a grant and were able to purchase a bus—I think an 11- or 12-passenger bus. We were able to employ a dispatcher, a driver, a headquarters, and start in.

We then had set up a Wayne County Senior Citizens Transportation Co-op Board and they handled the affairs at that time. The funding was through OEO and through model county, so that board handled the affairs of this operation.

It was my privilege, along with George Mosher, who was on the board also, to take this bus on its first trip. It didn't take us very long after we picked up a few riders and heard the commotion—how they began to lay plans for the future since they were going to be able to have this kind of transportation.

We realized that senior citizens transportation had a great potential. I watched this from then on and I watched this thing progress. I watched older people up in the little apartment on the third floor, in a little home of their own, or maybe in a housing program, wherever they may be—I watched them take on new—because why? Because they could now go down and do their own grocery shopping without having to send for it. They could keep a doctor's appointment. They could visit a relative across town or maybe in another town. Why? Because they feel so good about it. because they didn't want to obligate and ask their next door neighbor or their friends or their relatives, who would have been glad to have given it to them.

They would have, but yet you have to remember that these people at that age—our age, let's face it—reared their families some 40 or 50 years ago and they were brought up that they could only do it by being self-sustaining. They were not used to them doing all the favors that we have today.

They are proud people and so, therefore, if they could not do this within their budget and if they could not hire the taxi to take them these places where they wanted to go, they just simply didn't go. They just sacrificed themselves and stayed at home, as has been mentioned here before.

So with this type of transportation, they have been allowed to get out without being obligated to people. and to live like they would like to live, and live a lot longer. I am sure about it.

Now, getting back to the funding part that has been mentioned here. I hope, Senator, that it can continue to be funded through Federal. State, or however, rather than getting back at any local level.

Now maybe these things should come back to the local level, but if they did I am sure we would drag our feet enough that it would never be successful—to make a program like this efficient.

Indirect Assistance

Another thing. if it comes through these other levels high up, then we are not sensitive about it. We don't realize when we get on that bus that it is done because the board of supervisors, the chamber of commerce. the ladies aid all put some money in so they could do it. We are all too proud. It is coming indirectly and we hope it can be added to and expanded. I am sure it is going to increase riders and make every-

body ride it because the nice thing about this is what we promoted about it in our country—55 years or older, whether you have $50 million or nothing, you can ride that bus and we encourage that to see that people like that.

So for that reason I am greatly interested in the progress of it and want it to continue and not diminish in any way, but to expand. It is not going to last too long and you have a never-ending thing, except make it so it can stay there and grow.

I might say, too, that if you had been on that bus with George and I, you would be just as enthusiastic as we are.

Thank you, Senator.

Senator CLARK. Thank you.

I appreciate all three statements. I have ridden on the bus from time to time, in fact I am going to ride one on Wednesday again. I know what you mean because I have talked with a number of people who testified—in fact, even this morning over in Winterset—that, without that transportation, they never would be able to do the things that are important for them to do.

Mr. McMillin, you serve on the State legislative council of the American Association of Retired Persons. How do you represent the needs of elderly people on that council? I mean, what function? Do you have meetings? What is the mechanism by which you relate the ideas that you have to the council and what effect do you feel that they have?

Mr. MCMILLIN. Well, we are actually a legislative committee and we set up priorities during the year to go before our State legislature more than we do on a national level.

One of our top priorities the last 2 years, and will be next year, is transportation. Then we try to set up meetings with the chapters and units of the retired teachers to discuss these priorities, and they may contact their legislators to see that these priorities are considered through legislation like anything else.

It is a long process. Priorities stay at the top of the list all the way through.

Senator CLARK. Do you feel you have had a positive effect on the State legislature and on the programs?

Mr. MCMILLIN. The last session of the Iowa legislature provided an appropriation of $2 million to implement a State assistance plan for public transportation.

Also, an additional bill was passed to require the department of transportation, in part, to assist localities at their request, to coordinate transportation services as common carrier cab services, handicap, elderly, and private nonprofit agencies services.

We feel that our efforts have had some impact.

Ottumwa is in the unique position in Iowa that we don't have enough population to be in any Federal program. We are under 50,000.

Senator CLARK. Right.

DEPARTMENT PROMISES $40,000

Mr. MCMILLIN. So Iowa DOT has promised Ottumwa and Burlington about $40,000 to supplement their bus service in Ottumwa. The legislative process may seem slow to my peers, but I feel we are accomplishing something.

Transportation is just as important as the fire department or law enforcement and it is going to have to be subsidized by local taxing bodies as well as at Federal and State levels.

We have got to admit that we have to participate in this effort. People our ages paid their share before, and I think we will and can continue providing assistance.

Senator CLARK. Now, I was going to ask Dr. Burrows—any of you may pitch in on these answers where you may have some particular information. Do the elderly people of this community feel that there is a greater need for transportation—that the need is not yet completely met and that there is a greater need for services than we now have?

Dr. BURROWS. I am sure the answer is an unequivocal yes, they do feel that we need more transportation. As I mentioned, we need special days and longer hours. Our drivers work from 8 to 4, I believe. Who can get through their shopping or away from the doctor's office before?

Maybe it is 8 to 5, but they just don't have long enough there. So yes, we need more.

Of course, I am not sure, Senator, how the Federal revenue sharing goes, but I am pretty sure in our county that we get the small end of the stick on the Federal revenue sharing. I wish there was some way of gouging that up a little. I suppose that is a State affair. Maybe you don't tell the States how to share it, but I think it is there.

Senator CLARK. I might say in that regard that on a national level, only 1 percent of the revenue sharing is used for aging services, so it is very, very small.

Mr. MCMILLIN. Even under our city-financed transportation system with regard to the elderly people, Ottumwa does not have, as Dr. Burrows said, these longer hours. There is no way to get to downtown Ottumwa after 5:30, even when the stores are open on Thursday night. We don't have a way to get to the various supermarkets because the transit system is not flexible.

The cities need help to provide comprehensive transportation over the city and between towns. Some of our county seats don't even have bus service. We are lucky here to have as much as we do. Some county seats don't have any connections and it has to be provided by private, nonprofit, and/or Federal funds—a minibus service.

Senator CLARK. You only have one bus in each county, isn't that the setup?

Mr. MCMILLIN. Yes.

Senator CLARK. Is that adequate?

"WE . . . WANT TO KEEP GROWING"

Mr. GRISMORE. Senator, I say our county is only about 8,000 or 8,500, and I am not saying what is adequate. Maybe we have all we should have at the moment. We just want to keep growing. This is not true for the areas where I see these people here are from.

I will say these people make a trip twice a year—once in the spring, once in the fall. We have an all-out county picnic. We take that bus—we could use three, four, or five buses—but it would not warrant having to get other cars to do that. We just have a whale of a time. We do it twice a year and are looking forward to the next one, because

they meet Susie over here in the other county and they had not seen her for years.

Senator CLARK. Tell me, what did people do before these buses were developed in each county? You were in Wayne County, of course. How did people get around in Wayne?

Mr. GRISMORE. They just waited for their son to come in off the farm when he was not busy, and while he was willing to; but they didn't want to obligate him and they just stayed home. That is the answer.

As I said, they are a proud people and they are not going to obligate their friends and relatives any more than they have to. This is to let them live again, in my opinion.

Senator CLARK. Let me ask you one other question, Mr. Grismore. Given the status of the present program and what you have been able to do up until now, which is remarkably good, what ought we do to improve it further? What things would you like to see in the next 5 years or the next 10 years, and so forth? Do you have any particular recommendations?

Mr. GRISMORE. I am sure there are many things, but I cannot answer that as I should. I know we were able, through OEO a couple years ago, to trade back and get another bus and have money that was left over. It leaves us in a little different shape than the other counties, because we did have the go from the beginning. We had a good grant at the time and carried over enough money. Our bus is good, and so on. It would be fine if you could raise their wages—I am sure of that—because they do work hard for what they get as far as the personnel is concerned. But beyond that, I think they are giving us all that we are entitled to, compared with the way the rest of the counties are doing.

Senator CLARK. You pick up door-to-door, at the stations, or how?

Mr. GRISMORE. They pick them up door-to-door and make the arrangements in the different towns—visit the son in the evening or pick up in the evening—for a very economical charge, and it is being used.

Senator CLARK. How much is it?

Mr. GRISMORE. Thirty-five cents to anywhere in town—to go grocery shopping. Then, again, if they pick them up, it is another 35 cents. They will take them anywhere in the county for 60 cents.

Mrs. RYAN. It is not a charge, it is a donation.

Senator CLARK. Donation?

Mr. GRISMORE. That's right. I might say we tried a $5 membership to begin with as a donation. We dropped that just before Indian Hills became the sponsor about that time because we felt that even the $5, if you are watching your budget—and they live on a fixed income and a budget—they may say, "Well, we better wait and not do it." We did away with that, and the rest is a donation.

Senator CLARK. Would others like to comment on ways in which you think this program could be improved?

COMMITMENT NEEDED

Mr. MCMILLIN. I think the main thing is to have a commitment for these services from Federal, State, and local governments that these

programs are going to continue; then we can plan for the future. If we have commitments that they are going to commit funds for this type of transportation program, I am sure that the people in here, especially like this gentleman, Mr. Grismore, are going to work very hard to see that it is going to be a success.

Senator CLARK. In other words, that you not only get assistance to start the program, but that you get some operating funds.

Mr. GRISMORE. Yes.

Dr. BURROWS. More and more, I think, they are cutting down the proportion or adding to the proportion that the local must pay for, beginning October 1.

As the Senator was saying, Federal and/or State governments are going to assume less of the burden and the local has to assume more. It is hard to get the local government to go about those things, particularly in these poor rural counties.

In answer to one of your questions a while ago, we have a county that our bus runs out to—has a regular run on certain days—and goes to this town and that one at certain hours of those days, but we cannot do it but once a week that way. Most of the time it is served by more folks closer to Oskaloosa—a town of 11,000.

So we could use another bus on that and have another day's run out to these other villages, where folks are drawn together a little more.

So we do need more money for more buses. We are always, as they say, flying by the seat of our pants, because we don't know whether the Federal Government is going to come through with the appropriation the next time.

The State commission does not know, and we are all waiting, wondering, and hoping, and finally it is done. If we could get these moneys appropriated a little sooner so we could all know a little earlier what we are going to be doing the next year, it would help a lot, I think.

Senator CLARK. Good.

Mr. GRISMORE. I can understand the Government's feeling. They get these programs started and they should go back to the local level. I can understand that, but, in this particular thing, it was what I was trying to bring out a minute ago. I don't think it is advisable at all. I think it would be embarrassing to people. It would eliminate riders, and I think it should serve the people. It would be such a small amount—to do the whole thing, and do it as well as it should be done—to take care of the program; it is still not going to be a great amount, compared to other projects.

Senator CLARK. I think we might take some questions or comments from anybody here who might like to say something about it very briefly.

STATEMENT OF MATTIE HARPER, STATE REPRESENTATIVE, WEST GROVE, IOWA

Mrs. HARPER. Mattie Harper, State representative. I would like to say that you have talked all the time, and it is very interesting. I agree with everything you have said. We have worked very hard with that work, and I am glad to say that I was part of it.

You are getting money down in this area, but you must have a bus for the handicapped. I think it is very necessary to have a bus for

the handicapped with the wheelchairs. I was visiting with an elderly person here in Ottumwa just the other day and she said, "Oh, how I would like to go for a ride. We saw the senior citizens bus pass and we all know how necessary this is."

I think in our plans, as we look to the future, we should be thinking about this and including this in the bus transportation—whether you use the same bus or whatever. Everyone I talked to says they need a bigger bus in this particular area. Our counties might not need that bigger bus, but I wish you would be thinking about a bus for the handicapped.

The State has been very kind toward transportation this year.

Mr. GRISMORE. I am sorry. I had that on the tip of my tongue, because we do cater to that very much—we let it be known that 55 and older, or any handicapped.

Senator CLARK. Any other statements or questions that anybody might have?

Yes?

STATEMENT OF L. W. KLEIN, EDDYVILLE, IOWA

Mr. KLEIN. Transportation is wonderful and I am for it, but when you go to a doctor's office and he says he will see you in 2 weeks, what are you going to do about it? Now that is all over the country. I happen to do a lot of traveling. I was in Florida and I had a tooth problem. I went to the dentist. I was in a strange place and the receptionist said, "The doctor will see you in 2 weeks." I said, "Lady, I'm a snowbird and in 2 weeks I'll be so far away from here that the doctor can't see me."

I said, "If one of the two doctors in this office can't see me before noon, I want you to give me the name and address of every dentist in this town, because I have a toothache and there are some things that have to be done."

Well, she went in and came out, and the doctor—it was a father and son—and the old doctor said, "I will see him right away."

Now there it is. The majority of people when the receptionist says, "He will see you in 2 weeks," that is about all it takes for them to go out and get on the bus and go home without doing anything else.

Senator CLARK. Does anyone else have questions?

STATEMENT OF CATHERINE KURKA, FAIRFIELD, IOWA

Mrs. KURKA. Catherine Kurka.

I have a question. Cities that are not as large as Ottumwa or Burlington—say Fairfield, where I am from—we do not have a central transportation system, such as a bus. We do have a senior citizens' bus which does an excellent job for one bus, but what about people who have appointments in Iowa City, people who cannot pay or maybe have no relatives to take them out at the time? I am a Jefferson County volunteer chairman. All that the State will allow us is 15 cents a mile. For volunteers, this does not take care of your car. The bus will go once a month, and that is all.

Senator CLARK. To Iowa City?

Mrs. KURKA. To Iowa City, and you cannot always get the appointments for the people on that day.

Senator CLARK. Well, I think it is another indication of what the panel is talking about. We never have quite enough and, obviously, we could use more and use it intelligently.

Mrs. KURKA. Especially in these towns that are not as large as Burlington or Ottumwa. We depend on the bus to get everywhere in Fairfield.

Senator CLARK. That is your sole means of transportation.

STATEMENT OF CHARLES T. RINKEL, OTTUMWA, IOWA

Mr. RINKEL. Chuck Rinkel.

I agree with you in terms of employment and transportation as problems but, as you know from our correspondence, we also have the problem of social security being cut when other benefits are increased to the point where an elderly couple has to divorce in order to stay solvent and to be able to pay their bills.

I understand there is a hearing in Washington on this now. Is there anything else in on this?

Senator CLARK. Well, there is nothing in the last 2 weeks, in terms of things that happen. We have had lots of bills introduced. In fact, I introduced one of them—to disregard the social security increase when you get other increases, because if you don't, it means that the problem of inflation is just not offset.

The problem is simply to get 51 percent of the Members of the Senate and the House to start it first in committees and then the Congress. We think it is obviously one of the highest priorities we have.

STATEMENT OF MRS. FRANK HUSTED, OSKALOOSA, IOWA

Mrs. HUSTED. Mrs. Frank Husted.

We do need more transportation because I have been a widow nearly 10 years now, and I ride the bus every day. The doctor told me to get out for my own health. I go visit the shut-ins and by the time you get down there you don't have time to get around to people to visit; you just don't have time—and they need our help.

I am old, too, but they need our help. Someday I might be there, and we need to do that. We do need more transportation, especially. The bus we have—when you are as big as I am, you cannot get into those back seats.

Senator CLARK. I have that same problem. [Laughter.]

Mrs. HUSTED. Well, it is true. You cannot get into the back seats, and we do need that. I thank God for that because I would not have any other way to go, and I just thank God for it.

Senator CLARK. Thank you, and I want to thank particularly the witnesses because they did an excellent job.

Anyone else on transportation?

STATEMENT OF MILAN KENT, OSKALOOSA, IOWA

Mr. KENT. Milan Kent.

All I can say, we ride that bus every time, and the meals are here. They got two good drivers and they drive pretty well. They say, "We

will go anyplace," or "Are you in a hurry?" I say, "No; we have all day." The driver puts in pretty long hours.

Senator CLARK. Thank you very much.

I might say that we have these forms that are spread around at the doors, and so forth. If you want to testify or write down any ideas that you have, it will be made a part of the printed record.[1] It just says:

If there had been time for everyone to speak at the hearing in Ottumwa, Iowa, on August 16, 1976, concerning "The Nation's Rural Elderly," I would have said the following.

So you can just fill it out. We will be happy to have any other comments.

The next panel is going to be on employment programs for the older worker. We are going to hear from Shirley Campbell, Ruby Welcher, Robert Gilbert, and Francis Glick.

Again I am sorry that we don't have microphones; it would have been a little easier. I will ask you to try to listen as carefully as you can and we will ask the speakers again to speak just as loudly as they can so that everyone can hear.

We will hear from the witnesses in the order of the hearing list. First we will hear from Shirley Campbell.

Shirley Campbell is project director of the senior community service employment project here in Ottumwa. I know that this project, although it is located here in Ottumwa, serves a much larger area of southeastern Iowa. The project is supported by what we call title IX and title X programs which are to serve workers who are more than 55 years old.

Shirley is going to describe the program's successes and its weak points from her point of view so that we can try to get a better understanding of how these programs can continually be improved.

Shirley, if you will speak up very loudly—you may stand or sit, whichever you like.

PANEL ON EMPLOYMENT PROGRAMS FOR THE OLDER WORKER

STATEMENT OF SHIRLEY CAMPBELL, PROJECT DIRECTOR, SENIOR COMMUNITY EMPLOYMENT PROJECT, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS, OTTUMWA, IOWA

Mrs. CAMPBELL. The senior community service employment project, a national project, is sponsored by the National Retired Teacher's Association—NRTA—and the American Association of Retired Persons—AARP—funded through the Department of Labor.

The title IX project is a statewide program, and the title X program serves the Fourth Congressional District. Nine counties are served in this area: Appanoose, Davis, Jefferson, Keokuk, Lucas, Mahaska, Monroe, Van Buren, and Wapello Counties.

To participate in the senior community service employment project, applicants must be 55 years of age or older. Eligibility is also based on the person's income for the past 12 months. For example,

[1] See appendix 4, p. 143.

earnings for one person cannot be more than $2,800 for a 12-month period and the combined income for two members of a family cannot be more than $3,700 for 12 months.

Applicants who certify for the program are placed with nonprofit agencies 20 hours a week at $2.30 per hour. Enrollees earn sick leave and vacation time while working on the program.

Job development for unsubsidized placements is another important factor with the senior community service employment project. We work for permanent jobs with the agency the enrollee is placed in, and also in the private business sector.

The senior community service employment project puts the older worker back into the labor force, and not only supplements their incomes but also gives them a sense of value.

The older worker has proven to be a very dependable, responsible employee. Persons over 55 years of age still have a lot to offer their communities.

The local over-55 program has been allocated 145 slots in this nine-county area, and at present we have 133 enrolled on the program and still expanding. There are 77 persons working on the program in Wapello County.

Persons are made aware of the project through the news media, and we also receive referrals from the Job Placement of Iowa and other local resources.

The senior community service employment project is a very successful program and a great opportunity for the older worker. We would appreciate your support for continued funding and expansion of this program.

Thank you.

[A table submitted by Mrs. Campbell follows:]

SELECTED STATISTICS OF PERSONS AGED 55 OR OVER

	1970 census population	Jan. 1, 1977, population projection	June 1976 estimated unemployment rate [1]
County:			
Appanoose	4,651	4,350	4.7
Davis	2,394	2,610	3.9
Jefferson	3,877	3,300	3.6
Keokuk	4,194	4,010	2.8
Lucas	3,086	3,130	3.6
Mahaska	6,038	6,110	3.2
Monroe	2,817	2,820	3.1
Van Buren	2,692	2,750	3.1
Wapello	11,065	11,356	6.7

[1] As registered with job placement of Iowa.

Senator CLARK. Thank you very much, Shirley.

Now, Ruby, you work in this kind of program, don't you?

Mrs. WELCHER. I do, yes.

Senator CLARK. Your home is here in Ottumwa?

Mrs. WELCHER. That's right.

Senator CLARK. Tell us a little about why this has importance to you, why you think it is a good thing, and why you think the Government should continue to sponsor it—whatever you think about it.

STATEMENT OF RUBY S. WELCHER, OTTUMWA, IOWA

Mrs. WELCHER. About a year ago I found it necessary to go to work to support myself, because I had a very meager income. So through the employment agency and Mr. Gilbert—he interviewed me and hired me as clerical aid, and Shirley was then my supervisor. That was when the program was just under title IX.

In March of this year when the program was increased to title X as well, I was promoted and became Shirley's secretary which I have been ever since. It not only gives me the necessary funds to live as an individual and to be a responsible person on my own, because I am a widow, but it also gives me the opportunity to meet people and to help people to help themselves. I fill out their necessary papers that helps them attain work at 20 hours a week, which augments their social security, and they can be on their own and not on welfare or under someone's thumb.

As long as they are able to do this job, they are happy. They come in and I hand them their paycheck.

There is one gentleman that came to us who even asked for an advance on his salary, which we could not do. I mean when he applied for a job, he was that desperate. He is supporting a 92-year-old mother and a single person. This gentleman works in our office as a janitor. He says "God bless you" every time I hand him his paycheck.

Now this man is one of the best workers I know. The walls are washed, our office is clean. I invite you to come see it. He is happy and I am happy, because we are helping him. It gives me an emotional outlet to be working and I enjoy it very much.

Senator CLARK. How did you learn about this kind of program? You are not old enough, obviously, for social security.

Mrs. WELCHER. No; I am not.

Senator CLARK. To qualify for the program you have to be over 50?

Mrs. WELCHER. Over 55.

Senator CLARK. I see.

APPREHENSION IN SEEKING EMPLOYMENT

Mrs. WELCHER. I went to the employment office to apply for a job 6 months after my husband's death and I was told to go to two different supermarkets as a checkout lady—maybe I could get a job there. Neither one of them hired me, they just took my application.

About 2 weeks later they called me from the employment office to see if I could type, and I said yes. Well, they asked if I would come for an interview with Mr. Gilbert, and would I consider working 20 hours a week. I would have considered 10 hours a week—I was so happy to think maybe I would get a job. That was the beginning.

Senator CLARK. Do you know of other people that are in a similar circumstance that you think could profit from this kind of employment?

Mrs. WELCHER. Anyone I can, I tell them, and they come.

Senator CLARK. But do you know other people who are in similar circumstances and can benefit?

Mrs. WELCHER. Absolutely, but some of them may be $100, $200, or a little bit over this guideline. My only complaint is that I live in my own home, which has as much expense, except maybe food and clothing, as two people. But yet I could only make $2,700 to be eligible for this program. I was fortunate I did not have that much of an income.

People that make a little more and live alone like me have the same expenses I do—light bills are going up, the phone bill, everything is going up, yet they cannot make over $2,700. If they make a little more social security, then I think that ought to be raised. I think they ought to be able to make just a little more money and still come under our program.

Senator CLARK. I sponsored legislation to try to raise that, but so far we have not been successful in doing it.

Let me ask you one last question. What do you consider to be the greatest benefit of that job?

Mrs. WELCHER. Well, not only economically, but it does something for me. I can go home now and go to bed and I think that, well, today we put somebody to work. Emotionally the whole thing is very good for me, it really is. I just feel like living again finally.

Senator CLARK. So it is not just economic.

Mrs. WELCHER. No; it really isn't. There is something about that because it gives you a good feeling to help other people, and then I am being helped, too. I mean, it is not all unselfishness.

Senator CLARK. Thank you very much.

We will hear now from Mr. Robert H. Gilbert, who is the director of the senior community employment project in Des Moines, Iowa.

As I understand it, Mr. Gilbert, you have directed the pesticide program for older workers and you are going to talk some about that. It is an interesting program that has been developed in the State of Iowa, and I hope that among other things you will talk to us about that.

STATEMENT OF ROBERT H. GILBERT, DIRECTOR, SENIOR COMMUNITY EMPLOYMENT PROJECT, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS, DES MOINES, IOWA

Mr. GILBERT. First of all, I want to thank Senator Clark and his staff for inviting me here today. When we go rural, a lot of people say, "What's that big city dummy doing down here in the rural area?"

First of all, when title IX came into being, I came on board with the association in 1972 with a 67-slot program and worked hard to expand this to rural Iowa. So when title IX, the Older Americans Act, came in, we were mandated by Washington to work closely with the State commission on aging and the area agencies on aging, and the pesticide program came out of our meetings with the commission on aging. We started in Iowa with 72 older workers over 55 canvassing the complete State of Iowa for outdated and banned pesticides.

The second phase of the program was the empty container part of the program, informing the farmer and folks working with pesticides how to dispose of containers. We had a very successful program, which

has ended at this time, but it is known pretty well nationally for being a pilot project in the State of Iowa. We are all very proud of it and it proved to a lot of people at the capitol here in Iowa that our people over 55 could be trained to do a specific job.

For some reason they seemed to think that when a person became 55 his knowledge had been all drained out of him or something, and that he was not capable of performing these tasks. We proved a big surprise at the statehouse and they thought so much of our older workers program that last year the State funded an older workers program of their own.

This year they are starting a green thumb program with the State conservation commission.

I know you are interested in the older workers, Senator Clark, and you were pretty interested in the pesticide program. I didn't know at the time until just on the spur of the moment that this is what you really wanted to hear about.

Senator CLARK. I would like to hear about any other things you want to talk about.

Mr. GILBERT. Aside from this, I would like to mention that, first, we would like to see how much more intensive emphasis the Labor Department placed on the use of CETA funds to carry some of the load now carried by titles IX and X programs. We would like to see a proportionate amount of CETA money allocated to older workers based on the percentage of their total unemployment.

PROBLEMS FACING THE OLDER WORKER

Currently a little less than 4 percent of the CETA moneys are going to older workers. The job needs of older workers are no less great than those of younger workers, and they deserve no less attention.

Second, it would be helpful to the older workers if all upper age limits for compulsory retirement be removed. This discrimination has prevented older, able workers from working.

Third, older workers frequently complain about the limits set to wages they can earn without losing their social security benefits. This is unfair, as people living on dividends, interest, and pension income don't lose any social security benefits. This limit as to wages earned should be removed, particularly if inflation contines to rise faster than social security benefits.

Thank you very much.

Senator CLARK. Thank you.

I know, incidentally, that we have recently increased appropriations for title IX, and I think this was an amendment offered by Senator Kennedy which we cosponsored.

How do you think additional funds should be spent profitably in this case? We have some additional funding now; what kinds of things might we do?

Mr. GILBERT. I think just to expand what we are already doing—putting older people to work.

Senator CLARK. In other words, just finding useful employment that people are interested in and is productive, and expanding the program to more people?

Mr. GILBERT. That is right.

Senator CLARK. That is our biggest problem. It does not go far enough in terms of people involved. Is that a fair statement?

Mr. GILBERT. Yes.

Senator CLARK. You have got the positions, have you? In other words, if you had the money, you have the people and the positions?

Mr. GILBERT. At the present time, statewide, we have about 200 people waiting to go to work.

Senator CLARK. I liked your statement about mandatory retirement, because I think the most discriminatory single practice that we have in employment now is saying that when you get to be 60, 62, 65, or 70—that you have to retire. It is ridiculous. It is like saying that you cannot start working before you are 21 years old.

We were talking in Winterset about people in the arts who have made their greatest accomplishments after they were 65, many of them after they were 70 or 75. Some of the great painters—Picasso, who just died a couple of year ago—what was he, 90 years old, or something like that. Or Rubinstein. Many, many of the great musicians have reached their peak only after they were in their seventies, and I think it is true of a lot of other professions and occupations.

I think people ought to be able to continue. We ought to have a system in which people can retire early but that they aren't forced to retire. I mean, why should they have to retire simply because they reach a particular age? Who can measure whether somebody could continue to work effectively? It is just nonsense.

We have had discrimination in a lot of areas from time to time, and I think this is one now that we have to address ourselves to.

We are now going to hear from Francis Glick, who is here from Knoxville. I think you are going to talk to us about your own experience in these programs, what it means to you, and how it has worked, as far as you are concerned.

STATEMENT OF FRANCIS J. GLICK, KNOXVILLE, IOWA

Mr. GLICK. My name is Francis Glick. I am from Knoxville, Iowa, and I am presently employed as a clothing salesman in Des Moines.

Prior to this employment, I was unemployed. Through the senior community employment program, AARP and NRTA, in which Bob Gilbert was project director, I was hired as a liaison aide under title IX with the Iowa Department of Agriculture under the environmental protective association program which started in February 1975 and lasted approximately a year—to March 1976.

This job was on a part-time basis, 20 hours per week, starting at $2.15 an hour. About 10 months later it was increased to $2.30 an hour plus mileage. The work involves checking inventory of pesticides in the local stores and rural areas for nonregistration and open containers of pesticides, and reporting the accidents and incidents pertaining to these pesticide applications.

I was one of the 72 people that was picked in the State of Iowa. We left folders and information with the store owners, the applicators, and the farmers to instruct them as to the use of the pesticides. They gave us information on the pesticides they had, and possibly open containers, which were creating a problem with water pollution.

During this work I had quite an education in the proper handling of all types of pesticides, of which I was very unfamiliar to begin with. My work reports were mailed regularly to Mr. Lounsberry, secretary of agriculture in Des Moines, Iowa, at which time they were reviewed by Myron Van Cleave, who was supervisor of the pesticide section for the Iowa Department of Agriculture.

If any reports were of a serious or harmful nature, either to the store or to the customer, it was acted upon by Van Cleave's department.

"SENIORS COULD DO THE JOB"

The program helped get jobs for 70-some senior citizens employed through Mr. Gilbert's office. It proved that our senior citizens could do a job which the department was reluctant about starting to begin with.

Since this was a pilot program, we were to prove that a job could be done with the right people. During this part-time employment, I discussed future work with Mr. Gilbert and his department, also with the State employment office in Des Moines, on a weekly basis. This eventually led to my present job as a men's wear sales clerk where I am still employed, but not satisfied with the job. I am still looking for a better job. [Laughter.]

My previous employment was with the Marion County Community action program under Greater Opportunities, Inc., Operation Mainstream program for 1 month.

My job was to fill out Iowa State tax refunds for the elderly, which you all know about. I was discharged because my wife started 1 day ahead of me under the same program and was told that, according to the regulations, two in the same family was not allowed. She worked for approximatey 6 months and that left us without income.

Prior to that, I was self-employed in the investments and securities business which I had to give up because my net income dropped to less than $3,000 per year for 1973 and 1974, the previous 2 years. I was in this business full time for 12 years, and if any of you have invested any money, you know what happened.

Prior to this job, I managed branch offices throughout the Midwest for 13 years under a contract with the country's largest heating and air-conditioning company.

If this is any verification or confirmation that senior citizens can do the job, I think that Senator Clark should do something about it.

Thank you.

Senator CLARK. Good.

Just a couple of questions while you have the floor, Mr. Glick. I am just curious about how you found out about the pesticide program. What source brought you in touch with it?

Mr. GLICK. The pesticide program came to me from the Marion County Community Action Agency and Marion County Social Services. They said a job was available through the department to hire citizens 55 years of age or older, and I still had a 13-year-old child. I lived 50 miles from the office, but was glad to get the job.

I was not eligible for unemployment insurance by reason of self-employment, thereby I did the best I could with what was available at that time.

Mr. Gilbert got me this part-time job. Remember, 20 hours a week at $2.15 an hour does not put much bread on the table.

Senator CLARK. How did you hear of it?

Mr. GLICK. I lived in Marion County. After we completed the series of store and rural area inspections, another county was assigned to each one of us and as we completed that county, our reports were mailed in. The program was completed ahead of schedule. No more jobs were available through Bob Gilbert's office.

SPECIAL TRAINING NECESSARY

Senator CLARK. Obviously this took some expertise. I mean, I could not go out and check pesticides. Did you have some training to understand what these were, what they meant, and how they operated? How did you learn about it?

Mr. GLICK. The initial training was through the community employment program; Bob Gilbert was project director. We had a series of educational sessions at the area XI community college in Des Moines where we were instructed as to how to do this.

The Iowa Department of Agriculture supplied us with a manual describing the manufacturing of the products that were distributed by the wholesaler to the retailer for sale and use for controlling mice, rats, roaches, and what have you.

We found, through the book registration, the numbers that were supposed to be on these containers. I would say in my tour of duty about one-third of the products during the first 3 months I inspected had no USDA registration or no EPA number whatsoever.

There were open containers sitting up on shelves above counters and tables where packages were being wrapped below. Our job was not to tell them to unload it, or for us to pick it up. We were simply to report what we saw.

As I recall, no one complained or gave us a bad time. We introduced ourselves as being with the Iowa Department of Agriculture. We presented them with a picture identification which showed that we worked for the Iowa State Department of Agriculture. Only once did I receive any repercussion from the owners. One stated, "If you're so good at this, how come you are not telling me how to dispose of the empty containers?" Well, since I had no background in chemicals or the medical profession, I just told them that I would send the reports to the proper authority and then they would take action from that point on.

Of the 70 of us in the field—I am not speaking for the others. I never did get a report as to whether they followed through or not. I gave an accurate report of what I saw, but not what to do with the product. After about 2 weeks, we had a second educational program through the area XI community college. I learned a lot more because we were on the firing line for 2 weeks.

I learned more at the second program: how to present myself, where the problems were, how to discuss it with the retailer and what he should do, and the department of agriculture would come out and check him over.

Senator CLARK. We appreciate very much hearing some actual examples from someone who has benefited from the program. I am anxious to find out now if Bob can tell us what they did with the pesticide program. Did they follow up on it then?

Mr. GILBERT. Yes. Mr. Glick's testimony was very good, except it was the Iowa State Department, not the U.S. Department.

Senator CLARK. I didn't catch that.

FOLLOWUP ON REPORTS

Mr. GILBERT. Yes, they followed up on every report sent in. We had older workers working in the office also, and they were checking every report back against the big manuals in the main office in Des Moines. If the product was outdated, banned, or any type of unregistered pesticide, the Iowa State pesticide division would send an inspector out to either pick up, dispose of it, or make some other arrangement.

Senator CLARK. So all of this work was done through this program by people who were over 55?

Mr. GILBERT. Right.

Senator CLARK. Now, just one other question, Mr. Gilbert, and then I want to ask Shirley a couple of questions.

What is your chief obstacle in placing older workers? What is the major problem that you face in this program in terms of placing people?

Mr. GILBERT. Age discrimination.

Senator CLARK. Age discrimination?

Mr. GILBERT. Right.

Senator CLARK. What kind? Can you think of some particular kind where it is very clear to you that people are being discriminated against simply because of their age?

Mr. GILBERT. I can think of a lot of specifics, but we won't mention any names here.

Senator CLARK. Yes.

Mr. GILBERT. This has probably been one of the biggest. We work closely with private enterprise, but we cannot tell them who they can hire or anything else. We have done a fabulous job here in the State in educating a lot of the private enterprise people in hiring the older worker by proving to them through this program that these people are very good employees—often better than the younger people. It is rather hard to say that when you have two young folks sitting across the table.

Senator CLARK. No, it isn't.

Mr. GILBERT. I was just joking, knowing both of them.

Senator CLARK. Let me ask Shirley—can you give us an idea of the kind of jobs that you place people in? Ruby is an example which has already been discussed, but what are some of the jobs you fill?

Mrs. CAMPBELL. We have secretarial positions, receptionists, clerical, janitors, and maintenance workers. We have security guards and handymen. We have homemaker health aides. We also have tax consultants for the elderly.

For any type of job that exists, we can usually find a person to fill the job.

Senator CLARK. So you would fill about every job imaginable?

Mrs. CAMPBELL. Yes.

Senator CLARK. Again, these are people who are over 55; they are people that can only work 20 hours a week. Is that right?

Mrs. CAMPBELL. Twenty hours a week, right.

Senator CLARK. Do you have a lot of people, as Ruby discussed, that would like to work more than that?

Mrs. CAMPBELL. Oh, definitely.

Senator CLARK. How many of these people who are working and are restricted to the 20 hours would want to work more than that, would you guess?

Mrs. CAMPBELL. I would say over half of the people I have in the program.

INELIGIBLES ALSO RECEIVE ASSISTANCE

I might add, too, that we not only work with the people that meet the income guidelines, we also, when they come in and fill out their application—if they do not meet our eligibility qualifications, we still try to work with them. We have job developers who go out and visit the different businesses here in Wapello County. When they bring a job opening in to the office, I have an aide in the afternoon who will call, not only the enrollees who we try to find permanent jobs for, but also the people who are not eligible for the program, and we have them apply for these different positions also.

We have placed some who did not qualify for the program in the private business sector as well.

Senator CLARK. Let me ask you a last question. If you had the money, how many more workers could you place who really want work and who could use it effectively? Do you have any idea at all?

Mrs. CAMPBELL. Every day there is someone coming in and every day I receive calls from the other counties, "Do you still have openings? I have a person here who is eligible. Do you have an opening for him?" I could not give you an accurate figure.

Senator CLARK. But you could place a lot more people effectively?

Mrs. CAMPBELL. Yes.

Senator CLARK. All right.

Well, the panel has been very good, and I appreciate it. Again, I think we will give you an opportunity, if you have any statements or questions about employment, we will continue that, then we will open it up to other subjects.

Please identify yourselves so we can have it for the record.

STATEMENT OF JOHN ZUMWALT, IOWA STATE DEPARTMENT OF SOCIAL SERVICES, OTTUMWA, IOWA

Mr. ZUMWALT. John Zumwalt, Iowa State Department of Social Services. I would like to speak particularly on the program that Shirley operates in Ottumwa.

We were talking to Mr. Gilbert about restraints and he spoke of discrimination. He spoke very highly of the type of work that one receives in these programs. We have one young lady who works with us and is 82 years old. Last February we had a terrible snowstorm

that kept most of our employees from the office and this young lady was there on time and was one of 5 workers out of 32 that made it to work that day.

So I have employed over 21 workers at this program in the department of social services in the area. This is a very fine program.

They spoke of some constraints and I was speaking to you about the holding down of the amount of money that one has to have to be a participant in some way and still be a part of this program. I believe it would be a great opening. It is very positive and very productive. It is a good program.

Very few jobs that I know of are centered to make work. All of them are to make one feel more important and more a part of the mainstream.

Senator CLARK. Thank you very much.

STATEMENT OF WILLA MAE BENNETT, OTTUMWA, IOWA

Mrs. BENNETT. Willa Mae Bennett.

I would like to comment on compulsory retirement at 65. I just wondered, if they don't retire at 65, where are these younger kids going to work? If no one retires out of their jobs, there is going to be a lot more unemployment than there is now, it seems to me.

Senator CLARK. Certainly that is an argument and it is one that is commonly used, but I am not sure that it is more important that a person 65 not have a job, let's say, than someone 21. It just seems to me that there is so much need for productive work that we ought to be able to have a society in which people who want to work at any age could do so.

Mrs. BENNETT. Well, I think they should be able to work maybe at part-time jobs—something they wanted to do all their lives they can do after they retire.

You work 40 or 50 years of your life in a job and then you retire, you could do some of the things, maybe, that you wanted to do, and still make money.

Senator CLARK. But suppose you are, let us say, the greatest pianist in the world, or the greatest artist in the world, and now you become 65 and you are just achieving your greatest potential, or your doctorate, or you are a professor. Why should you have to quit at 65?

Mrs. BENNETT. Well, I don't say they should, but won't that increase the unemployment to a great extent?

Senator CLARK. I think that is right, if we don't find productive ways.

Mrs. BENNETT. I don't mean they should not be able to, but I think it would increase unemployment. Where would the younger ones go that are stepping into these jobs?

Senator CLARK. I think we have got to develop a system in which we have got jobs for everybody who is able to work and wants to work because we have got plenty to do in this country. I think it is true that if we are not able, we are going to have the high unemployment that we have now. For example, in Ottumwa we have about 10 percent unemployment—10 or 11 percent, the last I looked—under the present system. It is an enormous problem, there is no doubt about it.

Mrs. BENNETT. I heard a lot of people at John Deere say if they get a contract where they could have 30-years-and-out—retire—they would take it.

Senator CLARK. I think we really ought to provide opportunities for a fairly early retirement. I am not at all opposed to that. I think if a person wants to quit working and they can quit working at 60 or 62 or 65, that is fine—more power to them. I would not discourage that for a moment, but I just don't think we ought to say you have to. That is the only thing.

Are there other comments or questions? Yes?

STATEMENT OF LILLIAN BARBER, OTTUMWA, IOWA

Mrs. BARBER. Lillian Barber.

You were speaking of discrimination. In almost all of the Government programs, including this employment program, they discriminate against married people. The guidelines are $2,700, did you say?

Mrs. CAMPBELL. $3,700 for two people.

Mrs. BARBER. That is rank discrimination and that is just one group. If it is $2,700 for one individual, it certainly should be at least $5,000 for two individuals to be eligible for these programs.

The point I am trying to make is not whether two persons can live cheaper than one. I am sure you are aware that in many cases, when people are on a very limited income, they will share a dwelling place, sometimes an apartment, or perhaps rent a house. This is often two ladies, or two gentlemen, sometimes more.

This program for employment for the elderly is much needed in our area. However in the guidelines, the income limit is $2,700 for one individual or $3,700 for a couple. I consider this to be unfair, because the word "couple" refers only to persons who are married to each other. I believe this would be more equitable if each person were treated as an individual, or if more investigation were made of the living arrangements of the applicants.

Senator CLARK. Does anybody want to comment on that?

Ruby?

Mrs. WELCHER. Well, I still maintain two people only have clothing and food extra, if they live in a home, they still have the same utility bills as one person. I do not see that it takes $5,000 a year for two people if it only takes $2,700 for one, because I don't think their expenses are that great.

Senator CLARK. Thank you.

STATEMENT OF BILL HOLVOET, DIRECTOR, AREA 16, AREA AGENCY ON AGING, BURLINGTON, IOWA

Mr. HOLVOET. Bill Holvoet, Burlington, Iowa, area agency on aging director for area 16.

As I see it, the employment project is good, but it is unique. I don't believe any of our area in the southeastern corner, or maybe some of the other parts of the State, has this, so I think this needed to be brought out.

You said, "What would you do with the extra money." Don't pump it into the Ottumwa area.

Senator CLARK. In other words, if we are going to expand it, let's get it into all of the areas?

Mr. HOLVOET. Yes.

Senator CLARK. We have a comment back here.

Mr. GILBERT. We have had about four people from the area working on the pesticide program. You are right, and this is what we are trying to do. That is how the project got started.

STATEMENT OF ROGER BLOBAUM, SOUTHERN IOWA COUNCIL OF GOVERNMENTS, CRESTON, IOWA

Mr. BLOBAUM. Roger Blobaum.

Mr. Chairman, I am from area 14 to the west and am here on behalf of the Southern Iowa Council of Governments. We sponsor a number of aging programs. I have a statement that I would like to submit for the record.

In terms of the rural aspects of these programs, 77 percent of our elderly live in small towns or rural areas, and more than one-third are below the poverty line.

Senator CLARK. More than a third.

Mr. BLOBAUM. In addition, 25 percent of the people in our seven counties are 60 years of age or older—one out of four.

We have a fairly extensive program, but one of the difficulties is the ability, as one of the previous witnesses pointed out, of being sure that the needed funding is available. As we come to the end of each year, we have to scramble around trying to put together enough local money, State money, and Federal money to try to keep our programing level going, at least at its present level, for another year.

Programs in rural areas like this are more expensive. With our transportation program, for example, the vans have to travel a lot more distance. The meal preparation at our 12 meal sites has to be done on site—it cannot be done at a central place or catered in.

NEED FOR SPECIAL ALLOCATION

I was asked by our board and our aging agency to come over and make these points and to suggest that there should be some kind of special allocation, or a different kind of allocation, to make it possible to get more money into areas like ours that have a lot of low-income people, a high proportion of rural people, and a very high proportion of people over the age of 60.

Senator CLARK. Well, fine, Roger. I am pleased to have your statement so it can be made a part of the record. I do want to say that I think we do have a fairly good chance of maintaining most of these programs in terms of continuity. I know that if they were authorized for 5 years, 10 years, or so forth, you would be more assured of it.

For example, title IX that we have been talking about, we increased this year from $50 million to $90 million. We almost doubled it.

Now other programs were not that fortunate, but I really do believe that the interest that older people have had in the organizations that they put together and the kind of things we heard from the first panel has really brought an awareness to the Congress and, I think, to

the Presidency, so that it is given a high priority. It is very doubtful to me that the Congress is going to back off these programs.

I know that is not absolute assurance, but I think it would be very unlikely, because associations, groups, clubs, and centers have organized very effectively for political action.

Mr. BLOBAUM. There is a tendency under those programs, as you know, to get more of the financing taken care of at the local level.

Senator CLARK. Yes; particularly the transportation we were talking about.

Mr. BLOBAUM. Yes; boards of supervisors putting in more money; also the city councils. The aging people are raising a lot of money themselves in our area. But even so, every year we are in a really bad pinch to try to line up the money needed to get the program laid out for the next year.

Senator CLARK. Thank you very much.

[The prepared statement of Mr. Blobaum follows:]

STATEMENT OF ROGER BLOBAUM, OTTUMWA, IOWA

Mr. Chairman, I appreciate the opportunity to appear at this hearing as a representative of the Southern Iowa Council of Governments, the sponsoring agency for the area XIV agency on aging.

The local governments in our seven-county area give a high priority to this agency, established in 1973 to make a wide range of services available to the 24.9 percent of the people 60 years of age and older. This percentage of elderly is the highest served by an aging agency in Iowa.

Figures compiled by the Iowa Commission on Aging show that 77.5 percent of the elderly in our area are rural residents, by far the highest percentage of rural elderly in any area in Iowa. More than one-third of the people over 60 have incomes below the poverty level and many of the elderly, particularly those with low incomes, are widows living alone.

Deciding priorities and most of the policymaking is done by the senior citizens themselves and finalized in recommendations to the council of governments from the area aging advisory council. We are the grantee organization and have final responsibility for the agency and its programs.

The agency's first effort was the nutrition program, which the elderly in the area consistently place at the top of the priority list, and we have added others as funding became available. Our services now include congregate and home-delivered meals in 12 towns and cities, an areawide 5-days-a-week rural transportation system, handyman and homemaker programs, home weatherization, information and referral services, and an outreach program.

Our agency has working arrangements with several cooperators, including the two community action agencies serving the area. Others providing assistance include the department of social services, Midcrest Extension, the Southwest Iowa Sheltered Workshop, social security, and Southwestern Community and Graceland Colleges.

The programs authorized by the Older Americans Act meet genuine needs of elderly people. This is important because the senior citizens in our area are proud and fiercely independent and would rather be self-reliant than utilize most government programs. The aging programs have a good public image in our area, most of our senior citizens accept them, and we feel they make sense.

Our main concern as local sponsors is coming up with the money needed to maintain the programs we have. Sufficient funding was provided the first year when the allocations took into consideration the high percentage of elderly and low-income people in the area.

In the second year, however, the method of allocating Federal funds was put on a 60-plus population basis. The result was a 50 percent cut in title III funds for the period beginning in February 1975, and a 27 percent reduction in title VII funds for the period beginning in October of the same year.

Part of this deficit was covered when the legislature, for the first time, provided direct assistance to aging agencies. A substantial amount of money also

was raised locally. In the nutrition program, for example, 35 percent of the money came from county boards of supervisors and contributions received from the senior citizens themselves at the meal sites.

State Commission Supplemental Grant

For the coming fiscal year, we were able to fund current programs only because the agency obtained a supplemental grant of $40,000 from the State Commission on Aging, because meal site contributions again were greater than anticipated, and because larger quantities of commodity foods are available.

What we are suggesting is that programs for the elderly in rural areas require a stable, long-term Federal funding commitment. Once begun, these programs become very important in the lives of those who use them and their continuation should not be left in doubt at the end of each year. Once elderly people begin counting on the congregate site for their noon meal, or the vans to take them shopping or get them to the clinic, everything possible should be done to maintain these services.

Although we are grateful to the Iowa Legislature for starting direct assistance to area aging agencies, this funding cannot be relied on as a basic level of support. The $15,165 in administrative funds and $42,438 for congregate meals received from the initial funding saved this year's aging program in our area. But the legislature appropriated less money this past session and only $12,250, rather than $57,603, is available to our agency from this source for the year beginning October 1.

We have no choice, therefore, but to continue to look to Congress for basic funding for these programs. Further reductions in Federal support, combined at any point with discontinuation of State funding, would force our agency to make drastic cutbacks in some programs and to drop others.

Beyond the need to maintain present programs, there are many unmet needs. They include opening two additional meal sites to provide complete areawide coverage, upgrading several sites from the present three meals a week to five, providing more home-delivered meals, and providing more homemaker, home repair and other services that help older people remain in their own homes. There also is interest in programs involving health care and legal aid services and we would like to do more to stimulate construction of low-cost housing for the elderly.

We urge the committee to look into the possibility of making additional funding available to areas with a high proportion of low-income, rural elderly. This could be done by changing the present allocation formula, by special allocations, or by earmarking funds for rural aging agencies. A specific suggestion would be making agencies in economic development districts eligible for higher funding levels.

This special consideration is justified by lack of local services and financial resources in low-income rural areas with a high percentage of elderly people and the fact that programs in rural areas are by necessity more costly. The need for on-site meal preparation in the nutrition program and the long distances traveled daily by vans in the transportation system are just two examples.

Another important point, particularly in rural areas, is that services are quite limited, or not available at all, for people regardless of income. Many services simply do not exist in many rural counties. A large number of southern Iowa towns do not have mass transportation, dentists, doctors, low-cost housing, restaurants, and grocery stores. These services typically are available in urban areas.

We also would like to call your attention to a problem that has developed as a result of passage of the Joint Funding Simplification Act. We are aware of this because we are involved in funding simplification as the Nation's first rural IGA (Integrated Grant Administration) area. We have seen how well this approach can work, for example, in the way several Federal agencies have gone together to fund our areawide rural water system.

The problem is that HEW, and specifically the Administration on Aging, has insisted on writing a provision into the Older Americans Act to keep its funds from being integrated in areawide governmental units like ours. This creates administrative problems for our staff and we feel it is against the intent of joint funding.

We have been able to cut administrative costs and provide more services in our area by integrating all available Federal, State, and local resources. We would urge you to support the joint funding approach to all rural programs and to oppose the effort by the Administration on Aging to write itself out of the funding simplification legislation.

In closing, we would like to mention one additional problem that is not new where government programs are concerned. That is the problem of too much paperwork. We have the professional staff capability to submit the large amounts of paperwork necessary to bring services to the elderly in our area. But we also have highly competent people, both staff and policymakers, who could be delegated much more authority and responsibility. We feel the staff time involved could be much better spent in direct services to the elderly than in paperwork and would suggest a review of the Federal requirements for detailed plans, reports, and records.

Senator CLARK. I want to call on Jim Murphy, since we are talking about employment programs, because I know that he is with the Iowa Farmers' Union and they have had the Green Thumb program.

Could you give us a little bit about what that has done in employment and what you know of it?

STATEMENT OF JIM MURPHY, IOWA FARMERS UNION, GREEN THUMB PROGRAM, DES MOINES, IOWA

Mr. MURPHY. The National Farmers Union is a Department of Labor contractor for the Green Thumb program. This program is 11 years old and is being funded now by Congress to work in Iowa for the first time. We have the money for 49 part-time jobs for people 55 years old and older. We are going to have 15 of these jobs here in Wapello County.

I will be working with your area agency on aging people for these positions. We can provide the wages for workers 2½ days a week to help with winterizing poor people's homes or to help with public projects—work on parks and recreation areas.

Fifteen in Wapello County are about a third of the 49 new positions that Iowa has for this fiscal year. If we can make it a successful program with the older workers, Congress may extend and expand the program in the future.

I believe I should now ask for questions.

Senator CLARK. Any questions about Green Thumb?

Mr. HOLVOET. Yes. Again, on this particular point, we were to be able to solicit some comments from the State and we have not heard anything since then, but we are going to have 15 in area 15 already, so you know there is a communication thing here.

Senator CLARK. Between the State?

Mr. HOLVOET. Between the State commission.

Senator CLARK. State commission on aging?

Mr. HOLVOET. Yes. So I would like to have him address himself to that. I am wondering if our area—area 15—is going to have any of these slots.

Senator CLARK. Do you know the answer to that offhand?

Mr. MURPHY. I believe I do, Senator Clark. I have written to Mrs. Ryan, the director of area 15, agency on aging, and I have her reply when she acknowledges the 15 jobs, and she sent me her suggestions of what areas they should be working.

Now I intend to meet with Mrs. Ryan at her convenience to work on these jobs. This is a federally funded Green Thumb program sponsored by the National Farmers Union. This is not the Green Thumb program that works with the State conservation commission funded by the Iowa Legislature.

Mr. HOLVOET. That is fine, but how many agencies did you contact and talk with?

Mr. MURPHY. We contacted the area agencies where we have jobs available. With only 49 positions available, we want to concentrate them where they can be effective, probably 15 jobs at each county. I think if we tried to cover the entire State, we would have one person in every other county.

Mr. HOLVOET. The point I am trying to make is that it is not systematic. Everyone was not given the chance to make comments on this.

Mr. MURPHY. Yes, you are right, but by selecting Wapello County, I left out 97 others.

Senator CLARK. Mr. Gilbert.

Mr. GILBERT. I would like to address this question to you. This Green Thumb Farmers Union has a title IX project. Now, the Older Americans Act here in Iowa—why would they put out duplication of service to start duplicate administration when this is actually duplication of our programing?

Senator CLARK. I think under the new title IX authorization and appropriation, it is administered at a national level. I mean, it is not a separate program.

Mr. GILBERT. This is what I cannot understand, though. Green Thumb is one of the five contractors for title IX, so why would they move Green Thumb into Iowa when they are so heavy in Minnesota, and the Dakotas?

Senator CLARK. I think that a part of the great increase in funding, from $50 million to $90 million; a part of that increase went to Green Thumb. So obviously they are trying to go out and find additional slots as well.

Could you speak on that?

Mr. MURPHY. I think that is the major reason. The other is that Green Thumb workers on the project are restricted to rural areas. This is an attempt to expand work and find work for older people who are out of work in rural areas.

Mr. GILBERT. Do you generally work in crews on your program?

Mr. MURPHY. That is what we hope to do.

Senator CLARK. We have time for a couple more.

STATEMENT OF EDNA MORRIS, STOCKPORT, IOWA

Mrs. MORRIS. I have a comment to make. We have not talked much about the hundreds of congregate meals today. I am Edna Morris from Van Buren County in which a study [1] was made with the senior citizen group. We found that congregate meals are quite effective, and we did have some very good interviews. They were planned. There was

[1] See report, appendix 3, p. 141.

cooperation with the University of Iowa at Ames. Also, the department of health and various social agencies in Ottumwa, and others, felt it was a very logical type of interview that was made with our senior citizens.

One thing that I think came out of it was that our people felt that getting out each day was important. About 75 percent of them were widows or widowers, otherwise they would be eating alone at home. It was a good thing to get out, meet new people, get to go places in a group, and to get to meet new friends.

I think another thing that came out of our study was the fact that we found that some of our elderly citizens were not eating properly; they were not getting the recommended daily allowance of certain things. One of the things that we found was a deficiency in vitamin A, which comes from the green and yellow vegetables. They had a tendency to eat more cereals, sandwiches, soups, and things like that.

Another one was that they were not getting enough calcium. Of course, we do have a large percentage of our old people with bone structures that collapse, so we try to encourage our older people to use more milk, cheese, and things that would get more calcium into their system—and also vitamin A.

Senator CLARK. We appreciate very much having those comments. I might say that at another of our hearings we are going to feature nutrition, just as we did here on transportation.

Mrs. MORRIS. Where?

Senator CLARK. It will be either tomorrow or the next day.

Mrs. MORRIS. I was not aware of that.

Senator CLARK. We are trying to focus on different areas with panels. The nutrition program is easily the most popular single program under the Older Americans Act. It has been tremendously successful, both for nutritional and social reasons.

I know of its popularity. In fact, we increased the funding this year for the nutrition program by about $50 million. In Iowa, for example, this next year we have appropriated almost $2 million—$1,857,039. So we have recognized the importance of it. In fact, I have just eaten over at the Winterset title VII meal site before we came over here.

We appreciate your comments very much.

We have only about 5 minutes; but I do want to open it up, not only to employment, but to any of these things that you would like to talk about.

STATEMENT OF ETHAN CURTIS, FAIRFIELD, IOWA

Mr. CURTIS. Ethan Curtis, Fairfield, Iowa.

I presume you will cover this area tomorrow or the day after, but I want to get my 2 cents worth in. I happen to be chairman of the Public Housing Agency in Fairfield, and this information that I am very briefly giving is part of that from our housing applications. We have been following it up for the last 5, 6, or 7 years.

No. 1, the income of our elderly in Fairfield in 1976, as compared with 1970, has been increased only by the increase in the social security payments and supplementary security income. These increases, while helpful, have not yet risen with the increased cost of living.

No. 2, Fairfield has 3,060 elderly, and 37 percent are below poverty income limits. In other words, 1.13 people are in this low-income group. The source of this information is the U.S. Employment Office.

No. 3, the 1970 census gave 2,260 elderly in Fairfield. A 1974 actual count gave us 3,062, or an increase of 802 elderly people in the 4-year period. By applying these same figures in the past 6 years, 1970 to 1976, Fairfield has 1,005 more elderly in this group, or a total 1976 figure of 4,765. The source of this information is the Fairfield Chamber of Commerce.

SUBSTANDARD HOUSING UNITS

No. 4, we have 696 housing units occupied by low-income families. Thirty-seven percent below income limits means that we have 258 substandard units that most likely are occupied by our elderly.

In other words, the units did not measure up to the standards as being decent, safe, and sanitary. The source of this information was the Iowa State Employment Office.

No. 5, by actual count as of June 6, 1974, we had 84 vacant apartments in Fairfield. Forty-three of these eighty-four were unsuitable. Ruled out on account of location were 37, which gives Fairfield 6 qualified units for elderly housing.

We had a total of 44 vacant houses. Thirty-five of these forty-four were ruled out because they were unsuitable—because of location, condition, or rent—which gives Fairfield a total of 15 possible living units for elderly which comes within the Federal guidelines.

In 1975, the Area 15 Housing Coordinating Committee, following our survey, ruled that we had a zero percent vacancy rental for the elderly. So we are just playing dominos—someone moves in, someone moves out.

No. 6, our applications for 48 units for low-income elderly was approved in February 1976. Construction is slated to begin within 60 days. Even though this project would ease the situation a little, it will in no way meet the housing needs of Fairfield.

Thank you.

Senator CLARK. Thank you very much. That is a good report. I know that the figures that you cite are 37 percent substandard housing. It is roughly that same average all over the country, particularly in rural areas. There is an enormous area of need. In fact, I went out this morning in Winterset and went through their public housing there for the elderly—it is not just for the elderly, but it seems it is principally being occupied by the elderly. It is called the North Ward Plaza.

I have also been in units here in Ottumwa. The need is enormous. It is very hard to say we can up the income to match the growth and needed money. In fact, I have cosponsored, with Senator Church and others, an attempt to have the index reestablished every 6 months, instead of yearly, so that we don't run so far behind on increases in social security.

Well, we have a couple more minutes. Does anybody else have a brief statement?

STATEMENT OF ESTHER WHALEN, OTTUMWA, IOWA

Mrs. WHALEN. Esther Whalen, Ottumwa.

I agree that we need more buses, which is very enjoyable, and I think the meals are great. But I do say that I think there should be something done about we widow ladies. I know there are lots of us here who have a home to keep up and the minute the husband is gone, why, the social security goes down. Our bills go up, we still pay the same gas, the same amount of water, all for one person in the house. It is very hard to do it.

I don't know how to keep up unless we have some ways on the sideline. I think that social security, instead of being cut in half, should be a larger part, because we only get a percentage of that. If that is taken away, too, it is just a little hard to keep up.

Senator CLARK. Thank you very much.

STATEMENT OF BERTHA DREYFUSS, OTTUMWA, IOWA

Mrs. DREYFUSS. Bertha Dreyfuss from Ottumwa.

I would like to speak about full employment. I want to ask you, Senator, where the jobs come from, when you say let all work who want to work, out of a population tremendously increased and some jobs that perhaps employed five people 25 years ago which are performed by machines today. Everyone who is running for public office this fall is promising full employment. Where do we get the jobs from?

Senator CLARK. I think it is possible to have that kind of job market. In fact, take one country that comes to mind immediately—West Germany. They have a shortage of labor and 10 percent of their labor has to be imported from outside. Even though they have had an enormous population increase, the economy has been expanding in a way in which they do not have enough people to fill all the jobs.

One could cite other countries as well. I don't think that with modern technology necessarily comes the situation in which you have to have very high unemployment. I don't think the two can ever be economically incompatible.

The fact is that we have enough work that needs to be done. The solution is to have the economy expanding in a way which really provides those jobs.

MEDICAL ATTENTION DIFFICULT

Mrs. DREYFUSS. We need better medical care. Even those who pay their own way cannot always find a doctor who is willing to take on another patient. My husband who has become disabled the past year could not get a foot doctor in Ottumwa to take him. I had to pay someone to take him to the clinic in Bloomfield to get his toenails clipped. We need, in Ottumwa, an outpatient clinic where everyone gets service.

Senator CLARK. Any other statements?

Mr. BURROWS. I thought I would tell a joke if you folks are leaving. This is an old joke, but you folks are all young so maybe you didn't hear it when it first came out.

This son-in-law got a telegram from his in-laws. He lived way off here. The telegram says. "Your mother-in-law is dead; shall we embalm, bury, or cremate?" He writes back and says, "Do all three, take no chances." [Laughter.]

I think there is a lot of emergency about these programs, but what I want to say rather technically is very appropos. The old lump of labor argument has been brought out here—that there is so much of a wealth of labor here that if you have two folks do it, then each one could do half as much. That is all.

The old lump of labor theory was thrown out years ago when the first technology in printing was established. The labor organizations all said, "This is going to do the work of three people, and so we can't have it." They tore up the machinery, rioted, and what-not.

We have had more and more machinery and technology taking more and more jobs. We have also had a larger and larger percentage of our people gainfully employed. So we make our income and our wages as we work. and you don't have a lump there from which to take. That is one thing, I think, that has made this other idea very simple.

I thought that $2,700 ought to be moved up all along. It won't affect me. I have always been too wealthy to get help and too poor to be relied upon. [Laughter.]

So I am not sure. But it is bad for these $2,700 deals these days when prices have doubled.

Senator CLARK. I agree. Good.

Two more statements back here, and then we are going to break up.

STATEMENT OF IDA L. MILLER, CENTERVILLE, IOWA

Mrs. MILLER. Ida Miller from Centerville.

We have not talked about nutrition, but that is my first love, then transportation. When is the next hearing on nutrition?

Senator CLARK. The nutrition hearing is Wednesday morning at 9:30 in Sioux Falls, S. Dak.

Then we are going to talk about it again in Rockford, Iowa, Wednesday afternoon. Rockford is a small town up around Mason City. I would be happy to hear anything you have to say about it right now.

Mrs. MILLER. Well, I just want to know if our program is going to continue.

Senator CLARK. There is no question about whether it is going to continue. It is the most popular program, as I was saying to this lady, in the aging area. In fact, we increased the funding by $50 million this year.

Mrs. MILLER. It is the love of my life—the nutrition program.

Senator CLARK. Thank you.

STATEMENT OF TESSIE BURT, OTTUMWA, IOWA

Mrs. BURT. I am Tessie Burt.

Twenty years ago there wouldn't have been a hearing like this concerned with old people. Even if there had been, we probably wouldn't have heard about it. And if we had heard of it, we wouldn't have been able to get to it.

Things have certainly improved since then. People and governments care about the elderly, and they go out of their way to let a lot of us know that they do. And though we have some things, quite a bit is still needed.

Some towns don't have either community or senior centers, but when you get older you need some place to go so you can meet others, rest, or get a hot meal. You could have your blood pressure taken or learn exercises. But if you eat your hot meal in a church basement or a restaurant, you can't do all of the things that you want to do.

However, meals served in our own senior or community centers won't take care of those of us who are houseridden or bedridden. More money for meals-on-wheels programs would be good. And, to keep us from having to leave our own places for a nursing home, we need more homemaker aides.

Learning skills for retirement might not be a bad idea, though I think older people should be encouraged to work as long as they can instead of being made to retire at a certain age.

Being old has its advantages, and you, Senator, and others like you, have taken away some of the disadvantages.

Senator CLARK. Thank you very much. We appreciate it.

Let me just say now in conclusion that I think the witnesses and the testimony we have had today has been valuable to us. As I look back over the list, I particularly appreciated Ed McMillin talking about what the American Association of Retired Persons are doing and what the legislative council is doing; certainly Ben Grismore, in talking about how the transportation program was begun in Wayne County, and the value of it; Professor Burrows, who not only is a good story teller but knows a good deal about the problems of transportation—I thought that was valuable; certainly this panel with Shirley Campbell, talking about how as project director service employment has worked around this area; also Bob Gilbert talking at the State level about how these programs work; and then Ruby and Francis, as examples of that, and what it means to have these kinds of programs.

So I think it has been very valuable to us.

Any statements that you want to leave in writing or mail to me will be put in the record. We will have the record open for another couple of weeks so if you want to write something in a letter and say, "I think you ought to know about this, too," I will be very happy to have it and you tell me if you want it published in the hearings or if you want it kept private.

We are delighted that you came and we hope to see you again often.

Thank you.

[Whereupon, at 4:20 p.m., the hearing was recessed.]

APPENDIXES

Appendix 1

STATEMENTS FROM INDIVIDUALS

ITEM 1. STATEMENT OF PAM HUNT, TRANSPORTATION COORDINATOR, AREA XV AGENCY ON AGING, OTTUMWA, IOWA

I would like to present for the record some very positive things that are happening in the field of transportation for the elderly and the general public in area XV.

Area XV Agency on Aging, soon to come under the umbrella of programs sponsored by Southern Iowa Economic Development Association, is submitting a proposal for Urban Mass Transportation Administration funds under section 16(b)(2). These will be used to replace equipment currently being operated, as well as offering an additional service for handicapped people via special equipment in Wapello County.

South central Iowa community action program is applying for funds to provide a similar service for handicapped people in Wayne, Monroe, and Lucas Counties. These funds will also be made available through Urban Mass Transportation Administration section 16(b)(2).

The area XV Regional Planning Commission has received preliminary approval on a demonstration project for $250,000 to be spent over the next 2 years. Mr. Bruce Bullamore has initiated an advisory group to give input for the final application for this comprehensive rural system. The project would not only coordinate existing human service transportation systems, but also provide a demonstration commuter service for area XV.

Several rather significant activities have taken place in Wapello County in recent months. An agreement has been reached with the Ottumwa Transit Authority by the area agency on aging allowing the agency's bus to operate 3 to 4 hours daily inside Ottumwa's city limits. The service is aimed primarily toward those individuals who for one reason or another cannot utilize the city buses.

The State of Iowa has allocated $2 million for transit assistance. The Ottumwa Transit Authority will be eligible for application of those funds to help relieve the operating deficit. One application for these funds will also be accepted to assist rural operations in area XV. It is hoped that these moneys will be spent in a fashion acceptable to the legislators so they can see their way clear to reallocate funds to the Department of Transportation in the future for use in providing comprehensive transportation service in Iowa.

The major need which should be considered when allocating funds for transportation is operating assistance. After a system is operating or has updated its equipment, the major need is for operating assistance. In many grant applications the emphasis is on capital outlays, rather than operating expenses. In rural Iowa as well as other places, the strain of operating a system cannot be met by local support totally.

ITEM 2. STATEMENT OF JOHN H. KING, CHAIRMAN, BOARD OF DIRECTORS, SOUTHERN IOWA ECONOMIC DEVELOPMENT ASSOCIATION (SIEDA)

Thank you, Senator Clark, for the opportunity to speak at this special hearing on problems facing older persons.

I am presently chairman of the board of directors of Southern Iowa Economic Development Association, the community action agency that serves this southern Iowa area. In this role it has been my privilege to become directly involved with a number of groups of persons who have been directly affected by the work of an agency such as SIEDA. Among them are numbers of older persons, living in isolation in this southern Iowa area, out of touch with and unable to gain access to many of the services they need.

I am greatly concerned, Senator Clark, about the inability of many of our older citizens to get to a doctor, a dentist, or a pharmacy, all of which may be located in a county seat town a number of miles from where they live. There is a great need for additional congregate meal sites, now limited due to limited funding. There is a need for handyman service activities for many older persons, too proud to ask, or too poor to pay for little tasks they can no longer do for themselves. There is a need for senior service centers in some of our isolated areas, small communities in which older persons make up a large percentage of the total population. And finally, Senator, there is a great need to expand transportation services in rural Iowa to older and handicapped persons.

SIEDA will be addressing some of these problem areas I have alluded to beginning October 1, when our agency becomes the sponsor for the area agency on aging program. However, with all the expertise within SIEDA, and it is considerable, there never seems to be an adequate supply of funds or technical assistance that can be generated through both State and Federal sources.

There would seem to be a need to direct existing State and Federal funds more generously into areas such as we have in area XV—areas that have documented evidence of need that far outweighs need in other areas of Iowa. Surely the formula for parceling out money should be weighted for an area that has more older persons per capita than most or all other areas of the State. I would strongly recommend that the formula system for funding be more truly reflective of the identified need in terms of specific persons who need and require service.

As a case in point, much of area XV is economically depressed, a fact that has resulted in the area being designated as an economic development district. This would presume to alert the Federal and State governments that when funds of almost any nature become available, that area so designated would automatically become a high priority for funding and frankly, Senator, this does not seem to be the case.

Older persons' problems are not unique for southern Iowa, Senator, but they are somewhat critical due to the nonmetropolitan aspect of the area. As you know, when service is not available to you where you live, you have three options: do without the service, go to where the service is available, or have the service delivered to you. We would not suggest people do without service. We are attempting to get people to service and we will continue to bring service to people. The latter two options are both costly and time consuming in the nearly total rural environment of southern Iowa.

SIEDA has been able to assist many older persons through its community food program, through its energetic efforts to see more well-adult health clinics established, through property tax relief programs, and through such programs as RSVP—the retired senior volunteer program.

And although we feel good about our involvements thus far, we are likewise frustrated by our attempts to do more. Be assured, we shall continue to serve people who have need—it is our mandate in community action. We do need the support of persons such as you to demonstrate to the Nation that we are all committed to the effort; that we recognize the shortcoming but that we do have the energy, the enthusiasm, and the dedication of purpose to get the job done.

My lifelong work as an educator and administrator, Senator—working with youngsters is not unlike the problems we are experiencing in working with older persons. We are a catalyst for change in both areas—you, Senator Clark, along with your peers, are that catalyst at the Federal level to actively assist us in doing our task in a better and more effective way.

On behalf of the SIEDA Board of Directors, its staff, and the multitude of clients we collectively serve, may I express our pleasure at having such hearings in this area and my thanks for the opportunity to speak to you.

Appendix 2

LETTERS FROM INDIVIDUALS

ITEM 1. LETTER FROM VIVIAN B. HAMMES, SITE COORDINATOR, AGENCY ON AGING, FAIRFIELD, IOWA; TO SENATOR DICK CLARK, DATED AUGUST 13, 1976

DEAR SENATOR CLARK: As an agency on aging site coordinator, I would like to give you my views on the agency programs and what it has done for the elderly of Jefferson County.

This site was started in December 1973 with an average of 30 to 35. We now have an average of 65 to 75 daily. Most of these people come every day; the others on an average of twice a week. They even bring their children to the site so they can see where they spend their time and how well they do by themselves.

The agency on aging program has kept many elderly in their homes much longer and out of nursing homes, thereby saving the taxpayer thousands and thousands of dollars. This is every senior citizen's wish—"to stay in their home as long as possible."

These people have turned into happy people, for now they have a place to go, friends to see, and people who care about their welfare. We have seen them come out of their shells and "live again." (Granted there are a few we'd like to put back into their shells again.) The sociability is a great aspect of the program and without it the meals and minibus could never be.

Some cannot afford to pay for the meals or the bus, but this program does not leave them out. They can come—and do. The confidentiality of no one knowing if they can or can't pay keeps their dignity intact. They benefit the same as those who can afford to pay.

We have even taken the elderly home from the hospital by bus. They are taken shopping, to the doctor, drug store, beauty parlor, visiting, to the grocery store, laundrymat, the bank, to an attorney, etc. You name it, the minibus has taken them there.

These people even volunteer to help at the site. They volunteer in the community—selling tickets at the junior agricultural show, helping at the farmers market, TV marathons, selling bicentennial booklets, community parades, contest judges for school, foster grandparents to seventh grade students, etc. They are certainly no pikers when called upon, but each community must become aware that they are available, even though retired. Their experience is a vast resource for our Nation and, as yet, virtually untouched. Our elderly are a fantastic group of people and being with them daily has been a wonderful experience for me.

A prerequisite of our site is a smile, and it seems to work wonders—it is contagious. The sociability is so important—for they can be their own self and be once again important. They not only help the community, but help one another, which in turn helps themselves. They consider the site as "their home away from home."

The meals are well planned for them and they have a say-so at a monthly meeting with the dietitian. This, plus program suggestions, makes them know that this agency program is truly for them. Many claim that they would be dead except for this program.

No matter how big or small the problem, they know that my aide, Maxine Riley, the bus driver, Mescal Kennedy, and myself will listen to them and advise them if possible. We've sat at the hospital all night with them; we've stayed at the house when a death occurred; we visit the hospital when they are sick; and we go with them to the doctor. Having us there seems to lessen the fear, and they know they can depend on us anytime—night or day. Most have no families or they live too far away.

I could go on and on about the wonderful things these elderly do, but I could never do them justice. The satisfaction is seeing them smile and knowing the good the program is doing daily. Of all the programs the government sponsors, the agency on aging is one of the best and does the most good. More funding could be used for the continued support of this program.

Sincerely,

VIVIAN B. HAMMES.

P.S. Why not come and visit our site, "the best in Iowa," and see for yourself?

V. B. H.

ITEM 2. LETTER FROM MESCAL KENNEDY, FAIRFIELD, IOWA; TO SENATOR DICK CLARK

DEAR SENATOR CLARK: As the driver of our minibus, it is my opinion that the greatest blessing that ever came to Fairfield was the founding of the senior citizen site.

We have the perfect coordinator in Vivian Hammes, and assistant in Maxine Riley. They are not only interested in all of the participants while they're here at the site, but they will, and often do, look in on the senior citizens after working hours.

We have a team of volunteers who can't be beat. They are alert to other's needs, diligent workers, and extremely friendly and helpful.

Many of the elderly who seldom ventured outside their homes or apartments previously, except for visits to the doctor, began to gather 5 days a week at the site. It opened up a whole new world for them. Not only are they supplied with nutritious meals, but also the fellowship they enjoy is priceless.

The minibus is a godsend to many of the senior citizens. Those who had no means of transportation and hesitated to call on friends or relatives to drive them places now have an independence in calling their own bus for trips to the doctor, dentist, supermarket, beauty parlor, or anywhere they want to go.

It would be a great injustice to deny them this facility now. The senior citizens of Fairfield need the senior citizen's site and the minibus.

Yours Respectfully,

MESCAL KENNEDY.

ITEM 3. LETTER FROM CATHERINE KURKA,[1] FAIRFIELD, IOWA; TO SENATOR DICK CLARK, DATED AUGUST 12, 1976

DEAR SENATOR CLARK: I am a volunteer worker at the congregate meal site, and I would like to tell you how great I think this service is for our senior citizens.

I didn't really realize just how much this means to so many people until I started working at the site, once a week. It cannot be described fully to anyone who has not seen some of these people when this all started. Some of them did not get out of their homes. It is a pleasant place to enjoy a meal with friends and also to enjoy the entertainment that is offered on different days. You really need to be in the card room, or sit around and visit with the people, to get an idea of what it does for so many. We are very lucky in Fairfield in having a gal at the head of this that is so dedicated to her work. She will do most anything for these people. She is quite an advocate of theirs.

Please continue funding such projects for the senior citizens. They are a part of our country that is not as vocal as some of the others. They, for the most part, have not always had everything and have learned to "make do with what they have."

On their behalf, I thank you and please continue to work for them.

Sincerely,

CATHERINE KURKA.

ITEM 4. LETTER FROM PATSY SEALS, RSVP DIRECTOR, OTTUMWA, IOWA; TO SENATOR DICK CLARK, DATED AUGUST 16, 1976

SENATOR CLARK: The RSVP (retired senior volunteer program) began operation in Ottumwa on July 1, 1972, with a Federal grant from ACTION in Wash-

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[1] See statement, p. 110.

ington. Ottumwa was one of the first four RSVP's funded in the State of Iowa. The function of the RSVP is to work with people age 60 and over to find them useful and worthwhile volunteer work to do in the community. We try to match the volunteer to the work very carefully so that the volunteer and the volunteer station is happy with the match. Our program oftentimes involves counseling with the volunteer and trying to help them solve the problems that they might have. Some of the problems we work with are: difficulties with their check, especially when they get word that social security has overpaid them and they won't get a check for a period of time. These people oftentimes don't have the funds to carry them for 2 or 3 months or longer. They need help to apply for food stamps and other services that they may be eligible for during the period of time that they don't receive a check. Some of our volunteers have no families and it is difficult sometimes for them to get the medical care that they need, so we sometimes help them with medical problems. Some of our volunteers that do have families have feelings of being neglected or mistreated by their children, so counseling with this problem occurs frequently. To so many of our volunteers, the people they work with in their volunteer work is the only family that they might have.

For the first 2 years that the RSVP program was in Ottumwa, our grant was administered by SIEDA, which is a CAP agency. SIEDA felt our program should be spun off to a community organization and we started investigating possible sponsors. The Ottumwa Area Chamber of Commerce had been working with the idea of starting a volunteer bureau in Ottumwa and felt that the sponsorship of the RSVP might be a step in the right direction. The chamber of commerce took over the sponsorship and has been the sponsor for the past 2 years, and we are going into our third year with the chamber. It has been very good, for we are reaching a group of people that we had not reached before.

Some of the things that our volunteers do are:

—Help supervise the handicapped clients at the TENCO workshop and also sell items made by the clients at the county fair and the local "crazy day."

—Mending items and also fold brochures for the local hospital.

—Helping at the nursing homes by feeding other patients, passing out mail, writing letters, entertaining, helping with bingo, visiting with the patients, and other things that are needed to be done. Some volunteers have been taking the patients to the doctors and other professional people that they have needed to see.

—We have volunteers that help with the department of social services with the food stamp outreach program.

—We have volunteers that do typing for organizations such as the Ottumwa Area Chamber of Commerce, Boy Scouts, Indian Hills Lake Region Tourism Council, and many others.

—We have one volunteer that does the correspondence for the business/consumer affairs council which in Ottumwa acts as the better business bureau.

—We have volunteers that do special projects such as mailings, envelope stuffing, making lap robes, putting together packets for American Cancer and Multiple Sclerosis, and any other projects that can be done in a group setting.

—Some volunteers provide transportation for other people such as our volunteers. We have volunteers that provide transportation to other people that need to get to a doctor out of town and this is something that our volunteers do if the people can pay for their own transportation or if we can get funds from other sources such as the department of social services. This is one of the big problems of the elderly of Ottumwa—transportation to out-of-town doctors.

—We have volunteers that help serve the congregate meals at the area agency on aging and also volunteers that work in the Mystic hot meals program which is a nonprofit corporation that also serves meals to the elderly.

—We have volunteers that do telephone reassurance, which involves calling on others who are shut in their homes. Volunteers have taught minicourses in such subjects as knitting and crocheting in the schools, administered first aid at the YMCA camp, helped with the voter registration program. We have volunteers working on a 1 to 1 basis with clients at the lifetime learning center which works not only with young adults but also middle-aged people to help them get their GED certificates. Our volunteers also help these people with reading difficulties. There are some of the clients who dropped out of school that need help in learning how to write a check and also many other things that we might consider to be simple in everyday life.

To provide all of these services to the community and to benefit the elderly people that we serve, we need funds. Although we do reimburse our volunteers for their transportation and meals, it nowhere near takes care of expenses. Some of the meals that our volunteers eat while doing their volunteer assignment may be the only balanced meal they have for the day. How do we carry on the program when we so badly need more dollars?

FUND SHORTAGES

In the beginning the program was partially federally funded for 5 years, and at the end of the 5 years the community had to come up with enough funds to carry on the program. In the spring of 1976, the agencies in Iowa and all over the United States were informed that the ACTION agency had frozen the programs at 70 percent Federal funds and 30 percent local funds. The decision has been made for an indefinite period of time. Although the reduction in the local match has helped the programs get their local match, if the program is to grow at all they will have to depend on the local communities for the funds which leaves so many of the programs back in the same place that they were in the beginning—not enough local funds to go around to the different agencies. Although we are to be 70 percent federally funded, the programs do not receive 70 percent of their total budgets from the Federal Government. We have programs in the State of Iowa that are in their fifth year that are at the point where their programs can't grow anymore because of lack of funds. In this case, what do you do? Do you turn down people that want to be volunteers? Do you take them as volunteers and hope that the funds come from somewhere out of the blue? What alternative do we have?

The total budget for the RSVP programs in Iowa in Federal dollars is approximately $310,000. This has to stretch for funding the State office in Des Moines, and the 16 RSVP programs in the State which involves more than 3,388 senior volunteers as of June 30. At the present time there are two proposals in the State office for RSVP programs, and there are no funds. What can we, as citizens and also as RSVP directors, do to help find funds for the existing programs and also for new programs, not only in Iowa, but all over the United States?

It has been said that the older Americans are a valuable resource, and this statement is true—but let it not be forgotten. Our older people all over the United States have forgotten more than a lot of us young people will ever know. I hope that when I get old enough to retire, that there is something that I can look forward to being a part of, such as the Retired Senior Volunteer Program of the United States of America!

What can be done about social security checks being stopped with such suddenness when there is overpayment? So often an elderly person receives notice that their social security check will either be cut or they will not receive a check for a certain length of time due to overpayment; however, they don't receive notice of this until the day they would normally receive a check. What do these people do? If they could receive notice concerning this matter at least a month in advance then they could possibly make some kind of adjustments.

Also, our local RSVP program does a lot of transporting the elderly to out-of-town doctors (if they can pay for the transportation or we can find funds from other sources such as social services) because there is not any other way for them to get to these doctors. What can be done concerning this situation?

Also, the RSVP program would like to stretch out more into the rural areas to reach more of the rural elderly, but we need funds to help do this. Our rural elderly are needed as volunteers as much as our urban elderly. What can be done to get more funds for this purpose?

PATSY SEALS.

Appendix 3

REPORT PREPARED BY MRS. EDNA MORRIS,[1] VAN BUREN COUNTY (IOWA) COMMISSION ON AGING

An Evaluation of the Congregate Meals Program in Van Buren County

This was a pilot study conducted in Van Buren County. It was conducted for the Commission on Aging of the State of Iowa, under the supervision of the Food and Nutrition Department of Iowa State University, Ames, Iowa, and under the specific leadership of Dr. Pilar Garcia.

Other agencies cooperating were: Iowa State Department of Health; Iowa Department of Social Services, Ottumwa Field Office; Van Buren County Extension Service; Area XV Agency on Aging; and Van Buren County Commission on Aging.

As I have previously mentioned, this was a pilot program on and of Van Buren County. One of the reasons it was selected was, it has one of the highest percentages of persons age 65 and over in their population of the State. And it is also considered among the lower economic level counties.

Another reason was this county has four congregate meal sites. Two located in the local cafes, Farmington and Stockport, one in a hotel dining room, and one, at the time of the study, in a church basement.

The first segment of the survey was conducted during November and December 1974. This included 74 women and 31 men, or a total of 105. All were 60 years or older. In April 1975 was the followup or second segment of the survey. This included 50 women and 19 men, a total of 69—68 were interviewed in both surveys.

Detailed questionnaires were used by trained interviewers to obtain information: general characteristics of the group, nutritional and health related data, dietary intake on a 24-hour basis of both food and beverage consumed.

All of these interviews were held at the meal sites. All of the people participated regularly in the program. About half the dietary records obtained included the congregate noon meal.

Results showed that a higher proportion of the individuals received one-third or more of the recommended daily allowance for several nutrients from the congregate meal. It also contributed a higher proportion of the daily intake of food energy and several nutrients.

Most of the 68 participants who were observed in both surveys had adequate daily intake of protein, iron, riboflavin, preformed niacin, and vitamin C. Half of the group had a satisfactory intake of thiamin. Over a fourth had vitamin A values less than 50 percent of the recommended daily allowance. Over a third had calcium intake below 50 percent of the RDA. Intake of food energy tended to be low, yet 50 percent of the participants were overweight.

Eighty-five percent of the group were 70 years old or older and the majority were women. Over 75 percent widows or widowers and the majority lived alone, which meant they ate alone when home. About two-thirds of the group were in income levels below $300 per month—only 10 percent were in income levels above $500 per month. A majority did their own shopping and lived near or within 3 miles of a grocery store. About 15 percent of the participants over age 80 did not prepare any of their meals. These were mostly men.

Approximately one-fourth of the group were on some kind of a special diet of low cholesterol, low residue, sodium restricted, diabetic, bland, or combination of several. Most had been prescribed by a physician. Only about 30 percent reported the use of vitamins or supplements. The majority of the group claimed good to excellent health.

Some questions still are unanswered. How can we measure the effects of the program on the nutritional status of the people being served? And is it possible to show the impact of good nutrition on the health of the elderly?

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[1] See statement, p. 128.

This study and evaluation of the congregate meal program was limited to appraisal of the diets and some health-related information. One conclusion seemed evident that the participants' preference was generally low for foods that are high in calcium (milk, cheese, etc.) and in vitamin A values (dark green and yellow vegetables such as brocolli, greens, spinach, winter squash, etc.). So there is much need for more calcium and vitamin intake.

Over 40 percent felt they had changed their eating habits since beginning to eat at the congregate meals. Other benefits were indicated too: fellowship, making new friends, and better eating.

These are just a few of the highlights of the total report, as it was 31 pages long.

Dr. Garcia expressed her appreciation, "We are grateful to the congregate meal participants for their cooperation in this pilot study."

Appendix 4

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing on "The Nation's Rural Elderly," in Ottumwa, Iowa, on August 16, 1976, I would have said:

The following replies were received:

RAYMOND ANDERSON, FAIRFIELD, IOWA

The meals program is very helpful to me. We get a good balanced meal each day.

The social part is good for the elderly, too. It is a great help to get out for a few hours each day.

The minibus is very much needed and is being used by many elderly citizens with low incomes.

I hope these programs will continue.

BERNADINE BARKER, KEOSAUQUA, IOWA

I do not agree with Mr. Bob Gilbert that employment of the older person is the greatest need. Transportation for the elderly and provisions for congregate meals are the greatest needs. In Van Buren County we have around 2,000 to 2,200 over 60, out of a population totaling around 9,000. Many of these people would not eat a single balanced meal or go anyplace for weeks at a time without these programs. I could enumerate many personal stories about people who have more or less come back to life again since this program began. Many who participate are isolated in rural areas (some isolated in small towns) and depressed, with no reason for living. We feel in Van Buren it keeps many out of the nursing homes.

We need more and continued support for these programs. We have two part-time drivers who receive only $4,500 total for the job of minibus drivers and no provisions for overtime work which they do a lot of. Our funds have been drastically cut and we do not know whether we can continue the program beyond another year! I feel in order to continue to offer these services we need assistance for the services and more funds to be able to pay a living wage to employees. Coordinators, like myself, responsible for coordinating transportation and congregate meals, dispatching buses, etc., are not paid a wage comparable to other similar positions (presently $7,700) and are told wages are frozen for another year.

In other words, no one is working in the program unless they enjoy helping people. but you don't keep good employees with a continued rise in the cost of living on that basis alone.

Low-rent housing is another great need. We do have housing units in several communities, but there is a great need for some in Keosauqua. It seems the "powers that be" in that town did not want the competition of the low-rent units so we weren't able to build any. even though there is a great need for them. A week never goes by that I don't have inquiries on the subject! We need more in the other towns, too.

BERNADINE BATES, FAIRFIELD, IOWA

The congregate meals for the elderly help me because, when alone, I don't cook properly. It's also more fun to eat with my friends.

The sociability at our senior citizens site is wonderful for us. We see all our friends, and especially enjoy the cardplaying in the afternoon where we have so much fun.

The weekly exercise class helped me become more mobile and is keeping me that way.

The coordinator stayed with me during surgery. It helps to have someone who cares and will help when I need it.

I hope the Federal Government will keep on funding this program.

EVA BATES, FAIRFIELD, IOWA

I am thankful for the minibus and meals for the elderly. I was in a nursing home, and without them I could not have come back into my own home. When I was sick, congregate meals were delivered to my home by minibus. I now get to come to the site two or three times a week, and the other days I have a home-delivered meal sent to me.

The loneliness seems to go when I can talk and be with my friends at the site. I could never have managed without Fairfield's agency on aging.

CECIL BETTIS, FAIRFIELD, IOWA

First of all I want to thank you for helping me to finally get my black lung benefits. The coordinator, Mrs. Hammes, and I appreciated your followthrough.

The meals at the site have really helped me, because now my wife has had a stroke and cooking is a problem.

The people here couldn't do without the minibus either.

More funds are needed for this agency on aging program. I'm glad you are on this committee so you can keep helping the elderly.

Thanks again, and keep up the good work.

ONA MAY BIRT, FAIRFIELD, IOWA

The minibus is the most wonderful thing for the elderly. The taxi is too expensive and we need transportation.

Our congregate meals are good, well balanced, and help my budget considerably. The sociability at the senior citizen site helps get your mind on other things and the laughter is contagious.

We all appreciate our wonderful coordinator and bus driver because they both take an interest in everyone, and your problems are their problems, too. It gives us someone to talk to and confide in.

We like the privilege of being able to volunteer at the site and feel needed and wanted.

The coordinator even stayed with me when I was operated on when my family could not. It's nice to know I can rely on her when I need help. She tries to be a friend to all.

More funds are needed for meals and for the minibus for senior citizens. This program has done more for senior citizens than anything else. Keep funding the money, we need it.

SHERMAN BISHOP, FAIRFIELD, IOWA

I am a senior citizen 78 years old, and lost my wife in June 1975. I carried out meals from agency for aging while she was sick, then started eating there. It is a wonderful place for old people to eat, get acquainted, play cards, and help one another.

We have two wonderful coordinators in Vivian and Maxine. Also the minibus and driver, Mescal. They are wonderful for people who need them.

TWYLA BOOTH, FAIRFIELD, IOWA

You have done a good job in helping the elderly by funding programs for transportation and for nutrition.

This has kept many senior citizens in their own homes which makes them happy.

To be able to get the minibus to come to the congregate meals and have fellowship with others keeps them alert mentally and helps them physically.

To be on their own, to get to the doctor, to the grocery, or to visit friends is very rewarding. Since our community has no public transportation system, the minibus is needed.

I firmly believe these benefits are less expensive than putting our elderly in nursing homes or care facilities.

I have worked with the agency on aging program in Jefferson County since the beginning and can see the many benefits for those participating.

Thank you for your interest. I hope you will keep on working for the continuance of these very worthwhile programs.

IRENE CARLSON, FAIRFIELD, IOWA

I am a widow and can't get out. The minibus takes me to the doctor and the site for meals. I could not go otherwise.

The meals are good and the low cost helps the budgets of all the elderly.

Sociability means less loneliness for us. We need the Government to keep funding the agency on aging programs.

MILDRED CARTER, FAIRFIELD, IOWA

I have a better balanced meal and more variety at the site than when I cook for one and use leftovers. I enjoy seeing and visiting with others. It is a nice change from eating alone. Some who are unable to cook or come to the site have meals delivered. Exercises, bingo, cards, movies, etc., are enjoyed by many who come to the site.

The coordinator checks on those who are sick, takes them to the doctor, sees that they get their medicine, takes them home or to the hospital, and visits those in the hospital. She helps all who need help in many ways to make them feel they are not so alone in the world.

The site would be greatly missed by many—attendance in Fairfield is increasing. I hope the site may continue and that allowance will be made so it can grow.

ESTHER D. CHAMP, FAIRFIELD, IOWA

We'd like you to continue the funding for the senior citizen site and its programs.

The meals and the minibus are a godsend for me. This is my only means of transportation and, when sick, a carryout meal is delivered to me. I have no nearby relatives to help me so I, therefore, depend on these things.

RAY CLARK, FAIRFIELD, IOWA

The minibus and congregate meals at the senior citizen site mean a lot to me. I have to have medicine and oxygen every week and the bus takes me to get them. I also depend on the bus for groceries and trips to the doctor, as I cannot walk.

As for the meals, many times I would have done without anything to eat if not for them, for I am unable to fix something most of the time.

The site is also a good place to come to visit with the folks and for good, clean recreation and fun.

Keep on funding money for this program, it is so needed.

We ride the bus each day,
Travel on every street,
Gathering senior citizens
To bring them here to eat.

We ride the bus each day,
Travel all over town,
The senior citizens know
The minibus won't let them down.

We ride the bus each day,
Travel on every street,
We have no hat upon our head,
Worn shoes upon our feet.

We ride the bus each day,
Travel all over town,
The senior citizens know
The minibus will be around.

—by Ray Clark.

GLADYS E. DEGOOD, FAIRFIELD, IOWA

I believe the senior citizen site is the best thing that has happened for the senior citizens of Fairfield, Iowa.

The money that is appropriated for operation of the site by the city, county, State, or Federal Government is used in so many beneficial ways for senior citizens. It is wonderful how so little money can do so much for so many people.

I request that a larger sum be made available for the use and benefit of senior citizens.

The senior citizens enjoy better health because of the nutritious meals that are served to them 5 days each week.

They are happier because of the fellowship and sociability of being with other people.

The minibus affords transportation for many people to go to the doctor, to the grocery stores, to the bank or the post office, and to come to the site for meals.

There is only taxi service in Fairfield, Iowa, and it is quite expensive, if used. Many senior citizens cannot afford to pay the taxi fare. The minibus fare is 35¢ anyplace in town.

Our group has organized a senior citizen chorus of six senior citizens who enjoy many hours of music practice at the site building.

The chorus has become popular and is in demand to entertain in other towns for business and church organizations on special occasions.

The card room is generally filled to capacity with card players and it is a real fun place to spend an afternoon.

It is my sincere hope and wish that an increase in money for the program will be allowed so we can help more senior citizens.

I extend a special invitation for you to visit the senior citizen site and enjoy a pleasant, happy day.

LUCY DOUGHERTY, ALBIA, IOWA

The first priority, as I see it in Monroe County regarding transportation, is to assure us we will get to keep our minibus without relying on any more local tax money—as our small county cannot support much more. It is necessary to keep the Federal dollar coming. There is always room for expansion, but to keep what we already have is most important. Keep the money coming.

We would really welcome a visit of our sites in Albia and Lovilia by you. We also invite you to ride our minibus.

JOE EMERSON, FAIRFIELD, IOWA

I use the senior citizen minibus to go to congregate meals at the site. We need both the bus and the meals for the elderly. It has helped me.

We need continued funding from the Government.

MARY S. EVANS, FAIRFIELD, IOWA

By all means keep the agency on aging program going because it is so needed in more ways than one for the elderly.

The cost is within range of my budget and the budgets of others.

The minibus is wonderful for the elderly and has taken me to the doctor and to the site many times.

I hope the Government funds this program forever, because it is needed and the potential will always be there.

HARRY AND WILLA FULTON, FAIRFIELD, IOWA

Thanks to the agency on aging, the senior citizens of this site are very fortunate in having a very capable coordinator who knows how to cope with the elderly and handle funds efficiently.

Balanced meals are furnished 5 days a week for those who are able to come to the site, and carryout meals to those who are unable to attend. Volunteers help greatly with this operation, as well as many other duties required.

Periodic blood pressure tests and tooth examinations are made free.

Card games, bingo, movies, etc., are furnished, as well as exercise classes and other entertainment.

Counseling on social security problems, rent, and tax returns, how to get free blood through the State blood bank, and how to get help when needed through various agencies.

The sick are visited and cards signed by the participants are sent. An engraved plaque with the names of the deceased is hung in the lobby.

A senior citizens chorus has been organized that has an average age of almost 80 years. They are much in demand in the southeastern part of the State.

Birthdays are remembered monthly and cake and ice cream are usually served.

Wonderful cooperation by our city council, board of supervisors, city merchants, civic organizations, churches, and private citizens make this program a wonderful and beneficial help to the aged of this county.

WILLA HUSTON FULTON, FAIRFIELD, IOWA

First I want to say thanks to the organization of our government for making this possible.

Next, thanks for the individual who has blest us with her knowledge of people and their needs.

We are a general mixture of aged people with all the characteristics of all people.

We needed guiding. Many of us were lonely—many sitting and waiting—just existing—but each capable of contributing to life if we were given the chance. First we met to eat, but "VH" was not content with just that. She made us feel like living. We have been fed wholesome meals. We learned to consider the other fellow's needs; we learned all people had problems; we learned to minimize our own and help others to do the same. We found more interesting subjects than our health—others had them too. I would have to be more than an aging 80-plus to be able to tell all this organization has done to make not only my life but many others more livable.

MR. AND MRS. ORVAL GARRISON, OTTUMWA, IOWA

We are on social security. They said one time we'd get an 8 percent raise. Ford only wanted 5 percent—we only got 6.4 percent. Did Congress compromise with him?

Another thing, we wish they would tell the truth about social security—why its about broke. Nixon took $41.5 billion. That's why it's broke. Why can't they get that back?

Can't a law be passed to keep fingers out of that? When the money has been taken out of pay checks and company payments, it is not there to help balance budgets.

Can't the crookedness of medicare and medicaid be stopped? Congress knows what's going on and they just ignore it.

MRS. HENRY GATREL, NUMA, IOWA

This is in regard to the problems of elderly citizens, which you asked for the people to send further comments to the committee. I think we need a program in which to help us in getting eyeglasses and dental care; each of these cost a lot, which a great many don't have.

These are just as important to health and are as badly needed as many other things.

ETHEL GILMER, FAIRFIELD, IOWA

What I think of the center: First, it has been a wonderful thing for the old people of Fairfield. When you go to the center it is always so clean and neat. Everybody is so ready to help with anything. The girls that are ahead of it are perfect in every way. The meals are always great and one nice thing, they all say the blessing or a prayer. Well, I told just how I feel about the center—all the good things there are, and there are no bad things. I am 86 years old and have been going about a year. I hope the center will last forever. Thanks for everything.

MILDRED GLINES, FAIRFIELD, IOWA

I hope the Federal Government will continue to help finance the senior citizens' program. It means a lot to have someone you can depend on if you need help. When I broke my hip, our site coordinator was at the hospital before they got my coat off and stayed till I had my tray and some of my family were notified.

It means a lot to have the minibus as many have no other transportation at a price they can afford to pay, to go to the doctor, store, pay bills, and go to the site where they have nutritious meals 5 days a week. They also have fellowship with others of the same age group, play cards, have movies and bingo games every other week, also a free blood pressure and dental clinics every 3 months.

CHESTER AND FLORENCE HICKENBOTTOM

We enjoy being with the senior citizens as there are so many nice folks there. I can leave home feeling real bad and feel much better when I get home. As for us, it is a wonderful thing.

FERNE HILL, FAIRFIELD, IOWA

I attend the senior citizens site 5 days a week. I live alone and the minibus picks me up and returns me to my home each day. I enjoy the bountiful, well-balanced meals, take part in the exercises once a week, and especially enjoy the visiting and games each afternoon.

I feel that the senior citizens site helps me keep my identity as an individual and sincerely hope funds will be made available to keep this very worthwhile organization going for all senior citizens who need it so badly.

FRANCES AND HAROLD HITE, FAIRFIELD, IOWA

My husband is 78 and I am 74. We really enjoy the agency on aging meal site in Fairfield. We don't go but once or twice a week, but we know we will be going more as we get older and time goes on.

My husband is still active in appraisal work and attends board meetings, including the site board here.

I am very busy doing volunteer work for the Red Cross and hospital auxiliary, but I know I will have to give up someday. Then I can help more up at the site.

Vivian Hammes is hard to beat for a coordinator. She is really great.

We can see a great improvement in some of our elderly who go to the meals regularly. They have one good balanced meal a day. They also enjoy playing cards, visiting in the afternoons, and the exercises once a week.

RHODA HOLLISTER, FAIRFIELD, IOWA

Have you ever tried to cook for one? Have you ever tried to eat alone, day after day? Have you ever tried eating leftovers time and again? We senior citizens who are alone have, and I have found the senior citizen site for the agency on aging programs the answer to these problems.

The coordinator took me to the hospital for a cardiogram and got my medicine for me. I know she and her aide will help me if I need them.

The sociability is fantastic here at the site. Keep on funding the program so it can continue and grow.

ESTHER HORTON, FAIRFIELD, IOWA

The senior citizen site in Fairfield is one of my favorite places to visit daily.

We can eat a balanced meal each day, at a price we can afford. If we cook a balanced meal at home, some of it is apt to be thrown away.

For us especially who are living alone, and many are, the site brings us together to visit friends (old and new) and keeps us from getting lonely.

The programs they have for us are good.

We can't forget the transportation system, which we can use at a reasonable fee that most can afford.

We need the site now, and the elderly of the future will need it too.

WALT JOHNSON, FAIRFIELD, IOWA

I would like the Federal Government to keep on funding the programs for agencies on aging.

I am a senior citizen and handicapped. Without the minibus, I'd have a hard time getting around.

The congregate meals are good, but there is no need to cook so much.

The sociability of being with friends is wonderful. I especially like playing cards to help pass the time.

CARL B. KETCHAM, FAIRFIELD, IOWA

I need the minibus to go to the meals at the site. The meals are good and I don't have to cook as much. Being on social security, the low cost helps me out.

More money can be used to support the program and to expand it. The Federal Government is really helping its elderly.

MR. AND MRS. JOHN KOCH, FAIRFIELD, IOWA

We feel the senior citizens site and all its activities is very important to the senior citizens of Fairfield. The carry out meal program has helped many ill and aged to have a balanced meal once per day. And the minibus helps many to make their doctor appointments and to get up to the senior citizens site to eat each day. The fellowship of meeting together and getting a balanced diet is really important and they enjoy the food.

Those in our senior citizens choir enjoy singing together and we enjoy hearing them sing. They also sing for other organizations. The library shows us films and there is a social time of games and cards several afternoons. One day a week there are exercises and every other week there is bingo.

There is also opportunity for those who wish to help in the kitchen. And some help set tables.

It is also a place to make new friends.

BILL LARUE, FAIRFIELD, IOWA

I like the meals at the senior citizen site. They are good. The 75¢ cost helps my budget.

I like to talk to my friends at the site. It gives me a place to go.

Keep on funding this program.

CECIL J. LENT, LEIGHTON, IOWA

I am 65 years old, poor, and unable to work, so I feel I can speak on the matter you discussed at Ottumwa, Iowa.

It is too bad that Dr. Burrows of Oskaloosa spoke for the poor. He knows nothing about it, as he is rich. His only qualification is that he is 84 years old.

People in county seat towns can ride—and do—the bus for the elderly all day long for free. We out in the county can call in one day a week—Thursday. Now doctors offices close Thursday afternoons, so how can all the people out in the county be expected to get to the doctor on Thursday morning?

We have to run a car—the most costly thing to us that there is.

Put me down for transportation for the poor in rural communities.

JENNIE LOTHROP, FAIRFIELD, IOWA

I need the minibus to go to the congregate meals 5 days a week. I have heart trouble so this is a big help to me. It is hard to cook for oneself. The meals are balanced and good.

We need more Federal support for the program.

GLENN MARTIN, FAIRFIELD, IOWA

The senior citizen site means everything to the older people who can't get around.

It is better to be here to pass the time than to be home alone. Here they forget their troubles and their aches and pains.

The food is good and the price is reasonable.

Vivian Hammes and Maxine Riley, the coordinator and assistant, are the best anyone can get. They are interested in the people and look after everyone, seeing that they get to the doctors when necessary.

We wouldn't want to lose our site after the joy of having it.

CATHERINE MITCHELL, FAIRFIELD, IOWA

The deeply appreciated carry-in meals first came to me following a car accident. It was indispensible as far as I was concerned. Later I had the happy experience of going to the site and enjoying the meals with the others.

Getting acquainted with participants your own age is a joyous experience warmed by appreciation for people we would never have met otherwise.

One marked change has stood out in my mind in regard to the funerals of the lonely. Since we have become acquainted, the funerals have many friends paying their respects where there used to be only a handful. Farewells have become less tragic.

There is the possibility the equalization of salaries would increase the feeling of rapport.

BEVERLY NELSON, FAIRFIELD, IOWA

I need the good meals served here at the senior citizen site in Fairfield. I am handicapped, so it helps me not to cook. The low cost helps my budget.

The sociability of being with friends and playing cards is a wonderful part of the program.

Even though I can't speak, and have C.P., I have many friends there and enjoy myself.

Please keep funding the money to sponsor this program that helps so many people.

KATHRYN M. NICHOLSON, FAIRFIELD, IOWA

I like the senior center, as I live alone, and it is nice to be with people there. Everyone is so friendly and Vivian and Maxine go all out to make things pleasant for us. Hope it continues to be a meeting place for us oldsters.

P.S. The minibus is truly a wonderful thing and Mescal is such a nice person and so helpful to all.

ESTHER OSBORN, CENTERVILLE, IOWA

I have eaten more than 65 wonderful meals and enjoyed each and every one very much. It is very good food and very well prepared. I hope this program continues. It shortens the day by being with other people and enjoying their company while dining.

MR. AND MRS. RAY PEARSON, BATAVIA, IOWA

We wish to express our appreciation for the congregate meals, the games, and entertainment provided for us at the senior citizens site in Fairfield, Iowa.

Our coordinator and her helpers are so considerate to the crippled and other unfortunate people.

We hope this program can be continued for a long, long time.

From two people who are thankful for the program.

RUTH E. PEARSON, FAIRFIELD, IOWA

I think this program for aging is the best the Government has ever funded, and I am in favor of further funding by the Federal Government so we can expand our program. I think this program has done a lot for me in several ways, namely:

The meals have helped me budgetwise, and that is important as my resources are limited. I don't have to do so much cooking and I get one hot, balanced meal a day.

The minibus is very important to me; I don't have the money to hire a cab and it is good to know that there is a bus to take me to the doctor or to the store when I need to go.

I do volunteer work at the senior citizens site and it gives me a chance to put in my time where it is badly needed. The sociability means so much to me, as most of my immediate family live over 200 miles away and don't come very often. I depend on my friends here at the site for help and advice when I need it.

ED QUICK

I'm 87 years young, one out of many that has a perfect attendance at our senior citizen site, which serves meals 5 days a week.

The program offers many benefits—transportation by minibus, to and from meals, to doctors, to the hospital, grocery stores, nursing homes, at a price the

elderly can afford. The meals are always nutritious, and along with this is sociability, which we all want and need, plus movies, card playing, bingo, lectures. There is no other place I could go to get all of this.

Sincerely hoping, now and in the future, there will be funding money for our program, for without it, what would we do?

SOFIA RAJAMETTS

Five days a week I no longer have to cook a big meal, and the cost of 75¢ sure helps everyone's budget.

The minibus takes me to the doctor and I couldn't do without it.

I like to talk to my friends at the site.

More Federal money is needed for this program.

RUBY RAY, FAIRFIELD, IOWA

I benefit from the programs at the agency on aging senior citizen site. The meals are good and help me to not cook so much with my poor eyesight.

This is the best thing the Government has done for the elderly.

BERTHA E. RILEY, FAIRFIELD, IOWA

In regard to what the senior site means to us, I think it is one of the nicest and most necessary things that Fairfield has had for years.

The site coordinator and assistant are cooperative and nice to everyone.

In regard to the meals, we have a nice selection and get a good helping at a price we can afford to pay.

We have clean entertainment—the quartet sings, we have music, some play cards in the afternoon, and also we have bingo.

In regard to the minibus, the driver and helper are always so nice to everyone—helping them with their prackages and taking them anyplace they want to go.

Let's hope we can always have the minibus and site.

MAXINE RILEY, FAIRFIELD, IOWA

I've been working for the agency on aging since December 1973. It has opened doors, many doors, for the elderly and brought about changes in their lives.

Seeing is believing, as participants get on the minibus and hand our driver, Mescal Kennedy, their fare with pride, knowing they now can afford to go many places, such as to the hospital, doctors, and grocery stores.

The nutritious meals are served 5 days a week, and some of the comments we have heard are, "I'd been dead a long time ago if it wasn't for this place," "I didn't know so many people cared," or "I saw so and so I haven't seen in 30 years."

We have movies twice a month, bingo twice a month, and card playing every day, and sometimes lectures, which they all enjoy. Sociability is one thing in life we all need and want.

In closing, I hope there will be more money funded for this program now and in future.

LAVERNE ROBINSON, OTTUMWA, IOWA

There is a need for places for the elderly to receive care other than nursing homes. There is a great deal of difference between a person who can't physically maintain their own home and a person who needs nursing care 24 hours a day.

The people who fall in this middle area have a need for custodial homes, decent boarding homes, family life homes, etc., to be available to them. A person placed in a nursing home inappropriately may soon develop a need for the care

because too many things are done for them. We have to provide for peoples' needs and not just do things for our own convenience. (By the way, it would save us money.)

EVA M. SALTS, FAIRFIELD, IOWA

I think the senior citizens site in Fairfield is the best I have seen. We enjoy the good food, the sociable atmosphere, and the personal care and attention given freely by the good managers we have here. The entertainment is an extra bonus. There are many here who depend on this place as a ritual and important part of their lives.

MR. AND MRS. ALLEN SINES, CENTERVILLE, IOWA

I am writing in regard to the senior citizens' meals.

I think it is one of the best things that has happened for senior citizens.

So many are taking advantage of it. So many older folks probably wouldn't have a good balanced meal without it. We have been to several different ones and think our own home town here in Centerville is one of the best.

All the ones in charge of it also are so friendly and helpful.

We are so thankful for it all.

BERTHA SPIELMAN, FAIRFIELD, IOWA

The senior citizen site has done a great deal for me. I think I enjoy the sociability most because I like people and I have met people I never knew before. I also enjoy the meals which are usually very good. We have a leader, Vivian Hammes, who really cares for us. I would call her a very caring person.

P.S. The minibus is my main means of transportation. We have a wonderful bus driver, Mescal Kennedy.

C. J. WEAVER, FAIRFIELD, IOWA

I think the agency on aging minibus is the best thing that has happened for the elderly.

The senior citizen site is a place to come to—and there is something to do. I get to volunteer daily and be among my friends.

I no longer need to try to cook a big meal, and for a man this is a godsend. The meals are all good. Being on social security, we need the bus and meals badly.

We also need the Federal Government to keep on supporting these programs and more money could be used to expand the program to more people.

WILLIS WOOD, FAIRFIELD, IOWA

I ride the minibus to the meals at the site every day. I am on the over-55 program with Sieda and work at the site. I am 74 years old now.

I like the people there and have a good time. I've made new friends and see a lot of old friends, too.

We need the Federal Government to keep on funding the agency on aging programs. Even more money is needed.

ZELMA WOOD

I hope you do everything within your power to keep our senior citizens site operating.

It helps the morale of all the elderly to get together for recreation in cards, movies, bingo, and other activities.

Then, too, we get a balanced diet in our foods with our dietitian, as well as the social hour while dining together.

We have an excellent director, Mrs. Vivian Hammes.

STANLEY AND GLADYS WORKMAN, FAIRFIELD, IOWA

We think this senior citizen setup is one of the best things that ever hit Fairfield, and it is hard to understand why more lonely citizens do not take part.

The food could be better and could be worse. We also think if there is quite a bit left, anyone that wants seconds should be allowed to go back as long as it lasts, instead of sending it back to be wasted or thrown out. It has been paid for and the senior citizens should have it if they want.

All in all, our complaints are few.

P.S. We think the minibus is a fine thing.

THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 1—WINTERSET, IOWA

AUGUST 16, 1976

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The Nation's Rural Elderly:

Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove, Iowa, August 17, 1976.
Part 5. Sioux Falls, S. Dak., August 18, 1976.
Part 6. Rockford, Iowa, August 18, 1976.
Part 7. Denver, Colo., March 23, 1977.
(Additional hearings anticipated but not scheduled at time of this printing)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

THE NATION'S RURAL ELDERLY

MONDAY, AUGUST 16, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Winterset, Iowa.

The committee met at 9:45 a.m., pursuant to notice, in the Madison County Multipurpose Center, 114 North Second Street, Winterset, Iowa, Hon. Dick Clark, presiding.

Present: Senator Clark and Representative Thomas R. Harkin.

Also present: William E. Oriol, staff director; Deborah K. Kilmer, professional staff member; David Harf, legislative assistant to Senator Clark; John Guy Miller, minority staff director; and Alison Case, assistant clerk.

OPENING STATEMENT BY SENATOR DICK CLARK, PRESIDING

Senator CLARK. The meeting will now come to order.

Let me welcome all of you here this morning; I am particularly pleased that you came by. This is, of course, a hearing of the Senate Committee on Aging. I want to start off by particularly thanking the Hillbilly Band. You were great. [Applause.] We are very pleased that you came.

I also want to thank the people who made the arrangements for the facilities of the center for us to use. We have a number of witnesses—actually, panels of witnesses—today.

We were scheduled to start at 9:30, but we are a little bit past that, so I think we will go right ahead.

I want to make a brief opening statement and then we are going to hear from Mr. George Orr, executive director of the Iowa Commission on Aging.

Today the Senate Committee on Aging is represented here in Winterset at the start of a major inquiry into the problems and way of life of the Nation's rural elderly. In other words, we are emphasizing in these hearings, not just problems of the elderly, but, more specifically, problems of older people who live in small towns and in rural areas generally.

I asked that we meet in this community in order to set a tone of grassroots participation in all or most of the hearings that follow. Our subject—or group of subjects—is best seen up close. We cannot hope to know what's happening in rural America if we simply stay in Washington, D.C., and that is why these hearings are being held here.

I have been a member of the Senate committee since January 1975. Last year, when the Older Americans Act was up for extension, I suggested to our committee chairman, Senator Frank Church of Idaho,

that the committee hold a hearing to determine whether older Americans in rural areas were receiving their fair share of attention and help under that act.

He agreed, and I chaired that hearing. I was very glad to have the opportunity to do so.

The witnesses made a great case for flexibility and responsiveness in Federal requirements. As a result of the hearings, I attempted to advance legislation to achieve those purposes. We didn't achieve all that we wanted to, I must say, but I will certainly be offering legislation again in the next session as well.

Federal Programs for Rural Elderly

Federal policy on the rural elderly is not expressed solely through the Older Americans Act that you are familiar with. There are, of course, many other programs that affect older people. There are programs like the medicare program. It is supposed to provide equitable benefits to all older Americans throughout the Nation, but if, as in many parts of Iowa and other States, the older persons can't get to a doctor or if they have no doctor to get to, then one wonders how effective such programs are.

There are housing programs that the Federal Government sponsors through the Department of Housing and Urban Development and through the Farmers Home Administration, but again, if bureaucratic insistence upon inflexible standards stay blind to rural needs, then Congress certainly ought to act.

Then there is, also, the U.S. Department of Transportation which has funded literally hundreds of small transportation bus systems intended to serve the elderly and the handicapped. But again, if red-tape and fragmentation are getting in the way of real development of transportation systems which can become a working part of the community in which they serve, it is very hard for them to achieve that goal.

I could give other examples of Federal policies and practices which I think disturb many of us in the way they are sometimes carried out. I particularly will invite testimony on this at this hearing and other hearings. I will do so because I believe that we, as a Nation, have failed to do what we said we were going to do when we held the White House Conference on Aging in 1971.

We said that we were going to develop a national policy on aging. Certainly we have made progress since then, there is no doubt about that, and I think we are proud of the progress that has been made with centers of this kind and many of the programs that you are familiar with. But in terms of arriving at a set of national objectives and working toward them, we frankly have a very, very long way to go yet.

Now part of the problem has been within the executive branch. In my opinion, President Ford and his predecessors have beeen somewhat reluctant—in some cases, rather negative—when it comes to action on aging. I know that the President, in fact, went on record for 2 years in a row as favoring the so-called medicare reform plan which would actually cost medicare participants more and give them somewhat less. That measure was successfully opposed.

Another part of the problem has been the rather strange and strained economic state of the Nation—obviously inflation, along with unemployment. I think in many cases we have not faced up to those problems either.

In any case, we know that there are a number of programs that are working effectively in this part of the State and we are particularly anxious to hear about those. So the purpose of these hearings, simply put, is to listen to people who are involved in them.

Examination of Programs

Most of our witnesses—in fact, all but a very few—are people who are over 60 or over 65, and we simply want to hear from them—whether they think these programs are working. If so, in what way they are working. We also want to hear about their weaknesses. In other words, what are we doing right, what are we doing wrong, and what should we be doing better? That is really what it is all about in one sentence.

With that we will start. I did want to introduce three or four people so if you have a need to contact them or need particular information, and so forth, you will know who they are.

On my immediate right here is Bill Oriol, the staff director for the Senate Committee on Aging; John Guy Miller, at the far end, is the minority staff director; Debbie Kilmer, in the middle, is a professional staff member of the Committee on Aging; Alison Case, assistant clerk of the committee; and Annabelle Short, who is the court reporter.

Now we will be keeping an exact record that will be published. Those of you who wish to have copies, please leave your name with us before we leave, or drop a letter to me, Senator Dick Clark, U.S. Senate, Washington, D.C., and we will be happy to send those to you.

Well, I would like to start. We are going to be holding six hearings—four of them in Iowa, one in Nebraska, and one in South Dakota—in the next 3 days.

We are going to be hearing first from George Orr, the executive director of the Iowa Commission on Aging, who has a long history of public service to the State of Iowa. George, we are very pleased to have you come down to visit with us.

Then we are going to be having a panel of people from various areas nearby: Mr. Goeldner, Mrs. Hazel Stroeber, Mr. Willis Sprunger, and Mrs. Lucille Anderson.

Following that, we are going to be hearing from Woodie Morris, and then another panel with Mr. Pals, Mrs. Forsyth, and Jack Fickel. That will take us up to about 12 noon, I think.

We also have a form in case there are others here who do not have an opportunity to speak and who would like to be included in the record. It simply says:

> Dear Senator Clark: If there had been time for everyone to speak at the hearing in Winterset, Iowa, on August 16, 1976, concerning the Nation's rural elderly, I would have said the following.

So if you have testimony you would like to submit or write out, and so forth, we would be very happy to include that in the official record of the hearing as well.[1]

So, George you may proceed in any way you think appropriate.

[1] See appendix 4, p. 90.

STATEMENT OF GEORGE W. ORR, EXECUTIVE DIRECTOR, IOWA COMMISSION ON AGING, DES MOINES, IOWA

Mr. ORR. Thank you, Senator.

Senator Clark, members of the committee, and the others who have come here to work on these hearings, ladies and gentlemen, I am George Orr. I am a new director to the program but not new to Iowa, since I was born and raised in this State. I have a few things I would like to highlight with the Senator's and your indulgence.

You know, it seems to me that not having had direct experience with this, other than my natural life processes which somewhat qualify me for my job, we are long overdue to address the problems that I think will confront all of us at one time or another.

We are long overdue and, as I think about it, I guess I really had not given it a whole lot of thought. Maybe you did not either until it is right there, and then we try to figure out the best way that we can help.

I think that many people have been put out into retirement—and I don't say this as a dig at our distinguished U.S. Senator—because of mandatory retirement. As I look around and I see us working with our program to employ older Iowans—reemploy, I should say, because they want to work because they are productive—everything is going for them and they can look back on a lifetime of experience to bring those resources together.

We seem to satisfy many of the things that we are trying to do in this program which is to cause people to be independent longer, maybe forever—to stay in their homes and to be happier in that respect.

"I STILL HAD A LOT IN ME"

I talked to so many Iowans who said, "Well, gee whiz, I still had a lot in me," and you can tell by talking with a person because they are out working at something else now that they do have a lot to offer. So I am wondering—this is my own view, Senator—whether maybe that could be a basic problem.

If you want to look at just what 5 years would mean in terms of continued employment for those in high stress, those who are capable physically, mentally, and in all other respects, what a difference this would make.

Well, that is something that seems to me that maybe we ought to start looking at. I think if I read the experts around the country, those who write gerontology, that this is the coming thing—to consider using these valuable human resources a longer period of time.

I am particularly happy to be here with you because this is, I think, following Senator Clark's lead, what we really need. This is where the U.S. Congress can become aware. Right here is where the problems are that confront Iowans.

I think it is wonderful that this round of hearings is going to reach so many Iowans and I am just pleased as punch that we have got a full room here today.

The Senator was kind enough to write me a letter here a few weeks ago and he has asked for a more detailed report on some of the things that we are doing that are of concern to his special committee. For in-

stance, the report on the water and pesticides programs, the health facilities educator and, as it applies to rural areas, the information referral services and the older worker specialty employment.

Now I have already made reference to that latter one, and it is going well. I am also pleased to say that the legislature of the State of Iowa for the second year put its second $100,000 into this program to employ older Iowans.

If the first year was successful, and it was, the second year is steamrolling right on behind it. There are people being employed now who otherwise were sitting on their hands. They are very capable people and they have literally made placements up in the thousands, and we look for that to continue. That program seems to have a terrific impetus.

Information and Referral Service

The information referral program is kind of new. It was decentralized from the State, and the information and referral—meaning that when people have a question and they want to ask about that, they want to know something that might be particularly bothering them—where do you call? Where do you get the answer?

Well, we had one line prior to this and it went into the State. It was a 24-hour WATS line and it attempted to treat this, but a much better way would be to decentralize it to the 13 areas that we have in the State.

Now some of those are functioning already and, in fact to this date, they are receiving in those four areas that are doing it—four combined areas—to the tune of about 2,000 calls per month, and that would be expected to rise as the others get their capability. They are going to take your questions and your concerns, and they are going to try to give you an answer on them.

Now the other things I will cover more completely in the report to you, Senator, but I might just say this in closing, and then the hearings can really commence. What I found when I came to the State was that we had a need to, I think, reduce some of the bureaucracy and some of the excess layering that I saw there. I pledge to you that is what we are going to do, and I think there is a very good reason for that.

Every time we build another layer of somebody doing something, it costs money. Now the Congress or our State appropriates this money and I think, if I am reading it correctly, they want the majority of each and every dollar to go out to the place that it was really for—that is, for our elderly people in Iowa.

Every time we build something in, some artificial, bureaucratic, or administrative type of a control—it takes so many pennies away from that dollar, meaning that fewer pennies then get out to where they ought to go. That is what we are going to be doing.

We have already found that we can literally cut one heck of a lot of these things out and not feel any loss of momentum because of the way we are going to do it. This means that we could almost within a very short time, start swinging more money out which was allocated to our areas, as we have already done. So I hope this will meet with your satisfaction. Time will tell. I know that we are going to accelerate the nutrition sites throughout the States. That is coming up very fast and we are going to be coming up with about 122 percent

of what we did before, and that is a real number—122 percent of what we did before. That means we are going to be expanding both on nutrition, nutrition sites and, more importantly, aiming at the nutrition site with respect to where the people need the service.

Sites Not Always Convenient

Sometimes bureaucrats look at a map and they say, "This would be a peachy place for that nutrition site," but then they find that the people that it would serve maybe are scattered someplace else. It does not make too much sense, does it? It means you have to go into expensive transportation systems that you might not need otherwise. But if transportation is needed, we are going to try to get it there, and that is another thing that I believe is going to be very valuable. I am glad to hear a reference to that this morning, too.

Ladies and gentlemen, I certainly appreciate the opportunity to talk with you for a few minutes this morning and I hope that these hearings are going to give all of us a much better insight as to what the real need is.

Thank you very much, Senator.

Senator Clark. Thank you very much, George.

I think your point about mandatory retirement is particularly well taken. It seems to me, if you travel around this State and other parts of the country, that mandatory retirement in many ways is the most discriminatory practice that we have in this country. The fact that you have reached the age of 60 or 65 certainly ought not disqualify you from pursuing the occupation or profession that you have and that you prefer.

When you think of the number of talented people that have achieved many of their greatest achievements after age 65, you think of artists—Picasso, who died just a year or so ago—many of the great musicians—people who had their greatest years in their sixties, their seventies, and, in some cases, in their eighties.

I think it is not only true in the arts, but out of the arts. I think if there is one thing that we need to do in terms of reducing discrimination in this country, it is to eliminate mandatory retirements. I agree with you.

We are very pleased that you came, George, to get us started. In other hearings, we are going to be pursuing some of the things that you talked about, particularly employment programs—the kinds of things that you referred to in your testimony.

Thank you very much.

Now we are going to ask the panel here in the front row to come right on up to the desk and we will proceed with your testimony.

We are going to hear from Mr. Goeldner, Mrs. Hazel Stroeber, Mr. Willis Sprunger, and Mrs. Lucille Anderson.

As I understand it, Mr. Goeldner has a prepared statement, and others are just going to say what is on their mind or we will have questions and answers, however we decide to proceed.

Mr. Goeldner is chairman of the Central Iowa Area Agency on Aging, over at Earlham. I have had the pleasure of meeting him on many occasions before. He is formerly the publisher and editor of the newspaper in Earlham.

Mr. Goeldner, you may proceed in any way you like.

STATEMENT OF L. R. GOELDNER, CHAIRMAN, CENTRAL IOWA AREA AGENCY ON AGING, EARLHAM, IOWA

Mr. GOELDNER. Thank you, Senator Clark and friends.

It was suggested that I give a brief review of changes in rural Iowa during the past number of years. I think most of us here this morning can remember back in the early part of the century. Back in the early days the size of farms were smaller. What is considered an adequate size now—80 acres—would support a family, and 160 acres was considered a rather large operation. All the members of the family worked back in those days. We didn't hear of nursing homes. As a last resort, an older person would have to go to the county poor farm, which was considered just a pretty bad situation.

Most of the older people—grandparents or a maiden aunt—would live in with the family and contribute help with the farm chores and things for their remaining days.

Later on, when World War I came along, greater production was required to take care of our allies and our needs here in the United States. A sort of prosperity developed through the war needs. After the war, this continued for a short time and then we didn't need as many supplies as were required earlier, and the demand fell off.

In 1929, most all of us remember the crash when troubled times began, and we had the depression. Many lost their farms, their homes, and their life savings. People who would consider themselves fairly well to do found themselves destitute.

IMPACT OF THE DEPRESSION

At that time, relief programs were set up. One of them at that time to help those who didn't have resources was called old age pension or old age assistance. This was not a very satisfactory situation for the persons who had to receive it because they had been more or less independent. Now they had to sign over any assets they might have to the State or, if they stepped out of line, they could stand the chance of losing this pension.

Following this, we began to get our social security program established, and even with its many faults it seems to be the best program that has been improvised so far. It has restored a certain amount of dignity to the older persons who need assistance in their older days.

When World War II came along the greater strife became evident in agriculture. The farms needed to be larger, our equipment began to develop, and the horsepower began to disappear. Eventually, everything was mechanical.

The farmer in the depression time was assisted by new programs which allowed him to store his grain and to receive a loan so he could maybe take advantage of a higher market. There was land taken out of production which he received revenue for so there would not be a surplus on the market.

It is not uncommon today to have farms 800 or 1,000 acres. One farmer may operate 1,000 acres of land. He has probably an investment of maybe $50,000 to $100,000 in his equipment.

Back in the earlier days, a younger man could start out working and then rent a farm and, after a period of time, own it. In today's time it would take a large amount of money to buy the land, to buy the equipment, and stock his farm.

The older people today, when they get beyond the point where they can live in their own homes, go to a nursing home where they are taken care of for the remainder of their days.

I think that takes care of it.

Senator CLARK. Thank you very much.

Mrs. Stroeber, did you want to make any statement or were we just going to have questions and answers?

Mrs. STROEBER. Statement.

Senator CLARK. Very good.

STATEMENT OF HAZEL STROEBER, MACKSBURG, IOWA

Mrs. STROEBER. I am one of the aging. I am nearly 80 and I have lived alone on my farm since 1972 when my husband died. I am in fairly good health, only my eyes are so poor I cannot drive my car. I think, too, most of the people, as they become older—one of the biggest problems is transportation; although any time I had a real need to travel, there was always some of my neighbors or some relatives who would take me, but at times I felt very much like I was imposing on them and that maybe sometimes I was becoming a nuisance.

So I was really overjoyed when I read in the paper that there was a new minibus coming to Winterset and which would come out to Macksburg and take us in here to Winterset once a week on Monday mornings.

So right away I made an appointment with my dentist. The only time I could have was 11:30 and that is the time they eat lunch here so I didn't get to eat lunch with the group that day. The dental offices are at the edge of town, so after the driver brought me, he turned around and took me back out to the dental office; then at 12 o'clock he was there waiting to bring me back uptown.

Of course I could not eat here so I ate a little lunch at one of the restaurants, did shopping, and went to the grocery and gathered up a whole lot of groceries. The bus driver told me, "You must eat an awfully lot from the the amount of groceries you buy." I do buy quite a bit and put in the freezer because I am out 16 miles from town. Someone always will get me some, but then sometimes I need to have things there in that freezer, so I buy quite a bit whenever I get my groceries.

Well, on that first Monday, Delcie Bush and I were the first two that came in. We were the first two that used the minibus.

Senator CLARK. How long ago was that?

Mrs. STROEBER. February of this year.

TRIPS PROVE TIME CONSUMING

The next week I had an appointment with the doctor and that took up quite a bit of time. Then the next week I brought in my income tax and talked with a lawyer, and that took quite a little time.

Now there were three times that whoever brought me would have lost quite a bit of time, so I felt it was very much worthwhile. There are other times that I need to go to the bank and business and things, so in a business way it has helped me very much and I know it has relieved the pressure on some of my neighbors.

We ladies rather enjoy coming in on the bus. If we have nothing else, we come in and shop. The men—I think the big thing they like are those meals. [Laughter.]

Senator CLARK. Sounds typical.

Mrs. STROEBER. All of us live in homes by ourselves; we are all single living in our own homes. They are older homes. I don't think any of us have a fancy home. My house is over 100 years old, but we put in new floors, new windows, insulated it, and it is quite comfortable. I live there very comfortably and the minibus does help.

Now I do go to town once in a while. I don't depend on the minibus altogether; people bring me in for different things. There is something closed that is not open Monday and so other people do bring me in part of the time, but that minibus does help.

Everything that I can, I schedule for Monday, so I do not bother my friends.

Macksburg is just a little town of 142 people. There is nowhere that you can buy medicines. We have no doctor there. It was founded by a doctor—a Dr. Macks founded Macksburg 100 years ago. I have been around there for 40 years and there has not been a doctor there.

Senator CLARK. So the closest doctor would be what, 17 miles?

Mrs. STROEBER. About 16 miles. Well, maybe by the time you get in town it probably might be 17 miles. If you go the other way, it is a couple miles on farther to Greenfield. All of these are county seat towns. I don't know whether any of the little towns have a doctor any more.

Greenfield is the county seat to the west of us and I am 19 miles from it, so we are quite a little distance from a doctor. Of course, you know I must get appointments with my doctor on Monday; I can't get in through the week.

Senator CLARK. That is right; you can only get sick on Mondays. [Laughter.]

Mrs. STROEBER. I keep a kind of standing appointment once a month for a check-up, so I get along very well there.

A number of the people want to know why in the world don't I move in here to Winterset, but there is a housing shortage here. There is wonderful, low-cost housing for the elderly, but it is only half big enough. Because I own my farm, I could not get in there anyway. I might have to go up to the top of some of these stores and have a great long staircase to climb to find an apartment.

ADVANTAGE TO LIVING AT HOME

I am much more comfortable at home where I can have my garden, my flowers, and I can watch my crops grow, and go out and look my cattle over and see how they are doing, and so on. Usually if you live on your own place you see little things that need repair and things that somebody else does not notice. If it is stopped right in the beginning, it does not cost nearly so much to take care of.

This spring, we had so much dry weather. I thought, "I have never been down to that pond yet this spring. I should be going down to look at it." So I went down. It is quite a little walk down there but, I thought, I must go down and look. The pond supplies drinking water for the cattle. I went down and looked, and it was the lowest the water level had ever been while we had been there. I went around the pond.

Here was a little trickle of water flowing out and it was already only about half. Now it was not a big stream, but it was flowing. When that pond was so very, very low, and I discovered that, somebody might have pointed to that dry hole—would have come and told me that my pond was dry, that there had been a little ditch formed and the water was running out.

But I found it when it was a small amount running out and I immediately called a man that has a bulldozer to come and repair that dam, which he did. So there are a lot of little things that you can see and take care of if you are out on your own farm.

If I was in town, I would not know about it. As I say, I enjoy being out in the country.

Anyway, it is just a very small sum that we have to pay to ride in, which I pay each time when we come. I have felt this service is worth very much more to me than that, and I do give a larger contribution a couple of times a year—a single contribution—because I feel that it is worth that much to me—it is worth more to me.

Senator CLARK. Well, I am going to have some questions but I think before I question you, we are going to go on through and hear the other panelists.

I want to get all of your comments on a number of different things, so rather than asking you questions right now, I think I am going to come back a little later.

Next is Mrs. Lucille Anderson from Melcher, Iowa.

STATEMENT OF LUCILLE ANDERSON, MELCHER, IOWA

Mrs. ANDERSON. Melcher is a former mining community. I am just 15 miles from Knoxville, the county seat, and I have got a lot to say about transportation. We have had a bus for the past 2½ years and it goes to each of the towns in the county. There are six small towns.

Senator CLARK. Would you give your county?

Mrs. ANDERSON. Marion.

We have it on Friday and we have so many wanting to go that they call me to make a reservation. We have two trips on Friday with other towns. There is just one because they don't have so many wanting to go. There is no transportation to any of these small towns; none of them have anything, and people love to go to Knoxville.

A lot of them don't get out of town otherwise; they don't get away from home. They have the chance to go to the doctor, get medicine, go to the bank, go for the congregate meals, and whatever their needs are.

Of course, as I said, there are some that just never leave the house otherwise and it has been a godsend to them. We used to have the railroad; the railroad is still there, but we had a passenger train twice a day which was a big help. We went to Des Moines, but we don't have anything like that now.

Senator CLARK. How long ago did that train stop running, do you know?

Mrs. ANDERSON. Just the past, I would say, 5 or 6 years. I don't remember exactly.

Well, the passenger train—it has been longer than that, but we don't have the freights through any more either. I suppose it has been 20 years or more since we have had the passenger train.

Elderly Desire Independence

Of course, there are lot of people who will take you, but a lot of them just don't think about it. One thing I found out about these older people, they like to be independent, and if they can go on their own, they are not about to ask a relative to take them.

About 25 percent of the population in Melcher is elderly, and I imagine 25 percent of those are widows. They mostly ride in the van. I guess the men that have cars prefer to go that way. We do have some ladies that have cars and can drive, but they don't feel that they can trust themselves to drive any more.

I was born in Melcher and we had all kinds of businesses. We had just about anything that we needed there, but we don't have that any more. We had a nice clinic there and we had doctors coming from Des Moines but, as of the middle of June, they quit doing that so most everybody goes to Knoxville to the doctor or to get their medicine.

Of course, for a long time we didn't have pharmacies there. We had a sundry store, but they would order the medicine from the pharmacy in Knoxville and it would be picked up, so that was a big help. We don't have that any more. It is quite a chore sometimes.

Like the other lady said, you have to get sick on a certain day. Even when we had the doctors we could not get sick at night. I should take that back. We have a very nice rescue unit and the rescue van takes people, so we do have that.

That is true of all the little towns down around there. Any time that anybody can improve the transportation, fine. They need other things besides that. They need to take trips; they need to get out and see a little bit of the country, which they can't do.

Usually in the fall—in October—we have the use of the van on two different Mondays, and they go places. Last year we went to Lake Rathbun as the leaves were changing. We had a sack lunch with us and everybody enjoyed that—just to get away and for something to do.

Of course, housing is a big need, too. The majority of the people are on social security, but there are several older miners and their wives that are getting black lung benefits, which I am also getting as of last November. My husband signed up for it in October 1970 and he passed away in January 1971. I was turned down four times, but I just would not give up. If anybody told me something I could do, I did it.

Then in January 1974, I read in the paper where they were going to reopen some of the old applications, so I wrote to the social security representative about that and had an appointment with him. He said the only thing left that I could possibly do would be to ask for a hearing, which I did in February. I heard nothing until June 1975, to inform me that I had a hearing for July.

In the letter they suggested that I bring an attorney with me.

Well, I went to see the county attorney, but he was going to be in court that day. Then I saw three others; the last one said that it would not do any good for him to go with me as I had no more evidence to present.

Well, the main reason I wanted the hearing was to find out why I was turned down—what they were basing their opinion on. So my daughter and I went alone and I got to see all the documents—everything that had transpired in that 5 years. I saw the judge, and when I left his office my daughter and I both had the same opinion that that was the end of it, but he told me that he would not even look at this further information until October and I would hear by the end of the year.

In October I received a letter that he had decided in my favor, so the latter part of November I got a check, and it was retroactive. One thing I think could be done is to hurry it up a little more, especially for that hearing. Of course, there are a lot of people that don't get it even after the hearing. It is more or less up to the judge—what he decides to do about it.

I know for a fact that it is a wonderful thing that they have that and it really helps a lot of the people that do not get very much social security.

I believe that is all.

Senator CLARK. Thank you very much.

I want to hear now from Willis Sprunger, then we are going to have some questions and comments back and forth.

I had the occasion to meet Willis earlier this morning because I went up to visit the North Ward Plaza housing area where he lives. That is a very, very remarkable place, by the way. I had a chance to visit with most of the people there and to see various apartments, and so forth.

I hope, Willis, you might talk a little about where you lived before, how you happened to go there, and what your views are of living in the North Ward Plaza.

STATEMENT OF WILLIS SPRUNGER, WINTERSET, IOWA

Mr. SPRUNGER. I spent most of my life on the farm. That has been my past from the time I was a very young lad until I was disabled and could no longer farm. When I had to give up farming, we moved into town.

After we lived in town a year, we had our application in at the Plaza. There was an opening and we were offered the apartment that we have now. That has been our home ever since.

It has been 2 years since we moved in and I think it is a wonderful place to live. We have a lot of nice neighbors and I think I am acquainted with most of them now. It took a day or two to get acquainted, but there are not very many men there. There are mostly women there—just four men, and I am one of the four men.

Senator CLARK. You are one of the lucky ones, then.

Mr. SPRUNGER. Is that lucky? [Laughter.]

Senator CLARK. Yes.

Mr. SPRUNGER. I like the place very well. As I could no longer do the job I wanted. I had to give up on the farming. I think the place is just fine for a person to retire in.

I don't drive a car, but my wife does. Without her help, I don't know what I would do there. She does the cooking, keeps house, and drives

the car. Of course, I don't get to go as many places as I would like to go, but maybe I want to go too many places. [Laughter.]

Senator CLARK. You said you lived in an apartment when you first come to town. What are the advantages or disadvantages, let's say, of living at the Plaza compared to living where you did before you moved there?

Mr. SPRUNGER. Well, I just prefer the Plaza because it has its own heating system and it is a lot more even heat in the winter. We get too much heat in the summer, but I don't know what to do about that. We have an air conditioner, but if it runs long enough I freeze out and I have to go to the halls and visit with my neighbors a while to get warmed up again. [Laughter.]

CONVENIENT LOCATION

It is close to town; it is close to the grocery store. I don't go to the doctor very often any more. Maybe I should, but I don't. That would be five blocks, I believe, from the Plaza.

Senator CLARK. Can you walk to most of the things that you need from there?

Mr. SPRUNGER. My wife and I walked from the Plaza here this forenoon. I get awfully tired, and maybe I am a little lazy, but I would like to do more walking than I do.

Senator CLARK. How far are you from the grocery store at the Plaza?

Mr. SPRUNGER. A little over a block.

Senator CLARK. So you can walk to almost anything that you need. What about if you had to go too far? What would you do? What if you had to go someplace where you could not walk? What alternative do you have?

Mr. SPRUNGER. My wife would take me. We do go places away from Winterset, visiting. Some of our family live in Winterset and some of them live in Des Moines, but we don't drive to Des Moines.

Senator CLARK. Do you have access to a minibus—the people there who don't have cars?

Mr. SPRUNGER. Yes. I think I rode in the minibus once and that was a cold, snowy day. That was the last time I rode on the minibus. We have never called it since.

Senator CLARK. But if you didn't have a car, you would be using that more, would you not?

Mr. SPRUNGER. I certainly would. I don't think there are enough people who could ride on the minibus who do ride on it. They either don't know that it is available or they just don't want to ride on it. I don't know what the situation is, but it looks like a good deal for anybody that wanted to ride.

Senator CLARK. Let me ask you one other question, Willis. Do you know about how many people would like to get into the Plaza that are not able? I mean, the waiting list.

Mr. SPRUNGER. Well, I don't know how big the waiting list is, but there has been a waiting list long before we went there and there is still a waiting list. But I don't know how long it is. We had put our application in 2 years before we finally got in.

Senator CLARK. So there probably is a need for more units if they were built?

Mr. SPRUNGER. Oh, I am sure there is. I would not know how many more, but all the people that ever visited us there all think it is a wonderful place and they do ask questions like "How hard is it to get in?" I don't know if they are doing a little wishful thinking or if they are speaking for somebody else. I think that there would be more people come in if there was space for them or if there were more apartments or more available housing. In fact, I am sure that there would be more.

Senator CLARK. Mrs. Stroeber, I notice you said you stayed on your farm because you were able to; that is where your home is, and that is where you would prefer to live. You are obviously able to continue to live there and ride the bus in, and so forth. Have you ever had serious health problems where you felt that you were not going to be able to stay on the farm?

Mrs. STROEBER. Not in the last several years. Fifteen years ago I had cancer and was in the hospital for 3 months before I was able to come home, but my husband was still able to drive the car then. In these last few years I have been quite healthy.

Senator CLARK. The major benefit of any of the so-called elderly programs, as far as you are concerned, has been the bus?

Mrs. STROEBER. Yes.

Senator CLARK. That has been the most important thing as far as you are concerned?

Mrs. STROEBER. Yes; the transportation on the bus. Now it might be possible that, as years go on, if they build more onto that Plaza, that it would be nice. Even if they charged us more who could afford to pay more, still there would be any number that would love to live there, I am sure. As it is, I could not get in.

Senator CLARK. Let me ask you something else. It sounded as if you said when you come to town here, you come here to the meal site.

Mrs. STROEBER. Yes.

Senator CLARK. On Mondays—is that right?

THE MEALS PROGRAM

Mrs. STROEBER. Yes. I do not always eat here because if you have an appointment with a lawyer, if you have an appointment with a doctor, or some of those things, you can't get down there at 11:30.

Senator CLARK. But when you come here and eat, what do you see as the value of that program? In other words, is it a program that the Federal Government ought to continue—to try to help or not? What is your view of its value or the advantages or disadvantages of it?

Mrs. STROEBER. You mean of the meals?

Senator CLARK. The meals program, yes.

Mrs. STROEBER. I think there are big advantages, especially for the men folks who live alone. A great many of the people who have eaten here tell me that is the only hot meal they have in the day. Some of the older women just don't like to cook any more. As age comes on, it is more difficult to do things and it is easier to come here than it is to cook, so they don't cook.

Senator CLARK. Do you see any value to the program other than the food—other than the nutrition?

Mrs. Stroeber. Yes. They enjoy getting together. If somebody misses, they will say, "What was the matter? Why weren't you here before?" Of course, those that live here in town can come every day up until—I think on Saturday and Sunday it is not open, but they can come every day.

For us in the outlying districts, the bus just comes once a week. It takes a different corner of the county on different days, so we don't get in every day.

Did you hear the music when you came in?

Senator Clark. Yes, I certainly did.

Mrs. Stroeber. There is always some kind of entertainment. It is not always music—sometimes it is something else—but there is always some kind of entertainment. I think the last of the month there is a bingo game; I always notice that there are a lot more people here the day of the bingo game.

Senator Clark. So it is not just nutrition; it is a social get-together.

Mrs. Stroeber. Yes; socializing for a great many people. That has not been my reason for coming, because there is a little country church quite close to me. I am out in my own community and it is not necessary for me to come for that social life, though it is nice. As far as to come every day, I would not have time.

Senator Clark. You have to look after the cattle, you said.

Mrs. Stroeber. Yes, and I have to take care of my flowers and garden. Anyone who has a garden knows that weeds grow.

Senator Clark. I want to ask Mrs. Anderson some questions, if I may.

I was interested in the fact that you said that the doctors used to come to Melcher to the clinic from Des Moines. Did they come once a week, or what was that arrangement?

Mrs. Anderson. No, they came every day from the osteopathic college and they had been doing this for 2 or 3 years. It seemed to be going fine. They had a good business, but for some reason they decided they didn't want to drive down there any more. They were there for 5 days a week.

Senator Clark. Now you have no doctor at all?

Mrs. Anderson. We have no doctor at all; no. Years ago, Melcher had several doctors and dentists.

Senator Clark. How big is Melcher?

Population: 931

Mrs. Anderson. Well, as of the 1970 census, it was 931. It never was a great big town.

Senator Clark. That is a big town.

Mrs. Anderson. A big town, but I think around 1,200 is what it was at its peak.

Senator Clark. That is a big town for me. I was raised in a town of 450.

Mrs. Anderson. Then we have a large one. We have several new homes going up and the younger people are staying there, driving to Des Moines, Newton, or Knoxville to work. What we need is a good road.

Senator Clark. Now, according to my notes, there was also a pharmacy in Melcher until this spring; is that right?

Mrs. ANDERSON. Well, it was a sundry store. There was no pharmacy there, but the medicine was ordered from the pharmacy at Knoxville. One of the men that worked at the VA hospital picked it up and brought it in, so that was the one service that we could depend on.

Senator CLARK. Now you have lost that?

Mrs. ANDERSON. We have lost that.

Senator CLARK. So you have lost the medical center and the ability to get prescription drugs delivered in that way?

Mrs. ANDERSON. That is right.

Senator CLARK. If you need prescription drugs now, what do you do?

DRUGS DIFFICULT TO OBTAIN

Mrs. ANDERSON. Well, we wait until we can go to Knoxville and get them. Most everybody goes to the doctors there at the Collins Hospital Clinic. They can get their medicine there through the doctor or they can go to the drugstore in town and get their prescriptions filled.

Senator CLARK. Do a good number of people in Melcher receive benefits under block loan?

Mrs. ANDERSON. Yes. There are several of the old ministers still living there, but there are a lot of widows, too; several of them are getting it.

Senator CLARK. I know the long period of time that it takes to process the claims is the major complaint. I noticed you said that, too.

Mrs. ANDERSON. Yes.

Senator CLARK. What happened was, as I recall, about 2 years ago we passed new legislation saying that everybody who failed to qualify—and you referred to this in your statement—could reapply, and so suddenly there were literally tens of thousands of people who reapplied at the same time and it became an enormous problem.

Mrs. ANDERSON. Yes. I thought that was probably the problem because I had not heard for so long. Of course, when you are just sitting there wondering and waiting, all you are thinking about is yourself. I had just given it up. I thought, well, it is just one more time that I didn't get anything, but I would not give up as long as there was anything that I could do.

Senator CLARK. So as far as you are concerned, the major benefit of the programs that exist now is that you get black lung benefits and social security?

Mrs. ANDERSON. Yes.

Senator CLARK. What about the meals program—do you have access to that?

Mrs. ANDERSON. We don't have it in Melcher, but they have it in Knoxville. The people that want to go over there. We have one van which makes the trip at 9 o'clock and then there is another one at 10. If they want to eat, they try to go on the 10 o'clock van so they will be in Knoxville longer and will be able to eat. If they go at 9 o'clock, they come home before the time for the meal.

Senator CLARK. Do you have any housing programs in Melcher?

Mrs. ANDERSON. No. We need that, too.

Senator CLARK. Let me ask Mr. Goeldner a couple of questions, if I may.

I have a copy here of a magazine article published by the Department of Health, Education, and Welfare called *Aging*,[1]—the November 1963 issue. That is some time ago—nearly 13 years. It has an article in it about Earlham and their homemaking/home health aide nursing services, and so forth.

I was wondering if you might talk a little about some of the things that have happened in Earlham. It looks like you were doing these things already 13 years ago—a number of these new programs now in homemaking/home health care aides, and so forth. Tell us a little bit about the services affecting older people in Earlham.

Mr. GOELDNER. Well, we felt it would be well to keep the people in their own homes as long as possible, so we worked out this program with the assistance of some of the county welfare people in HEW. The State department of health was the agency that put up the assistance money, so we set this program up for the Earlham community. After it was in operation for a year or so, HEW suggested that we expand it, so presently it covers the entire Madison County.

Mrs. Murray Smith, who was here this morning, is presently director. When we first set up this program we had a number of different kinds of assistance, such as homemakers, meals-on-wheels and handyman services, friendly visitation or telephone visitation, visiting nurse, and transportation services.[2]

There was an elderly gentleman there who contributed his time. I think they paid him a quarter for each trip if he brought somebody downtown, or a little more if he took them to Dexter, Des Moines, or someplace else to the doctor.

We found that with this program many of the people spent their remaining days in their own home; otherwise, they would have had to go to a nursing home or some other place.

Some of them required more assistance than others. Maybe a homemaker would come in for half a day, two or three times a week or, if the person needed more help, they would come in every day for a part of the day.

Senator CLARK. Now, would you talk a little bit—in case there are people here who have not been involved in homemakers—about how they come into the home once a week, or more than that, and what kind of things they do?

HELP IN THE HOME

Mr. GOELDNER. Well, as people grow older, they need more help in things like vacuuming their house, cleaning the house or they need to have someone come in and prepare a meal for them. This was before we had congregate meals.

Maybe if there are some dirty dishes stacked up, they would wash the dishes—any particular need that the person might have. They might do a little laundry work for them or just take care of the extra things that take a little burden off the older person.

Senator CLARK. I am reading from the recent article that says that they had a meeting in Earlham with the home health aides, as well as homemakers, and the homemakers had assisted in 61 homes. I assume that is in one county.

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[1] See appendix 1, p. 39.
[2] See brochure, appendix 1, Item 1, p. 41.

Mr. GOELDNER. That is Madison County.

Senator CLARK. During the month of June, totaling 844 hours of service by—in this case it was home health aides—and 35 visits to patients' homes were made by registered nurses. Can you talk a little about the home health aides and the nursing programs?

NURSES VALUABLE IN HOME HEALTH

Mr. GOELDNER. Well, I think the nurse, when she visits the home, if necessary, is capable of giving shots, taking blood pressure, and seeing that the person is taking their medicine properly—things of that nature.

Senator CLARK. So between those various programs, your people are able to live in their own homes much longer than they would otherwise.

Mr. GOELDNER. Yes, many of them have. Some of them lived out their remaining days; I know three persons now in nursing homes, but they lived in their own homes 10 years longer than they could have otherwise.

Senator CLARK. What about nutrition programs now in Earlham?

Mr. GOELDNER. Well, Earlham participates in the congregate meals program. Then, of course, the county bus comes over on Tuesdays to take those who need to ride the bus.

In the beginning when we first started congregate meals in the aging program, some of the people said, "Well, that is just for poor people," or "It is charity," or the like. They are getting over that notion now.

I think, as it was brought out here before, the people enjoy visiting, reminiscing, playing games, or having some music like they have here in the multipurpose center.

Senator CLARK. I want to thank you all very, very much for your testimony. It was most interesting. Thank you very much.

We are going to hear next from Dr. Woodrow Morris, and then following Dr. Morris we are going to be hearing from the other panel this morning with Mr. Joe Pals, Mrs. Forsyth, and Dr. Fickel.

Woodie, come right on up here, please.

We particularly wanted to have the doctor with us today because he played a very major role, in fact, in two White House Conferences on Aging, and I know he was appointed by the President to the National Task Force on Aging in 1970. I know that the chairman of this committee also appointed him a member of an advisory board of the committee in 1971.

I must say that I regret that in recent days Iowa has lost his services as chairman of our commission on aging. I think he knows more about problems of aging than anybody I ever met.

So we are particularly happy, Woodie, to have you here. You just proceed in any way you think appropriate.

STATEMENT OF DR. WOODROW MORRIS, ASSOCIATE DEAN, COLLEGE OF MEDICINE, UNIVERSITY OF IOWA, IOWA CITY, IOWA

Dr. MORRIS. Thank you, Senator Clark, for those kind words. I am not sure that it is all true, however, because I am following a panel that just participated a few moments ago who said almost all of the things I want to say better than I can probably say them.

I appreciate that panel's presentation very much because it was a most interesting discussion, and maybe what I can say will illuminate a little further some of the things they said.

I am delighted that you are back home, Senator.

Senator CLARK. Thank you.

Dr. MORRIS. We are always glad when you come back and conduct these important hearings. It is good to see Mr. Oriol, John Guy Miller, Miss Kilmer, and other members of the staff here.

Senator CLARK. I just want to say before you start, because I didn't make this a part of the record, that Dr. Morris is associate dean of the College of Medicine at the University of Iowa.

Dr. MORRIS. Well, as most of you folks know, I have been long interested in and deeply concerned about the need for us as a society to provide the kinds of programs and services which elderly people need and want.

I have been very pleased at the progress which has been made in this country and here in our State in working toward these objectives.

But as an Iowan of some 28 years, I am particularly concerned that we not simply pay lip service to the elderly or mislead them into believing programs and services will be available, only to have them never reach fruition in reality.

This sort of misleading is already all too prevalent in what I consider the broken promises which strew the path of the medicare program. It concerns the delivery of medical care and the provision of long-term care facilities in adequate numbers and quality to respond to the health care needs of our aging and aged citizens.

Similar remarks might also be made about the hopes engendered in the hearts and minds of the elderly that up-to-date, 1976 housing will be made available to them, only to have time pass with little or nothing actually happening in the way of actual construction of adequate housing for those who need it most.

I was delighted to hear Mr. Sprunger talk about the housing program here in Winterset, and I cannot help but think that many folks may be sitting in the audience wondering why they can't have that kind of housing in their communities. That concerns me, too.

Far too many of our older adults are living below the poverty level with no truly creative plans or programs on the drawing boards to permanently solve this problem.

It is true that we have social security and supplemental security income programs, but neither has been able to keep pace with the inroads of inflation, and neither was designed to permit older people to maintain the standard of living to which they have been accustomed or are deserving.

But these remarks are focused on the elderly in general; in Iowa and in other Midwestern States, in particular, we have a special problem, and that is the rural elderly—those to whom Senator Clark is addressing these hearings this week.

A SPECIAL PROBLEM IN IOWA

Unhappily, so far as I am aware, there is no national or State of Iowa policy regarding the rural elderly. Even a cursory examination of the situation of the rural elderly will suggest that they are all too

often underserved and underrepresented—or not served or represented at all—in Federal and State programs which should be serving them and their basic needs.

What good is it, for example, to provide even inadequate medicare benefits to the rural elderly if there are too few physicians, dentists, nurses, physical therapists, audiologists, and long-term care beds to provide the health care the rural elderly need?

Similar questions might be asked about the various programs and services provided for under the Older Americans Act and other Federal programs for the elderly in the areas of information and referral, legal assistance, housing, senior centers, congregate meals programs, and readily available and convenient transportation services.

In most if not all of these, the rural aging and aged have been overlooked and neglected. Part of this, I am sure, is due to the fact that there was no Federal emphasis on this aspect of the aging problem.

State agencies on aging and, indeed, area agencies on aging found themselves so caught up in the day-to-day business of establishing new programs and services, trying to work out the meaning of State and Federal mandates and directives, seeking adequate funding for desirable programs, and lacking manpower trained in the field of aging, simply were unable to give adequate attention to the special needs of special groups such as the rural elderly.

Designating Problem Areas Within States

As I have reported on previous occasions, it is possible to divide various areas of a State—such as counties or planning and service areas—on the basis of the general weight of the problems such areas face because of the relative dependency needs of the elderly citizens which make up a portion of their population.

It turns out that what I fondly call high-senescity counties—those with a high proportion of older citizens—are essentially in rural areas, while low-senescity counties comprise the urban areas of the State of Iowa.

I was interested, Senator, that among the materials that were distributed this morning was a copy of the Senate hearings you conducted in Washington on April 28, 1975.[1] Those of you who are interested will find in that a description of what I just referred to, high-senescity and low-senescity counties, and a map of Iowa shows where those counties are.

The southern two tiers of counties are our most high-senescity counties.

Senator Clark. Why is that true, if I could just interrupt you 1 second?

Dr. Morris. Well, I believe it is essentially true because people are moving out of these counties, particularly young and middle-aged people, and they are the people of child-bearing age. The end result of all this is that the people who are left tend to be those who are older or very, very young. This leaves a proportion of the population in these counties, which is in the range of 20 percent or more, in the age range of 65 and over.

[1] Hearing, "The Older Americans Act and the Rural Elderly," U.S. Senate Special Committee on Aging, Washington, D.C., Apr. 28, 1975.

One of the aspects of serving the needs of the elderly in rural areas is related to the density of the population in high-senescity counties in contrast to the population density in low-senescity counties.

Density data are of some interest because, in a gross way, they reflect the relative concentration or dispersion of the people who are entitled to various governmental services. It would be easier, for example, to serve 100 people living within the confines of a single square mile area than it would be to serve 100 people scattered over an area of 50 square miles.

That is all this concept means. The former situation is more characteristic of populated areas such as cities; while the latter are more typical of rural areas.

Relating this to congregate meal sites suggests that it is conceivable that a single nutrition site could easily provide services for 100 elderly people in an urban setting and none would have to travel very far to reach the site.

In the other hand, in a rural setting elderly participants would either have to be transported several miles to reach the site, or more sites would have to be provided so that they would be more accessible to the elderly.

In either case it will be more expensive to mount a satisfactory program in a rural area than it would be in the urban setting. In general, these same factors—senescity, density, and related factors—will operate to effect the establishment of senior centers under title V of the Older Americans Act, just as they are now affecting the congregate meals program under title VII.

Accessibility Is Key Factor

Accessibility to services, then, becomes a key factor which must be taken into consideration if those we wish to serve are to receive the services to which they are entitled and for which the programs were designed.

In this connection, it is obvious that one of the most important variables to be considered is to have—as you heard from the panel repeatedly this morning—a comprehensive transportation system.

In general, it is safe to say that programs now underway have not been designed to take accessibility to services into consideration when funds are allocated either by the Federal Government to the States, or by the State of Iowa to its constituent area agencies.

Furthermore, it will be difficult to do this at this point in our history without making some basic changes in the policy of both Federal and State governments to recognize the special needs of the rural elderly.

It will be difficult because the area agencies have, for a period of years, become accustomed to their portion of the Older Americans Act and other funds as they have been allocated to them. To change the formula now, without adjustments, will mean taking funds away from some areas in order to make them available to the rural area agencies.

Similarly, if corrections are to be made now in the formula allocating Federal funds to the States to take into account the rural features of some States, it will mean taking funds away from the more urban States.

In addition to the two particular programs mentioned earlier, rural areas differ significantly from urban areas in a number of other important ways. Time does not permit me to discuss all of these this morning, but let me just note a few.

They include a higher percentage of families living below the accepted poverty level, greater severity of poverty, lower population density, fewer primary care physicians, lower accessibility to the services of primary care physicians and dentists, and a less desirable relative health status index.

Finally, it seems to me that what is called for is a truly national policy regarding the provision of programs and services to the rural elderly of our Nation. Such a policy would serve to focus attention on the special situations of the rural elderly, their special needs, the requirement that specially devised progams need to be developed to respond to those needs, and that these programs be specially funded so that State units on aging will be able to respond to the grass-roots requests from the area agencies on aging.

Present Data Under Study

Senator Clark, there is much more that needs to be said about the rural elderly. We are beginning to collect relevant data at the University of Iowa and data are available and under study at Iowa State University.

Senator Clark. Thank you very much.

I think you have spoken particularly relevantly to the question of accessibility of services because, after all, it may well be that the Federal Government has the service or that the service exists from some other source, but if one cannot get to it, it really does not make much difference.

As you say, the allocation of funds in the past and at the present have not been made on the basis of how difficult it is to deliver those services.

I wanted to get your judgment on two or three specific programs that are now being funded, how you think they might be improved, or what your assessment is of these programs in rural areas.

First of all, the question of housing. Is it your judgment that we have an enormous way to go yet in our rural areas in providing the kind of housing that we talked about at the Plaza which I saw this morning? Have we begun to meet the need there, or do you think it has not been reasonably met?

Dr. Morris. No, I don't think it is being reasonably met at all. I am delighted that there are programs. I have not seen a recent survey of available housing programs for the elderly in Iowa, and you are going to hear later in this week from Governor Blue who is more expert in the field of housing that I am. He has been interested in this for many years.

I was visiting with Governor Blue just last Friday and one of the things he said to me was, now that he and I are no longer going to be intimately involved on the Commission on Aging, perhaps we and some others could work together toward providing more adequate housing for elderly people throughout the State, with particular emphasis in the smaller towns and cities in the rural areas of the State where housing is, I think, desperately needed.

I think we have a long way to go yet.

Senator CLARK. What about health care in rural areas? What do you see as the greatest need there? What should we be working toward as far as this State is concerned?

Dr. MORRIS. You are going to have an expert in a few minutes. Dr. Fickel will be talking with you about one of the most fascinating programs in the State, and Bruce Brenhold is here from the University of Iowa College of Medicine, and he has been working with Dr. Fickel on these programs.

My personal attitude toward this is that the college of medicine is working in the right direction toward developing an approach toward a solution to some of these health care delivery problems.

BETTER ORGANIZATION STRESSED

The approach is, in essence, to develop units which will provide a demonstration of how a community can organize itself better—particularly the health care community can organize itself better—to provide care throughout the community and the surrounding area.

I think if the college of medicine can continue to work toward the development of such approaches throughout the State, and if other communities will read the story of the development of a program such as the one you will hear about later in Red Oak, the whole State can lift itself up by the bootstraps.

In essence, that is the story of Iowa. You are also going to be conducting a hearing in Ottumwa. Ottumwa is in an area of 10 counties which incorporated and called themselves Tenco. This was designed to do the same thing for that whole area in general—to pull itself up by the bootstraps—by its own efforts.

This is the kind of thing I look forward to. I think this would do the most good in the health care area, the housing area, and a lot of other areas.

Senator CLARK. Good. We thank you very much, Dr. Morris, and we appreciate your coming down from Iowa City to testify.

Our last panel is going to be made up of Joe Pals, Louise Forsyth, and Dr. Jack Fickel, who has just been referred to.

We are asking each panelist to try to limit their remarks to 4 or 5 minutes so we will have plenty of time for questions. I am hoping, too, that we might end soon enough to get some questions from the audience of the panelists or members of the staff of the committee.

First, let's hear from Joe Pals who is the former executive director of MATURA Action Corp. in Orient, Iowa.

STATEMENT OF JOE J. PALS, FORMER EXECUTIVE DIRECTOR OF MATURA ACTION CORP., ORIENT, IOWA

Mr. PALS. Senator Clark, staff, and friends, I have heard it said that if you are getting a lot of static, you are not tuned in to the right wavelength. So I hope you keep me on the right wavelength this morning.

I am suposed to talk to you this morning about some of the programs that we had at MATURA—winterization and services or programs for elderly, and the future of CSA.

CSA is the national name. MATURA began in Creston, Iowa, April 25, 1966, representing six counties: Madison, Adams, Taylor, Union,

Ringgold, and Adair. At that time we were known as OEO—Office of Economic Opportunity—better known as the poverty program. The words "poverty program," I think, is one of the things that took us out, because it was more or less downgrading, or I have always thought so at least. About a year ago, our name was changed from the Office of Economic Opportunity to Community Services Administration. CSA are the initials we use.

Our primary function or mission is to help people help themselves, by referral to other agencies or into other programs or jobs. Our philosophy from the very beginning was that of cooperation with other agencies, rather than competing. Having worked in public works a good many years before I came with MATURA, it was my thinking that the only way we could accomplish anything was to work with other agencies rather than to try to compete. A new agency coming into the community, I think, probably made some of the other agencies wonder. "What are they going to do? Are they going to be taking part in what we are doing?" There were some agencies that were somewhat apprehensive about what part we would play within the community.

It has been a long road. How did we build it? I am going to talk a little about linkages for just a moment. What do we mean by linkage and linking the programs together? For example, at the Corning Center, the county board of supervisors and the AAA—the area agency on aging—bought an old school bus. We at MATURA furnished the money for the gas and oil and the part-time driver to operate the bus. So you see, you have three various entities there. You have three agencies operating together or working together to provide a service within that community.

Then what was the service for? The service was for transportation. Again we have transportation coming up, and I am sure, from what all the others have said, that we are pointing out the need here for transportation. We served approximately 45 people from towns like Carbon, Mount Etna, Brooks, Nodaway, and Prescott. These people were picked up in the rural areas and brought into different towns to buy groceries, to see the doctor, or whatever services they might need.

Besides that, there were approximately 35 people picked up within the town of Corning that were taken to the meal site within Corning itself by this same bus. MATURA also furnishes a driver and pays mileage for the car that the driver uses. The driver—in this case it happens to be a lady—uses her own personal car. She is paid mileage for this. We have transportation from Bedford and Lennox to take people to Clarinda, Maryville, Grant City, Creston, and Corning.

Few Medical Facilities In Area

This is mainly for medical and dental care. This is pointing out what Dr. Morris said a little bit ago, medical care being what it is now. We are thinking in terms of the number of doctors in the area—there aren't many. In all of these small towns, there are just no medical facilities, so somebody has to see that people get somewhere so that they can be taken care of.

Again, we are pointing out that transportation is a very, very vital thing in the area, and so is medical care. As Dr. Morris said, social security is not keeping pace. These people out there are below the poverty line at the present time, and they are underserved; some are not served at all. I think that was a statement that was very well put.

Now some of the other things that we have done, we had $18,000 of CSA money that was "one-shot" money. By that we mean it was money that was given to us that we could do with what we saw fit. About the time that we received this money, some of the meal sites were being set up in the six-county area but they didn't have funds to purchase equipment for the meal sites. Many of the programs were financed for the meals, or part of them, but they didn't have funds to buy stoves or refrigerators and that sort of thing.

Sometimes you can get used equipment. But when do you give a refrigerator away? Usually when it is worn out, sometimes not. You don't have the type of stove, usually, that they need for that. That $18,000 was distributed among the sites so that they could buy equipment, so the sites could get started, so they could have meals in various areas.

Then another $5,000 that we received from CSA was emergency food money and was supposed to be used for emergency food in some manner or other. We felt, if we called in the social service directors within the six-county area and talked to them and asked them perhaps what would be the best way, that they might have suggestions. So we called in the social service directors and talked to them. We said, "Now we have $5,000; do you have any need or can you use it or dispense with it in any way?" They said, "Yes, we can use emergency money." There are times when people come in and have to have emergency money for food and we don't always have that.

The upshot of all that was this: We gave five counties $800 each—one county $1,000. They allocated the money and sent the bills to us. We made the check out to them. That is the way it was handled.

Then we have the center systems, of which there are five. We don't happen to have one at Bedford, but they are in the backbone of our total system. You are looking at one of the centers right here—you are sitting in one of them. Louise Forsyth, sitting right next to me, will be talking about that a lot more later.

I am not going to go into any more of the organization or any more linkages of the programs, or that sort of thing. We will go into the winterization program. I think, perhaps, this is one of the best programs that we have had in a long, long time. It is one of the programs that has gotten a lot of good for a lot of people. Within this program, the original grant amounted to $26,150 Federal money and the State of Iowa allocated $3,495.

The Winterization Program

Whenever money of any kind, Federal or State, is allocated, there are always guidelines that you have to follow. Federal dollars were for all age groups, but 90 percent of the homes that we worked on were elderly occupied and, again, this was because of the need. The guidelines for the elderly poor—we could go 25 percent above poverty guidelines for winterization. State dollars were earmarked for 62 years and over. In other words, for people 62 years and older, we could use State money.

The work schedule or accomplishment: What did we do or what have we gotten done within that program? First of all, under Federal regulation we could not exceed $250 per home.

Senator Clark. You could not spend more than $250 on a home for winterization?

Mr. PALS. That is correct.

We planned to work in 185 homes. I will explain this a little more clearly. Actually, we worked on 302 homes. Now there are different phases within this project. For example, we started out, first, with what we call protecting the home from air infiltration by using plastic and caulking the home, doing the best we could. We get those that have the greatest need.

We finally decided perhaps a storm window might be a better route because plastic would not last that long, and maybe there was a better way. So we started with storm windows and we did quite a bit. We started doing that and we had 40 homes that had permanent storm windows, which was better. Then we went to ceiling insulation, and we have done 57 homes so far. So you see, we have various homes in various phases—not all complete, but in various phases. We will go back and do more next year.

Besides this, we have put in vents in the roof, vents in the side walls, and this sort of thing. We traded off 55 tons of old paper, enough to do 20 attics. We are the only agency in the State of Iowa to have done this and we have to give credit to the center people and you people who brought in old papers. This was trucked to Des Moines and traded in on insulation. We got enough by trading in to do 20 attics free; this is what it amounted to.

Then we generated 1,160 hours of volunteer time. We picked up 1,000 old storm windows. We put on plastic, and used windows where possible. Those that didn't fit right into the old windows were screwed on to the outside. We could not use all of them.

It would not have been possible to do all this without the help of our center supervisors—our CETA people. What are we talking about? We are talking about CETA people—the Comprehensive Employment Training Act.

MATURA is, or was, using five carpenters provided by CETA under titles II and VII. All of them are under a title II contract, presently, because of the funding within the two programs. The title VII funding ran out within the area, so it was all transferred to title II, and presently they are on that. As I understand, that is to run out on January 1, and I am hoping that that will continue, Senator.

Senator CLARK. We are going to be voting on that, as a matter of fact, in about 7 or 8 days, so we are hopeful that it will.

CETA FUNDS NECESSARY

Mr. PALS. It is indeed fortunate that MATURA could avail themselves of the CETA contracts, as it would have been impossible to have accomplished what we did because neither our own budget nor the winterization budget had allowed for this kind of needed manpower. Without CETA, MATURA would need at least an additional $30,000 to $35,000 to continue a program of this kind another year.

Now, as to the future of CSA—it has been kind of up and down, as you all know, and my guess is that is true of any new program. I will read what I have here on the future of CSA. I hope I keep within my time.

For those working within an organization like MATURA, especially those who have any tenure at all, realize the many frustrations we have gone through; we have never been quite sure each year if we

would be funded. When President Nixon's order came out to dismantle the total organization, this was very disheartening to CAP people. All agencies seemed to lose ground and, again, when it looked like President Ford might transfer us to HEW, it seemed almost as bad. After 10 years of dedicated work, it seems as if we are still struggling up a fairly steep incline, whereas we should be on a plateau progressing forward with less concern about annual funding as well as how much funding we will receive. MATURA has had the same funding level for the last 5 or 6 years. With cost-of-living increases—increases in rent, utilities, telephone, et cetera—there is only one answer, and by now you've guessed it.

Thank you.

[A poverty guideline table submitted by Mr. Pals follows:]

CSA POVERTY GUIDELINES FOR ALL STATES EXCEPT ALASKA AND HAWAII

	Nonfarm family	Winterization	Farm family	Winterization
Family size:				
1	$2,800	$3,500	$2,400	$3,000
2	3,700	4,625	3,160	3,950
3	4,600	5,750	3,920	4,900
4	5,500	6,875	4,680	5,850
5	6,400	8,000	5,440	6,800
6	7,300	9,125	6,200	7,750

Note: For family units with more than 6 members, add $900 for each additonal member in a nonfarm family and $760 for each additional member in a farm family.

Senator CLARK. Thank you very much. You may be on the incline, but it looks like you have accomplished a great deal; in particular, the winterization program which is the kind of program that, it seems to me, can have a lot of practical effect with a fairly small amount of money expended. We compliment you on that.

I just want to point out that Congressman Tom Harkin on my immediate right, as you know, is also sitting in on the hearings.

We are going to go ahead with the panel and then, Tom, if you have anything you would like to say at that point, we would be happy to hear you.

Representative HARKIN. Thank you.

Senator CLARK. We are going to hear now from our next witness who is, in fact, the director of this center, Mrs. Forsyth. I want to start, Louise, by saying we are very, very grateful to you for making the arrangements here and allowing us to use your center.

STATEMENT OF LOUISE FORSYTH, DIRECTOR, MADISON COUNTY MULTIPURPOSE CENTER, WINTERSET, IOWA

Mrs. FORSYTH. We are most happy to have you, and we are glad to do it. Welcome to everyone who is here. I am extremely pleased to see such a large turnout and so many strange faces. This means there are people from without our area.

My roots are planted quite firmly in Madison County. I was born and raised in Lincoln Township and have lived in Madison County all my life, except for 9 months spent in California in 1955–56. My great grandfather was a country doctor in that neighborhood in the late 1800's and early 1900's.

My personal association with Madison County Multipurpose Center was on January 16, 1974, when I began work as assistant director on a part-time basis. I did not know at that time that I would become the director, as I have in a short 2½ years. The center staff at that time consisted of the director, Mr. Herb Flint; a part-time outreach worker; and myself.

I knew relatively little about CAP agencies—their purpose, operation, or funding. When I started work, the funding for future operation was very shaky, and remained that way for quite some time. The first experience I had in dealing with public officials and others outside of the CAP agencies was when we compiled a report on center activities and services, presenting them to the mayor and city council and enlisting the support of the Madison County Board of Supervisors just in case we were not funded again through the OEO program.

When I came on board, the title VII nutrition program was operating in four sites: Earlham, Truro, St. Charles, and Winterset. The meals for Winterset participants were served 5 days a week at the multipurpose center and the associate director for the program had—and still has—her office at the center.

Countywide Transportation System

In the summer of 1974 we—the area agency on aging staff, Madison County Board of Supervisors, center people, and other interested people in the community—began putting together plans for a countywide transportation system for our senior citizens who could not provide their own and needed such a service in order to remain in their own homes. Mrs. Stroeber has told you this started off on February 3, and she and Mrs. Carter from Macksburg were the first riders.

As we worked on this plan, Glenda Knight, a planner with the area agency on aging, began to think of expanding the use of the transportation service by multifunding. This could be done by setting up a contract for purchasing services with the Department of Social Services, thereby making it possible to provide transportation to the blind, the handicapped, and the disabled, as well as those over 60 years of age.

I think, probably, if I had known how much bookwork, extra hours, headaches, hassles, et cetera, were involved, I probably would have opted out of any involvement with the program. Nevertheless, I am not sorry I didn't know, and I feel it has worked out very well. We are in our second year of operation and are gaining friends and participants every month.

One project leads to another. In the spring of 1974, the nutrition program in Winterset, particularly, was not gaining—people were not participating. With some funds that MATURA had available, they purchased a used car—a 1968 Bel-Air Chevrolet four-door—and provided a driver and gas for 6 months as an experiment to see if transportation lack was part of the reason for the low numbers participating. On about May 1, 1974, the car was put in service.

We were also aware that there was considerable misinformation circulating in regard to the program. The area agency decided to use some funds allocated for supportive service to provide an outreach worker to work exclusively at contacting people over 60 and explaining the program and its purpose.

In the 10 weeks this outreach person worked, meal participation in Winterset doubled, and also increased in the other sites. The transportation provided by the center car was a factor that could not be taken lightly. If my memory serves me correctly, I think that 60 percent or more of the people availing themselves of the use of the car were coming to the meals; this percentage has continued.

We still are operating this 1968 Chevy. We have not received any Federal, State, or county funds since the end of the first 6 months. This operates exclusively within the city limits of Winterset. The donations of the participants, the community, and the city keep it going from day to day. Sometimes it gets a little shaky but, so far, faith, the community, and the people that use the car have kept it going.

The only other public transportation in the town of Winterset is one taxi and the county van, when it is in town and which is not available 5 days a week for the people in Winterset to use. Neither the car nor the van operate on weekends, so this means that people are without transportation unless they have their own.

On February 10, 1975, Therese Brittain, associate nutrition director, and I attended a town meeting called to discuss community needs. Except for a group interested in finding a solution to the problem of inadequate sewers, we were the only ones attending. A representative from the Central Iowa Regional Association of Local Governments gave a brief résumé of the Federal Housing and Community Development Act of 1974 and the related community block grant program.

Certain city activities were eligible for funds under these programs. The one that caught our attention was acquisition, construction, and reconstruction of senior citizens' centers. Now we knew why we had attended the meeting.

Needed: A Kitchen

By this time it was becoming apparent that any congregate meal program, particularly in a small community, could operate more economically if the food was prepared at the serving site. The kitchen facilities in our center were inadequate to prepare a full meal, so we submitted plans and estimates to the city council to build a kitchen in another room of the center—the room occupied by the kitchen to be converted to office space.

Our plans were made part of the application sent to HUD for approval. On Friday, August 1, 1975, confirmation of the approval by the Department of Housing and Urban Development of the grant for $293,000—$285,000 for sewer improvement and $7,500 for the center kitchen—was received by the city mayor. Then came a long period of frustration of planning and estimating, waiting on approval, et cetera, and, in the meantime, everything had gone up in price.

Finally, all the adjustments, deletions, and changes were made and a contract to get the work started was let the first of June 1976. The kitchen is practically completed. We still lack a garbage disposal and the booster heater on the dishwasher. Today we are initiating it and will soon be preparing meals for our elderly.

I think we have proved that, with the cooperation of the community, a goal can be achieved that would have been impossible for one segment alone.

In each of the projects that have been initiated and brought to a successful completion, I think that a number of people that did not know anything about the multipurpose center or what a community service agency is supposed to do, except that we existed in what used to be the "old creamery building," now know what we are, what we do, and why we do it. I sincerely hope that such joint efforts will bring many more projects to help our fellow man to successful completions in coming years.

One of the biggest hurdles for any people program, particularly those involving people in rural areas, is reaching those people with accurate, unimbellished information about the program and its aims. I feel that personal eyeball-to-eyeball contact by an adequately trained and informed outreach person is the only answer.

Outreach Allocation Should Be Updated

Every program written and implemented should allocate enough money for this outreach. CSA centers are operating on the same allocation that they were 10 years ago so therefore cannot provide the outreach personnel necessary to reach the number of people that need to hear the news. Their expertise could be used to train and supervise the people needed to reach the prospective participants in these programs and to assess the value of the programs.

I would like to infringe on, maybe, a little bit of extra time to express my appreciation and thanks to the following people:

Herb Flint, director of the multipurpose center from its beginning in 1966 until January 1975 and under whom I started to work; H. W. Callison, Reese Bridenstine, Harvey Davis, and Joe Pals for their confidence and backing when I became acting director of the center and later as director. I could not have made it without them. To the mayors, past and present, of Winterset; the city council members, past and present; the Madison County Board of Supervisors; the area agency on aging, particularly Kay Samec, Vada Babcock, Glenda Knight, Rhonda Varnum, and Vance Baird: Les Goeldner, chairman of the area agency on aging advisory board; and the Central Iowa Regional Association of Local Governments, that is, Gary Pryor, Jerry Franke, Judy, and Joe. And for the efforts and help above and beyond the call of duty in getting things ready and in shape for this hearing today: Yvette Wilson, transportation secretary and all-round handyperson; Betty Berry, outreach worker; Fred Vierling, Dan Rater, Helen Grandfield, Lillie Moore, Florence McCauley, and Wilma Barker; Roscoe Tyer, general contractor for our kitchen; and his personnel and subcontractors.

Finally, I would like to introduce my mother, Mrs. Neva McKibban, a member of the Hillbilly Band and an active participant in center activities.

Senator Clark. Yes. Stand up, please. We need the drummer.

Mrs. Forsyth. And I would like to say a special "thank you" to her and my father, now deceased, for raising me in a home where love, thoughtfulness, and concern for others was a daily part of life.

Senator Clark. Thank you very much for an excellent statement. We appreciate it very much. We can see why people are doing so many excellent things around here.

Mrs. Forsyth. Thank you.

[A prepared statement of Mrs. Forsyth follows:]

PREPARED STATEMENT OF LOUISE FORSYTH[1]

The Madison County Multipurpose Center, located in Winterset, Madison County, Iowa, was opened in 1966, in a building that had been used to house a creamery (some of the vats and other equipment were still there and had to be removed), cream-buying business, and hatchery. There were no ceilings—just unadorned beams and hollow tile walls.

The reason for the opening and continued existence of any CSA (prior to 1974 CAP) Center was, and is, to provide help for people, particularly those with low incomes, the handicapped, blind, disabled, and/or disadvantaged.

We feel that over the past 10 years we have helped to coordinate programs that have provided help in many areas and have generated other needed programs.

From the beginning the center people have worked a great deal with the elderly and the handicapped. The center was instrumental in starting, and continues to work with, seven senior citizens' groups in the county. The center serves as the meeting place for four of these groups.

The center conducts, and has since shortly after opening, a class for adult handicapped people; most of these people reside at Horton's Custodial Home just north of Winterset. This class consists of a craft project and refreshments. The help in teaching the craft lesson and providing refreshments is all volunteers—most of whom are senior citizens.

Two very important things, or benefits, to the participants in this class have been self-discipline (learning to complete a task) and a sense of accomplishment.

It was through the center staff's concern and interest in these handicapped people that an effort was launched to start a challenge center as a satellite of the Southwest Iowa Sheltered Workshop, located at Afton, Iowa. This challenge center began operation early in 1975.

A class is still held at the center one afternoon a week for those handicapped people who are unable to attend the challenge center.

In past years the center director and others directly involved with center have worked with the health planning council to encourage doctors to come to our county and in getting new nursing homes (4) and a custodial home in operation. They also have been active on the board of the home-health agency (Earlham CARE program) and in recruiting home-health aides.

Our center has operated a rent-a-kid, or busy kid as it is now known, service for the past 5 or 6 years. We also keep in close touch with the Job Service of Iowa and make referrals to them and to the EDS Manpower Office.

Head Start, Neighborhood Youth Corps, GYOP, and many other self-help agencies received our full support and cooperation.

GED certification classes, classes in sign language for those wishing or needing to communicate to the deaf, classes in needlecraft and ceramics are held regularly at the center.

We maintain a close contact with various health agencies: i.e., the Commission for the Blind, Easter Seal Society, the Cancer Society, Crippled Children of Iowa, and Planned Parenthood.

One of our greatest areas of influence has been in alerting the community to the need for coordinated volunteer activities. Over the years a great number of women (over 200) have been involved in: (1) a clothing room (used clothing donated for use by those who need them); (2) personal shopping service to three nursing homes; (3) library service for nursing home residents; (4) friendly visitors; and (5) handicapped class once a week.

Other activities and services that came from the center's efforts are the hospital guild; Madison County Title VII Nutrition program; a car that provides transportation for people over 60 within the city limits of Winterset; the Madison County Title III Transportation System; a HUD block grant to build a kitchen at the center so that the congregate (Title VII Nutrition) meals could be prepared on site in Winterset; 51 homes weatherized (attic insulation, caulking of windows and cracks, storms and screens put on); a summer recreation (1976) program for youngsters from low-income families, ages 8 through 13—50 enrolled; approximately 400 homes reached with direct (one-to-one) information on SSI; property tax relief; rent reimbursement; countywide transportation; nutrition meals (since September 1975); and a kitchen.

As the months and years fly past, it is our hope and aim to continue to serve the people in need in our county to the best of our abilities and to continue to

[1] See also appendix 1, item 2, p. 43.

seek and enlist the help of whatever agency or individual that is needed to provide this service.

The real challenge for community centers is to be foresighted enough to recognize the changing needs of the community and be prepared to meet these needs.

Senator CLARK. I would like, Dr. Fickel, to call on Congressman Harkin. I know he has office hours downtown starting about 10 minutes ago.

Representative HARKIN. That is right.

Senator CLARK. We will take your statement now, then we are going to have Dr. Fickel's, and we will be closing.

Go right ahead.

STATEMENT OF HON. THOMAS R. HARKIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Representative HARKIN. Thank you very much, Senator Clark.

Dr. Fickel, I appreciate your indulgence.

I had previously scheduled office hours in a mobile office starting at 11:30. I am a little late.

I deeply appreciate the opportunity to be here. I am no stranger to this place, as you all know. I was just invited to stay for lunch, but I guess I am going to have to miss it.

Senator CLARK. I will eat for both of us.

Representative HARKIN. I appreciate your coming out here and having these hearings. It seems that whenever Congress holds hearings on anything about rural affairs, especially on the elderly, they usually do it in Washington, D.C., where people can't get to the hearings. So I think we ought to be thankful to Senator Clark for bringing his committee out here to where the problems really are. If there is one thing that I discovered in just a year and a half in Congress, it is that you know the answers are not in Washington—the answers are out here where the problems are. So by bringing the committee out here for the hearings, I think they will gain a very good insight into where the problems are that the rural elderly face.

Rural America in the past few years is becoming less visible in terms of priority in our Federal programs. This is so because, let's face it, those of us who represent rural areas are becoming fewer and fewer in Congress. The district that I represent is one of the most rural in America. Out of 435 congressional districts, this is the eighth most rural.

Now if I had been elected to Congress about 25 years ago, there would have been about 125 Members of Congress from areas about like this. Now there are only about 25 of us. As rural America becomes less and less visible in terms of the Federal Government, the elderly who are becoming less visible all around the country have become even less visible in the rural areas.

RURAL ELDERLY SUFFER MORE

As bad as things have been for the elderly in the cities, their problems have doubled and quadrupled in the rural areas because of the low visibility. These older persons become isolated. The poor health standards in the rural areas are something that has recently come to our attention in Washington. Also, problems with housing, and especially transportation.

Recently I just read in the *Congressional Record* the "Bicentennial Charter for Older Americans" prepared by the Federal Council on Aging. I don't know if anyone brought it up here yet to see, but it outlines a "bill of rights" for the elderly in our society which I think ought to be adopted by our Government:

(1) The right to freedom, independence, and the free exercise of individual initiative;

(2) The right to an income in retirement which would provide an adequate standard of living;

(3) The right to an opportunity for employment, free from discriminatory practices because of age;

(4) The right to an opportunity to participate in the widest range of meaningful civic, educational, recreational, and cultural activities;

(5) The right to suitable housing;

(6) The right to the best level of physical and mental health services needed;

(7) The right to ready access to effective social services;

(8) The right to appropriate institutional care when required; and

(9) The right to a life and death with dignity.

While all older Americans have had many of these basic human rights denied to them, those living in rural areas have suffered most of all. For example, in 1973, the Department of Health, Education, and Welfare spent only $7 million out of $175 million on health services delivery in rural areas, although statistics show that approximately 140 rural counties in the Nation do not have a physician and that they have very limited auxiliary health services. In the Congress we have passed legislation designed to encourage health service professionals to practice in rural areas. But it is just a step, and there is much more that needs to be done.

We do have some of the minivans now. They have been very good but, as we all know, there is not enough of them and they only service a very small fraction of the people that really need them. The Labor-HEW appropriations bill which Congress has enacted provides more funding for senior citizens and more than requested by the administration. Title III of the Older Americans Act has been increased quite a bit. The nutrition program, which provides for the congregate meals, has also been increased. One provision that I was especially pleased to see finally get funded was title V, the multipurpose senior citizens program, which has not before been funded. I suppose we have just touched on this.

Senator CLARK. This kind of center.

MUCH REMAINS TO BE DONE

Representative HARKIN. Yes. This now is being funded for the first time. Again, while we have made some progress, there is a lot more to be done. I believe that I am well represented on the Committees on Aging by Senator Clark from the Senate and Congressman Blouin from the Second District in the House of Representatives.

I am sure that it comes as no surprise to all of you here that Florida has, as I understand it, the most percentage of its people who are elderly, and second to Florida is Iowa. So I think it is very mandatory that we have someone on the Committees on Aging like Senator Clark and Mike Blouin.

Let me just wrap up by talking about money. We are all concerned about inflation. We are all concerned about the fact that those of you who are on fixed incomes see a real decline in your purchasing power because of inflation. We want it stopped, and we are trying to do everything we can to bring our Government spending under control. I hope that we can bring our budget into balance in the next few years and bring our inflation down to a reasonable level of maybe 1, 2, or 3 percent per year, but that means we are going to have to change some priorities.

You know we only have so much money and we are going to have to decide where that money is going to be spent and how it is going to be spent—that is where we need your input. No longer can we continue to go to the Federal Government to fund this and fund that, no matter how well-meaning a program may sound. So we have got to decide on our priorities.

Just let me mention one thing. The House of Representatives this year lost by 17 votes—17 votes—in an effort to stop funding for the B–1 bomber. Let me just tell you what that B–1 bomber is going to cost. I was a pilot; I flew for 8 years in the Navy, and my brother was an Air Force pilot. I can tell you the B–1 bomber is the biggest boondoggle that has ever been foisted upon us. To build a fleet of B–1 bombers and service them over a lifespan of about 20 years is going to cost this country somewhere in the neighborhood of $60 billion.

Now I just see here from the memorandum from your committee, Dick, that the Senate just approved $480 million for the Older Americans Act for the entire United States. Let's just round it out and say that is $500 million. For the cost of the B–1 bomber, we could fund the Older Americans Act at its present level—actually a little more than its present level—for 120 years. Now you tell me where your priorities are. I know where mine are, and they are with the Older Americans Act.

Thank you very much.

Senator CLARK. Thank you very much, Tom. [Applause.]

Representative HARKIN. I just want to say, again, thank you. I have to go to my office hours.

Senator CLARK. We are going to hear now from Dr. Fickel who, I think, is in a position to talk with you about a program in Red Oak that has been one of the most successful and one of the most exciting programs in terms of rural health care in America, and certainly leading the way in showing the rest of the country how this kind of program can work. So we are very, very pleased, Dr. Fickel, that you are here to talk with us about your program. Please proceed in any way you think appropriate.

STATEMENT OF DR. JACK FICKEL, MEDICAL DIRECTOR, FAMILY CARE CENTER, RED OAK, IOWA

Dr. FICKEL. Thank you, Senator Clark.

I think I will read this in the interest of brevity because I tend to wander if I speak extemporaneously. I tend to get off on another subject.

I would like first to thank you for this opportunity to present testimony to your committee. Any serious effort to consider problems of the rural elderly must, early on, deal with their health and the health care delivery system available to them.

In this brief presentation I will not attempt to define the specific health problem of the aged. It is well documented, however, that the elderly do have an incidence of chronic illness, debilitating disease, and other medical conditions requiring nursing, medical, and paramedical care which exceeds that of the general population.

Compounding the problems of the rural elderly is their decreased and decreasing access to health care facilities and personnel. They share poverty with their urban counterparts, although at a significantly higher rate. In Iowa 11.6 percent of the State's total population had an income less than the poverty level of 1969; of those over age 65, 29 percent had an income less than the poverty level. Of the urban elderly, 30.9 percent were below the income poverty level while the rural elderly, who did not derive the majority of their income from farming, had a staggering 40.6 percent. Four out of ten rural elderly were below the poverty level.

Iowa's system of indigent care at the university hospitals in Iowa City and the advent of medicare and medicaid has measurably eased the barrier poverty imposed on access to health care in those services covered by these programs. One serious problem for the elderly in their utilization of the medicare programs is the paper storm with which they are deluged by the computers after a claim is filed.

Keep in mind that many of these recipients have loss of vision, often are somewhat confused, live alone, and are totally unaccustomed to business forms and computer correspondence. Further most really do not comprehend the concept of usual and customary fees, the ever-changing level of deductibles and percentage payment of allowable charges and the variability in the percentage of payment for similar services when provided as a hospital inpatient, outpatient, or in the doctor's office.

With this in mind, then, imagine the confusion created in the mind of the poor recipients when they receive a form which gives them the detailed results of these policies, regulations, and calculations. The fact that all of the forms have the words "This is not a bill" printed in large letters is little comfort when the reader has no idea just what in the world it actually is. This problem has turned off elderly from applying for benefits under medicare; it also has caused them confusion and they have thrown away checks for the benefits. Simpler forms with less detail would aid the patients. More detailed information could always be obtained for those interested in obtaining it.

Lack of Accessibility to Health Care

The greatest problem facing health care in the rural elderly is their lack of physical accessibility to the health care delivery system. In larger urban centers, hospital outpatient facilities, public health departments, increased physician-patient ratio, and the availability of public transportation greatly facilitates the patient's entry into the system.

In rural areas, however, there is little or no public transit. Farms and small towns are remote from physicians and hospitals. Public health services in rural counties often consist of only one nurse in the entire county, and some counties have none at all. In several rural counties with a public health nurse the supervisors have been quoted as saying that they will have public health nurses in their counties

only so long as they have Federal funds to pay for them. Public health programs in the rural Midwest, if left to local government initiative and funding, will remain inadequate at best and too often will be nonexistent.

Despite efforts by the University of Iowa College of Medicine to retain primary care physicians in Iowa, the supply of doctors in rural areas continues to fall. The proportion of elderly physicians in rural counties sometimes exceeds the percentage of elderly in the country's general population. This affects both the availability and the quality of care.

In Red Oak we have initiated a program which we believe will reverse the worsening of the physician-patient ratio, improve the quality and availability of rural health care, initiate community health programs, teach medical students and family practice residents in a rural setting, and provide a model replicable in other communities who desire to achieve the same goals in their areas.

Ours is a private practice assisted by community effort and aided in the teaching and model aspects of the program by funds from the Kellogg Foundation. Two of us in private, solo general practices joined in establishing a group family practice. We adopted problem oriented medical records and relocated in a new medical office building adjacent to the local hospital. We established a satellite office in Malvern with a population of 1,200 20 miles away. We employed a family nurse practitioner who worked both in the central office and the satellite. The community actively recruited board certified family practitioners to join our group.

Within 1 year we had employed three such physicians. Red Oak had been unsuccessful in attracting any new young family practitioners since I came there in 1953. One of the new doctors joined us in July 1975 and the other two in July 1976. Our family nurse practitioner has since retired from practice for personal reasons and we are actively recruiting another physician extender at the present time. While she was in our employment we were dismayed to find that the Federal Government was imposing a major obstacle to the use of physician extenders.

Reimbursement Disallowed

Medicare refused to allow reimbursement for physician extenders' services provided in the absence of direct supervision—that is, the physical presence—of the employing physician. This makes it impossible to utilize either a physician's assistant or a nurse practitioner in an efficient and meaningful way to improve the availability of health care in rural areas.

Senator, I am aware of your efforts to direct this problem, at least in relation to the family nurse practitioner. Iowa's medicaid-medicare carrier has successfully induced HEW to include at least some of the 40 or so physician extenders employed in the State in a Social Security Administration contract study with the University of Southern California. When approved those physicians employing the physician extenders as part of the experimental study program may be reimbursed. Approval has been extremely slow and, as of my latest information, none were yet receiving reimbursement unless it was stated that the physician was present at the time of service. If the Federal

Government is truly interested in finding ways to improve the availability of quality health care in rural America, reimbursement should be available when State license and practice standards are met.

Although our program in Red Oak is in its infancy, we are encouraged by its acceptance in the community. Our successes and failures will serve as guideposts to other communities in their efforts to provide better health care. Evaluation studies are being developed to measure the impact it has on the health and well-being of the citizens it serves. Because of the age distribution of our area's population, a significant percentage of them will be among the rural elderly.

Senator CLARK. Thank you very much. I know that this program that you are developing there has been a particularly enlightening one and we enjoyed hearing about it. If you have any additional information, details, or material that ought to be made a part of the record about the center, we would be very, very pleased to have those as well.

Dr. FICKEL. I would appreciate the opportunity to submit a written report [1] in the next few weeks, Senator.

Senator CLARK. Good.

What can be done, Dr. Fickel, to promote the physician-extender concept around the State? Should the Federal or the State help? Could they be of some help by giving training, or is that not practical? In other words, what can be done to extend or to encourage physician extenders to go to the very rural areas? Are there any circuit-riding programs, or the like? Do you have any ideas about what might be done?

RESULTS MUST BE DEMONSTRATED

Dr. FICKEL. I think that to demonstrate that it works is probably the greatest tonic. As you know, six Iowa nurses went through a program at the University of North Dakota. I was preceptor for one of them. They have come back to Iowa to practice in the employment of physicians here. In Iowa, under State law, any physician extender must be employed by a physician, which I think is quite proper to provide quality health care. But proving that these will work and that they can provide service without sacrificing quality, I really think is the answer. Then we are going to have a need for funds in training large numbers of them, because I think there is a definite need and we believe that it is a very sound concept.

Senator CLARK. Thank you very much.

I notice that the hour of 12 o'clock has arrived and I know that they want to use this room to serve lunch. Thank you very much for coming and I particularly thank the witnesses that have testified. I am very pleased to have George Orr here who is the new executive director of the Iowa Commission on Aging. I thought we got a good bit of information from the panels that was very valuable to the committee.

I thought in particular the testimony in the first panel, the two ladies that talked about transportation—talked about some other problems, too, but particularly transportation—was helpful, as well as Mr. Willis Sprunger who spoke particularly about the Plaza—the housing area—and what that has meant to people who live there. Mr. Goeldner spoke about the very excellent example that we see in Earlham where they started, I guess, about 12 or 14 years ago to really

[1] Not received at time of publication.

begin to work in homes with homemaking, home health care nursing visits, transportation, meals-on-wheels—or I should say congregate meals in this case—all of the programs that they were able to develop in this kind of rural community.

We also, of course, were very pleased to have Woody Morris here who knows so very much about these programs and hear his point, particularly about the necessity for these Federal programs to deal with accessibility—not just the fact that we have got the programs, but whether or not anybody can get to them or whether they can get to the people one way or the other.

Then, also, this last panel. I particularly enjoyed Mr. Pals' talk about what you can do with a small amount of money in terms of the winterization program—the number of homes—300 some, I think you said—you were really able to help with a fairly small amount of money. Then Mrs. Forsyth, whom you have just heard, and the things that they have done here in the development, not only of a multipurpose center for so many things, but now also the development of this kitchen so that meals can be prepared right here. We also appreciate your testimony as well, Dr. Fickel. It has been very valuable to us.

We are going to go on over and hold hearings this afternoon in Ottumwa starting about 1:30 or 2 o'clock. So we are going to continue to hear various views. I think we are hearing that the major problem still seems to be lack of funds; that is to say, financial. I am speaking about an individual having enough money. The figures that you gave, and particularly Dr. Fickel, show that about 40 percent of the rural elderly are living below the level of poverty, and that is a distinguishing figure.

I think the accessibility of medical care which Dr. Fickel talked about still is obviously a problem in rural areas. We have seen the success of nutrition programs—the kind of program that we are going to take advantage of here, if I quit talking—and transportation which seems to mean so very much in rural areas, the housing, and the community center. We have started on all these things and they are very, very important, but we have got a long way to go.

Thank you very much for coming.

[Whereupon, at 12:12 p.m., the hearing was recessed.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. MAGAZINE ARTICLE AND BROCHURE SUBMITTED BY L. R. GOELDNER[1]

[From *Aging*, U.S. Department of Health, Education, and Welfare publication, dated November 1963]

A SMALL TOWN ORGANIZES BASIC SERVICES FOR ITS AGING

Earlham, Iowa, 30 miles west of Des Moines, is a farming community with a small central business district surrounded by pleasant homes in wide lawns. Earlham boasts a bank, one restaurant, an automobile dealer, a clinic, a school with a fine new addition, a weekly newspaper, and a farmers cooperative. The farmland around the town is rich and productive, except where the farms have been displaced by three gravel quarries.

Earlham is a pleasant place to live, and the people of Earlham are forward-looking and interested in improving their community. But Earlham is a small town. Only 800 people live there, only 2,000 in the entire school district, and 15 to 17 percent of these people are elderly. As in rural communities across the Nation, the percentage of the older population is higher than in most cities.

Many small American communities have thought of doing something for their older people, but most of them have felt too small or too poor. But Earlham went ahead with its plans and, in doing so, it made itself a model for community action.

As *Aging* goes to press, the Earlham Care program, initiated July 1, 1963, has already started the following activities: (1) Homemaker service; (2) Handyman service; (3) Activity center; (4) Counseling service; (5) Transportation within the community; and (6) Meals-on-wheels.

Care is planning to start friendly visiting and a telephone service this fall, and it has a visiting nurse available.

FIRST STEPS IN COMMUNITY ACTION

A group of Earlham citizens, calling themselves the Earlham Community Development Committee, started meeting informally to discuss the town's future. Earlham, they felt strongly, was a good place to live and they could build on this asset by making it an even better place. Among the things mentioned were greater services for the older people in the community.

In the spring of 1962, two members of the committee contacted the town's ministerial association with the request that the ministers secure the backing of the nine churches in town for a nursing home project. By fall, the association had decided on a thorough investigation and appointed a committee of three ministers to make a study of nursing homes and to report with definite recommendations.

By the end of 1962, the three ministers were almost ready to make their report and to recommend that funds be raised for a 25-bed, nonprofit nursing home. But, at that point, they contacted the State Department of Welfare in Des Moines. There they received suggestions on other services which might be of benefit to the elderly, and they were urged to talk to Amelia Wahl, Kansas City Regional Representative on Aging for the U.S. Office of Aging.

[1] See statement, p. 7.

DEFINITION OF NEEDS

In early January 1963, Miss Wahl and Mrs. Virgie Love of the Madison County Welfare Department met with members of the development committee and the ministerial association. At this meeting, they discussed such basic services as homemaking and home nursing care, and made plans for a survey to learn what services the elderly population needed and wanted.

By March, Earlham had a survey form ready. It asked such questions as: Do you like living in Earlham? Would you participate in an activity center if one were made available? Do you feel a nursing home is needed in Earlham?

Many of the questions were preceded by a statement explaining a particular service, for example: "Some communities provide services to help persons stay in their own homes as long as possible. They have available persons who do part-time meal preparation, grocery shopping, and some housekeeping. These programs are called homemaker services. Do you feel this kind of program is needed in Earlham?"

Thus, the survey not only produced usable information but also began the community education that was necessary before the program would be accepted. The local weekly helped by carrying stories on the survey and its purpose, and it was the weekly that called for volunteers to conduct the survey.

On March 28, the 41 people who had volunteered to act as interviewers met at the Methodist Church for a short training session conducted by Miss Wahl. During the following week, 331 people in the district who were 60 years of age or older were interviewed and their responses recorded.

APPLICATION FOR GRANT

Earlham now had the information it needed to develop a realistic program for its older people. The idea of eventually building a nursing home in the town was not abandoned, but the concept had changed slightly. When the nursing home is built, it will probably be in conjunction with the Earlham Activity Center and, possibly, with housing for senior citizens.

With the data from the survey and the help of people at the State and regional level, a proposal was developed for an Earlham home care program and submitted to the Iowa State Department of Health. The proposal included a statement of objectives, a description of the way the program will be administered, the resources available, and the services proposed. The proposal stated that the "program was being set up on a demonstration basis for an anticipated 5 years dependent upon the availability of funds to support it." It also mentions the plans for a nursing and custodial facility which will become the headquarters for both the home care program and the activity center.

Fortunately for Earlham, not all of the State formula grant funds had been committed in Iowa. These funds are allotted to all States by the Division of Chronic Diseases of the Public Health Service, U.S. Department of Health, Education, and Welfare, to be used for just such local programs. A sum of $21,000 from the Iowa funds was approved for the Earlham program.

EARLHAM CARE PROGRAM

Shortly after Earlham was notified that the proposal had been approved at the State level, the Earlham care program was incorporated and a program director was elected by the board of four officers and five members. Final approval of the project by the regional office of the Public Health Service in Kansas City was received on July 1 and the program started to operate in a temporary office next to the bank. By the time the permanent office and the community activity center were ready for occupancy, several services were already in existence.

In late August, a short institute was held to train future homemakers for the program, with speakers from the Polk County Home Care-Homemakers Service, the Des Moines Health Center, the Iowa State Department of Health, the Public Health Nursing Association, and the Iowa Heart Association. Six housewives had volunteered to do this work and three were employed almost immediately.

The elderly people using the homemakers services are billed by the care program which, in turn, pays the homemakers. The program operates as a clearinghouse, receiving requests and referring them to qualified people.

A handyman service, operated on the same basis, has proved very popular. Although one handyman is available—and two boys who mow lawns—the Care office has received so many requests it could use another man. The handyman replaces lightbulbs, makes small repairs, and is available to put up storm windows before winter comes.

One of the members of the Care board is a graduate nurse, and she is on call to visit the homes of elderly invalids.

Arrangements have been made with the local retirement home to provide meals-on-wheels.

The Care office has already been helpful in counseling elderly people on financial problems, and it also serves as an employment service, recciving requests for part-time help and helping those who desire jobs to find employment.

Earlham is off the regular route for buses going into Des Moines and efforts are being made to remedy this situation. In the meantime, an arrangement has been made with an elderly retired man, who owns a car, to furnish transportation within the town.

On Sunday, September 15, Care held an open house at the new office and activity center. A total of 135 attended the function and many others dropped in during the following week. The center will provide space for parties, programs, and table games.

A shuffleboard court has been constructed across the street, and many of the elderly men of Earlham are busy each day from 9 to 12 and from 2 to 5 playing shuffleboard, with time out in the middle of the day for lunch and a rest.

FUTURE PLANS

The future of the Earlham Care program depends on Earlham. The county welfare department is happy to see such programs as home care, homemakers service, and meals-on-wheels underway in the community. It is cheaper to pay fees for these services for recipients of old-age assistance and medical assistance for the aged, than it is to pay for nursing home services. Sooner or later Earlham may also initiate foster home care.

This fall, again with the help of the ministers, the Care program will begin a friendly visiting program. Plans are also being made for a telephone service or some other communication system for keeping in touch with those among the elderly who are ill or unusually frail. Regular contact with these people, especially if they live on isolated farms, can often prevent a tragedy. When there is no answer to a regular call, someone will investigate at once.

MODEL FOR OTHERS

Any demonstration project is designed to show how something will work. The Earlham Care program had already demonstrated one thing even before it started operating on July 1—the importance of community planning and the steps to be taken in introducing such a program. On a small scale, Earlham's program is a model for community planning.

Earlham's effort can make other communities realize that they, too, can do more than they have, that they have available resources of their own, as well as resources at the State and even Federal level, which are still untapped. But other communities may not be so fortunate as to find that, at almost the end of the fiscal year, the State department still has uncommitted funds. People in these communities should start working now toward their goals and contact their State health department as soon as they have an understanding of their needs and a plan for meeting them.

Furthermore, in many States, welfare departments may also, under the 1962 public welfare amendments to the Social Security Act, obtain demonstration funds for local programs.

For information on how these funds may be used, write to your State health or welfare departments or to your State commission on aging. For further information on the Earlham Care program, write to John R. Carson, program director, Earlham, Iowa.

[1966 brochure]

EARLHAM HOME CARE PROGRAM

(A pilot project for Earlham and Dexter communities)

What is the Care Program?

The Care program is a concerted effort of the community to extend a helping hand to the aged and chronically ill residing within Earlham, Dexter, and the surrounding communities.

Existing Services:

1. Homemaker service.
2. Visiting nurse service.
3. Handyman service.
4. Transportational system.
5. Friendly visitation and telephone visitation.
6. Meals-on-wheels.
7. Employment and counseling service.
8. Intercommunication system.
9. Community center.

Who Are the Homemakers?

Each homemaker is a mature, competent woman, carefully chosen for good health, dependability, and homemaking ability. She has had a professional training course.

Responsibilities of a Homemaker:

Homemakers shall assist the family in maintaining a cheerful, relaxed home environment enabling them to live in their own homes as long as possible.

The homemaker will perform household tasks such as light routine cleaning, preparing meals, caring for patients, marketing, and other similar tasks.

Visiting Nurse Service:

A visiting registered nurse acting under the supervision of one's own physician will make home calls as prescribed by their doctor.

Handyman Service:

Handymen put on storms, screens, rake or mow yards, etc. Fee based on type of work and time involved. This has proved to be of invaluable assistance for people within the community.

Transportation Service:

Transportation in town is 25¢ one way or 7¢ a mile out of town.

Friendly Visitation and Telephone Visitation:

This volunteer service by individuals or church groups within the communities helps shut-ins realize someone cares.

Meals-on-Wheels:

Balanced and/or special diets are available through meals-on-wheels.

Employment and Counseling Service:

As a courtesy service to the community, the office assists employers secure personnel, and job-seekers to find employment.

The office is happy to assist in counseling such subjects as insurance, social security, financing, etc. Your problems are confidential to this office.

Intercommunication Service:

An intercommunication system is available upon request.

Community Center:

Citizens are invited to visit and enjoy the facilities available in the community center located within the main office building. Please feel free to enjoy its comforts.

Requests for Service and Who Pays?

Earlham is proud to welcome the Dexter community in their program effective April 1, 1966.

Home care services are available to all senior citizens and the chronically ill.

Earlham, Dexter, and their communities may request services through their physicians, nurses, social and health agencies, and individuals by personal contact or by dialing 4341, Earlham, Iowa, or after office hours, 4711 or 2471.

All personnel are paid by the care office. No money is to be exchanged between the personnel and the patient.

All financial arrangements are made prior to commencement of services. If funds are not available, efforts to obtain assistance will be made by the office.

All charges are billed to the responsible parties monthly. All payments are to be made to the care office.

Hours Available:

Except for emergency situations, when special rules will apply, the general homemaker services will be available 5 days a week, 10 hours a day, Monday through Friday. Part time services are also available.

ITEM 2. ADDITIONAL INFORMATION SUBMITTED BY LOUISE FORSYTH[1]

WELCOME TO WINTERSET

(From the staff of the Multipurpose Center, 114 North 2d Street, Winterset, Iowa)

Through the courtesy of the Welcome Wagon, we would like to tell you about some of our activities and invite you to enjoy them with us.

We have activities for most age groups and hope to get more going soon. Most of our activities are for the senior citizens—those over 60.

To give you an idea of what we are all about, here is a list of things going on at the center regularly:

The ceramics class meets on Tuesday afternoon at 1:30 p.m. (The regular ceramics class is limited to those over 60. There are a few that are interested in cold ceramics and we have a gal in town who is willing to give some instruction. This group will be open to all ages.)

The kitchen band is one of our most active projects. It is under the direction of Gertrude Shoemaker. They practice at the center and entertain at the nursing homes, at the covered bridge festival every fall, and anywhere else they are invited to entertain as long as it is within a reasonable distance.

On the second and fourth Tuesdays of each month, the social security representative is at the center from 9 a.m. until noon.

Wednesday: A representative from the Care office at Earlham, Iowa, is here at the center from 9 a.m. until 12 noon. Care provides homemaker/home health aides for the aged and infirm in their own homes; the acute and chronically ill, the disabled and lonely, children, and entire families at times of illness in the home. This service is available countrywide.

On Wednesday afternoon the class for the handicapped meets at 1:30 p.m. Mrs. Pearl Flint is in charge of the planning end of this class and oversees the volunteers in executing the program. She is always in need of people to volunteer their help with this activity—one of becoming involved and acquainted in a new community.

Thursday: The needlecraft class meets at 1:30 p.m. Our teacher, Mrs. Peggy Taylor, can teach you a new skill or help with an individual problem.

Friday: On the first and third Friday afternoons of each month the Young-in-Heart Card Club meets to play pitch. Anyone over 60 that enjoys playing cards is welcome to come and join the fun.

On the second Friday of each month the Golden Years Club meet for a potluck meal and a program. In the winter, they meet at 12:30 p.m.; during the rest of the year, they meet in the evening.

On the fourth Monday of each month the Sixty-Plus Club meets at 1:30 p.m. for an afternoon program, bingo, and refreshments under the direction of Mrs. George Montross and Beulah Mundell.

On Monday evening and Tuesday evening from 4 to 5 p.m. we are having a needlework and craft class for fifth and sixth graders. They will be learning to knit and crochet first and other skills and crafts later as time goes on. These classes going on now have mostly girls enrolled but we will be setting up some classes for boys if there is enough interest.

Other services originating from the center are the shopping carts and bookmobile to the nursing homes. Every Tuesday and Friday mornings the clothing room is open. There is a variety of good, usable clothing available just for coming in. We also appreciate donations of good, used clothing.

We provide an information and referral service to the community as far as our knowledge and time will allow.

The staff at the center would like to again say "Welcome to Winterset." We will be happy to assist you in solving any problems that come within our area of service and invite you to come in and take part in any of our activities that interest you.

HERB FLINT,
Director.
LOUISE FORSYTH,
Assistant Director.
BEULAH MUNDELL,
Outreach Worker.

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[1] See statement, p. 27.

NUTRITION MEALS FOR THE ELDERLY

A nutrition program for persons 60 years of age and older, and their spouse, started in Madison County, Iowa, in November, 1973. A good, hot, nutritious meal is provided at the multipurpose center in Winterset at 11:30 a.m. Monday through Friday. Cost of the meal is on a sliding scale—pay what the meal is worth to you. Reservations should be made in advance, either with Esta Bishop (462-1620) or the multipurpose center (462-4704).

Here is a sample of some of the menus served recently:

Creamed chicken on biscuits, mashed potatoes, buttered corn, cole slaw, and peaches.

Fish with tartar sauce, mashed potatoes and gravy, buttered peas, lettuce salad, and vanilla pudding.

Minishrimp, mashed potatoes and gravy, buttered peas, bean salad, and fruit cocktail.

Coffee, milk, and juice and bread and butter are served with each meal.

The meal is served by the site coordinator, Esta Bishop, and at least two volunteer helpers here at the center. Come and enjoy a good meal and companionship. Make new friends.

For further information, contact Terese Brittain, project director, at the multipurpose center (462-4704).

Madison County, Iowa, has a total population of 11,558. Out of this number we have the largest percentage of people over 60 of any county in the State.

There are 2,631 persons aged 60 and over in the county; 1,329 of these people have incomes below the poverty level.

If we stay in existence, we hope to take some kind of count right here in Winterset to determine approximately how many people living here are over 60 years of age.

The following is a partial copy of facts taken from our quarterly report to Matura for the months from December 1, 1973 through January 31, 1974:

Volunteers (number of people and total hours worked):

Nutrition program—18 women working a total of 445½ hours (this is not counting the women and hours worked from the other sites in the county serving nutrition meals (Earlham, Truro, and St. Charles).

	People	*Hours*
Shopping carts to nursing homes	29	260
Clothing Room (2 mornings a week)	18	272
Bookmobile	10	32
Kitchen band	27	432
60 Plus Club	44	176
Golden Years Club	18	54
Young-in-Heart Card Club	24	24
"500" Card Club	6	6
Friendly Visitor	1	36

Nutrition meals (average attendance per week) 68.3

Other projects and meetings and estimated attendance:

GED—80 people have gotten diplomas in the past 4 years.

Needlecraft Classes (12 meetings) average attendance 6.

Sign Language Class (8 meetings) average attendance 17.

Ceramics Class (7 meetings) average attendance 6.

Estimated number of people attending other meetings such as Boy Scouts and Cub Scouts, Hospital Guild, card clubs, etc., 309.

Total number using some facility of the center or attending a meeting here—1,363.

Total number of volunteers in all programs	219
Total number of volunteer hours	1,923

113 different families or individuals visited the clothing room—some more than once for a total of 246 visits in the three month period. Each of these times those people came in they found some item or items of clothing that they could use. All the clothing is donated.

Madison County title III transportation costs from February 3, 1975 through August 31, 1975, and other interesting data. Number of people served during this period:

18 Madison County handicapped.

15 Polk County handicapped—residing at Horton's Custodial Home or a foster home in Winterset.

1 Wapello County handicapped—residing at Horton's Custodial or a foster home in Winterset.
3 Dallas County handicapped—residing at Horton's Custodial or a foster home in Winterset.
167 other individuals.

Total number of miles driven from February 3 to August 31, 1975, is 12,830. The van is averaging 10 miles per gallon of gas.

ACTIVITIES BY AND FOR THE AGING THROUGH THE MULTIPURPOSE CENTER IN WINTERSET, IOWA

(1) Sixty-Plus Club—average attendance 120.
(2) Golden Years Club—average attendance 50.
(3) "Young-in-Heart" Card Party—average attendance 30.
(4) "500" Card Club—average attendance 12 to 15.
(5) Truro "Guys & Gals" Club—average attendance 25.
(6) St. Charles Seniors—average attendance 25.

AARP meets at the center once a month (has a membership of over 125 Madison County people). Center director assisted with organizing group and occasionally assists with programs.

(7) Earlham Care Homemaker Service: A representative is at the center every Wednesday morning and they hold their training classes at the center.
(8) Earlham Sixty-Plus Club: We work with this group.
(9) Ceramics classes and workshop (the kiln is owned by the center).
(10) Needlecraft of all types.
(11) Employment Service: The ISES representative is no longer here every week but we make referrals when we can and received job lists from the ISES office in Des Moines.
(12) Rockhound Club: No longer meets at the center but they began under the center's wings.
(13) Clothing room is maintained at the center and staffed by volunteers two mornings a week. (The volunteers are recruited and schedules made up by Betty Berry, outreach worker for the center.)
(14) Shopping cart to nursing homes.
(15) Bookmobile cart in nursing homes. (Items 14 and 15 are also staffed by volunteers recruited and scheduled by Mrs. Berry.)
(16) Big print songbooks.
(17) Big print Scriptures.
(18) Talking book machines.
(19) Big print books.
(20) Monumental park project.
(21) Senior citizens festival.
(22) Toys-for-tots.
(23) Friendly visitors.
(24) Antique show at covered bridge festival.
(25) Antique sale at covered bridge festival.
(26) Hobby show at covered bridge festival.
(27) The center is open for use as a comfort station both days of the covered bridge festival—coffee and cookies are on tap and interesting wood carvings are on exhibit.
(28) Trips to points of interest—art center, science center, Perry Conservation Park, Red Rock Dam, State fair every year, hobo day at Britt, Iowa, and many more.
(29) Programs and demonstrations on clothing and food for the elderly.
(30) Bread project—this project was discontinued with the closing of the Goode Bakery but is worthy of note. Mr. Goode bakes small loaves of bread—just the right size for a person alone.
(31) Campaigned for low-rent housing for the elderly—successfully. We now have 43 units operating as North Ward Plaza.
(32) Programs for and in nursing homes.
(33) Golden voice choir.
(34) Kitchen band (men and women) average two performances a month (25–30 senior citizens—most of whom are past 70 years). Hillbilly Band. All senior citizens.
(35) Attempted to cooperate with every agency, both governmental and voluntary, that can aid the elderly of our county.

(36) Meals-on-wheels—meals are prepared by the hospital and delivered by volunteers coordinated by Mrs. Lee (Peggy) Taylor.
(37) Nutrition meals (title VII)—these are meals served each weekday at the center. Anyone over 60 may participate, regardless of income.
(38) Classes in sign language and lip reading—have had three classes (all ages included).
(39) Transportation—we are working with CIRALG and any other agencies available to see what we can accomplish.
(40) Entries in arts festival.
(41) High school equivalancy classes—we have had 6 classes with 20 per class. Also one basic education class where four people completed the course that could not read or write.
(42) Class of handicapped people (from Horton's Custodial Home and others in the county).
(43) Young mothers group.
(44) Boy Scout Troop No. 114. Cub Scout Pack No. 114 meet at the center at this time. When there was a Webelos Pack, it met here.
(45) Lending library (mainly paperbacks)—extensively used.
(46) Administered the N.Y.C. program, Head Start, and GYOP and summer recreation program for 8 to 12 year olds.
(47) Helped dropouts.
(48) Started (helped) hospital guild—they still have an occasional meeting and their bazaar here.
(49) Representative from WINN is here every week.
(50) Recruiters for the Army and Air Force are here every week.
(51) Polling place.
(52) Groups who meet regularly at the center:
(a) M.C.A.R.C.
(b) Red Cross.
(c) American Cancer Society.
(d) N.F.O.
(e) Farm Bureau ladies' guest day.
(f) Health planning council.
(g) Girls softball meeting.
(h) Republican caucuses and meetings.
(i) Democrat caucuses and meetings.
(j) Goodwill pickup station.
(k) Classes for knitting and crocheting (for fifth and sixth graders).
(l) Showers, receptions, reunions, parties (December is already book-full for reunions and family dinners).

In the future:

(1) To acquaint more of the people living and working in Madison County of the center (for both young and the elderly) and also some of the problems of our area as concerns the elderly/particularly.
(2) Transportation—increased use in the city of Winterset and countywide.
(3) Workshop for the arthritic, elderly, and handicapped in cooperation with the extension office.
(4) Get more things going for the youngsters in the way of crafts, sewing, etc.
The equipment to operate the center and equipment materials effectively is all here: tables, chairs, the public address system (which was designed especially for the building by Fred Kuntz), game tables, and equipment.
Greater involvement by the youth of the community in recognizing and meeting its needs.

SUMMARY OF CAR RECORDS, NOVEMBER 29, 1974, THROUGH DECEMBER 30, 1975

Receipts:	
Donations from clubs, churches, and service organizations	$864.00
Participants (people who ride) donations	852.71
Trash and treasure sales and food sales	196.11
City of Winterset	1,025.00
Total	2,937.82

Expenses:		
Driver		2,225.50
Gas and repairs		541.75
Miscellaneous		25.00
Total expenses		2,792.25
Balance		145.57
Grand total		2,937.82
Unduplicated people that rode in car		140
Unduplicated handicapped people that rode in car		24
Total number of trips (one-way)		2,773
To congregate meals	1,012	(37 percent)
For shopping	280	(10 percent)
Doctor or dentist	111	(4 percent)
Recreation	232	(8 percent)
Center class and challenge center	233	(8 percent)
Other, miscellaneous	259	(9 percent)
Trips of pickup congregate meals	550	(20 percent)
Errands for senior citizens	95	(4 percent)
Trips relating directly to congregate meals		(57 percent)
Miles driven from November 29, 1974, through December 30, 1975 (according to my figures, this is about 53 cents per mile, or about $1 per person)		4,956

This car is a 1968 Bel Air Chevrolet which was purchased in May 29, 1974, to be used to provide support for the nutrition program. Since this car was purchased, it has been driven 9,474 miles. Practically all of them within the city limits of Winterset.

Appendix 2

LETTERS FROM U.S. DEPARTMENTS AND AGENCIES

ITEM 1. LETTER FROM WILLIAM B. PRENDERGAST, ASSISTANT, DIRECTOR FOR CONGRESSIONAL AFFAIRS, ACTION, WASHINGTON, D.C.; TO SENATOR DICK CLARK, DATED JULY 27, 1976

DEAR SENATOR CLARK: Thank you for your June 21, 1976 letter that advised ACTION of the intent of the Senate Special Committee on Aging to conduct field hearings in Iowa, Nebraska, and South Dakota in August. We welcome this opportunity for the committee to see firsthand some of the results of the Older Americans Volunteer Programs and other ACTION programs in the communities where the volunteers serve.

For ease of reference the questions contained in your letter are answered below in the same order as received:

Question (1). What is the official definition of a rural area in your agency?

Answer. ACTION is guided by the definition used by the Bureau of Census, with the result that communities with fewer than 2,500 inhabitants are regarded as rural.

Question (2). Do you agree with the designation—as in Administration on Aging programs—that an "older American" is of age 60 or over?

Answer. In our three older American programs, we accept as volunteers only those aged 60 or over. This standard has been set by Congress in P.L. 93-113, the Domestic Volunteer Service Act, which provides the statutory authorization for these programs. None of these programs has the statutory requirement that the recipients of services be older Americans; however, we try to maintain this as the principal thrust of the Senior Companion Program.

Question (3). How many Foster Grandparent, RSVP and Senior Companion programs are currently operating in each of the three States mentioned above; what are the locations and sponsoring agencies for each; how long has each project been in operation; what is the total volunteer enrollment for each; and what are the current total program obligations of Federal funds provided through ACTION for each project?

Answer. Note: Current Federal funding is for 1-year budget period unless otherwise indicated.

Project sponsor and location	Project beginning date	Volunteers (as of July 1, 1976)	Current Federal funding
IOWA			
FGP:			
Iowa Commission on Aging—Des Moines	June 1972	97	$183,752
Department of Social Services—Glenwood	Feb. 1972	71	152,279
Dubuque Area Project Concern for Elderly and Retired, Inc.	June 1976	32	98,083
Rock Valley Rotary Club	June 1974	50	109,281
City of Fort Dodge	June 1973	47	105,823
Total	do	297	649,218
RSVP:			
Southwest Iowa Learning Resources Center—Red Oak	June 1973	141	13,603
Clinton Senior Citizens, Services, Inc	do	115	16,115
Northeast Iowa Council on Aging—Waterloo	do	338	27,902
Chariton Rotary Club	do	139	15,000
Four County Benevolent Non-Profit Corp.—Belle Plaine.	June 1974	210	15,346
Department of Planning and Development—Burlington	June 1973	164	19,450
Senior Citizens, Inc.—Webster City	do	121	13,926
Story City Senior Citizens, Inc	do	280	21,000
Dubuque Area Project Concern for Elderly	June 1972	431	22,366
Newton "Y" Community Center	June 1973	156	15,215
United Way of Greater Des Moines	June 1972	735	43,862
Hope, Inc.—Fort Dodge	June 1973	175	17,654
Region XII Council of Governments—Carroll	June 1974	118	14,586
Northern Iowa Area Community College—Mason City	do	105	20,189
Ottumwa Area Chamber of Commerce	June 1972	218	15,527
Winneshiek County Crosslines Council—Decorah	June 1974	154	18,000
Total	do	3,600	309,741
Grand total	do	3,897	958,959
NEBRASKA			
FGP:			
Volunteer Action Center—Gering/Scottsbluff	June 1974	55	[1] 202,925
Nebraska Department of Public Institutions—Lincoln/Beatrice.	June 1972	74	[1] 239,986
Eastern Nebraska Human Services Agency—Omaha	June 1976	19	[2] 145,700
Senior Citizens Industries—Grand Island	June 1973	64	124,520
Total		212	713,111
RSVP:			
City of North Platte—North Platte	do	154	16,038
Crawford Cultural Center—Crawford	do	98	14,633
Lincoln/Lancaster County Commission on Aging—Lincoln.	do	300	[3] 15,063
Dawes County Commissioners—Chadron	do	101	16,289
Housing Authority of Falls City	do	160	[4] 19,946
City of Ogallala	June 1974	97	17,290
City of Grand Island	Dec. 1972	166	20,670
Nebraska Indian Inter-Tribal Development Corp.—Winnebago.	June 1973	175	17,576
Good Samaritan Village—Hastings	March 1973	191	19,279
Eastern Nebraska Human Services Agency—Omaha	June 1972	420	43,661
City of Alliance	June 1973	159	13,118
Mayor's Office—Henderson	Dec. 1972	50	8,019
Sheridan County Commissioners—Rushville	June 1974	97	19,256
Total	do	2,168	249,923
Grand total	do	2,380	954,039
SOUTH DAKOTA			
FGP:			
Aberdeen Area Senior Center—Aberdeen	June 1972	50	125,865
Pine Ridge Indian Reservation—Pine Ridge	do	40	99,211
Total		90	225,076
RSVP:			
Brown County Council on Aging—Aberdeen	June 1974	150	26,790
City of Canton—Canton	June 1973	160	17,240
Huron Senior Center—Huron	do	180	17,525
Dakota Wesleyan University—Mitchell	May 1973	180	15,000
City of Rapid City—Rapid City	June 1974	200	22,500
Senior Citizens Services—Sioux Falls	do	180	22,924
N.E.S.D. CAP—Sisseton	June 1973	177	21,004
Spearfish Senior Service Center—Spearfish	do	192	15,000
Meade County Senior Citizens Center—Sturgis	do	150	14,700
Total	do	1,569	172,683
Grand total	do	1,659	397,759

[1] 19 mo. [2] 13 mo. [3] 6 mo. [4] 18 mo.

Question (*4*). Are there any VISTA projects or special volunteer projects serving the rural elderly in each of these three States? If so, can you provide a description of project activities and goals; sponsoring agency and location; number of elderly served; and current total Federal program obligations for each?

Answer. Note: In Fiscal Year 1976, the average Federal cost in direct payment to each VISTA volunteer was $4,470. This figure should be added for each volunteer in addition to the other support costs indicated.

Sponsoring agency and location	Number of elderly served and description of project	Current total Federal program obligations
IOWA		
VISTA:		
Commission on Aging, Des Moines.	4 VISTA's serving 600 rural elderly (with potential to 1,500)—increase awareness programs for the elderly to improve nutrition and health and raise income.	
Voluntary Action Center, Cedar Rapids.	1 VISTA serving 300 rural elderly—food stamp program awareness and Telecare.	$1,200 for volunteer transportation.
Iowa Western Community College, Council Bluffs.	4 VISTA's serving 3,500 rural elderly—identify health needs of senior citizens in 8 counties for health education and related courses.	$2,400 for volunteer transportation.
Mid-Sioux Opportunities, Inc., Remsen.	1 VISTA serving 1,500 rural elderly working with Meals on Wheels; transportation for the elderly and Telecare.	$500 for transportation contract on GSA car.
Volunteer Bureau, Waterloo	1 VISTA serving 30 rural elderly encouraging them to participate more fully in their communities through voluntarism.	$1,410 for volunteer transportation.
Minigrant: Mid-Sioux Opportunities, Inc., Remsen.	Coordinate volunteer opportunities for 15,995 persons over age 60 in 5 counties.	$2,275.
NEBRASKA		
VISTA:		
Center for Rural Affairs, Walthill.	4 VISTA's serving 180 rural elderly—establish Co-op food stores and provide information on agricultural issues.	$6,112 for volunteer transportation.
Nebraska Indian Inter-Tribal Development Corp., Winnebago.	2 VISTA's serving 120 rural elderly providing legal assistance to Indians.	$11,136 for volunteer transportation. $19,686 for volunteer supervision (both for 16 mo).
SOUTH DAKOTA		
VISTA: Northeast South Dakota CAP, Sisseton.	1,300 elderly low income in rural areas in fields of consumer education, health and nutrition, transportation, arts, crafts, referrals.	$3,000 for volunteer supervision and $2,000 for volunteer transportation.

Question (*5*). In addition to the information requested above for the Senior Companion program, can you supply the committee with a description of the volunteer settings and the number of elderly served by each of the Senior Companion programs in these three States?

Answer. As indicated above, there currently are no operating Senior Companion projects in the three States where the initial field hearings are to be held. It is contemplated that one Senior Companion project each will be funded in Iowa and Nebraska in the near future.

Question (*6*). Has your agency been unable to fund any grant applications from these three States for RSVP, Senior Companion, or Foster Grandparent programs during the last two years, and if so, how many?

Answer:

IOWA

Foster grandparents:

Cedar Rapids.

Clinton.

Ottumwa.

Senior Companions: Council Bluffs.

NEBRASKA

RSVP:
Columbus.
Kearney.
Loop City.
Seward.
Foster grandparents:
Kearney.
Loop City.

SOUTH DAKOTA

RSVP: Yankton.
Senior companions: Sioux Falls.

It is hoped that this information will be beneficial to the hearings. Please let us know if we can be of further assistance.

Sincerely,

WILLIAM B. PRENDERGAST.

ITEM 2. LETTER FROM FRANK B. ELLIOTT, ADMINISTRATOR, FARMERS HOME ADMINISTRATION, WASHINGTON, D.C.; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR SENATOR CLARK: This will reply to your letter concerning Federal programs for the elderly. You specifically requested information about the rural housing program of the Farmers Home Administration (FmHA) to be used at the Special Committee on Aging hearings which will be conducted in Iowa, Nebraska, and South Dakota.

We will answer the questions you asked in the order they were presented:

(1) Rural areas. Because of the nature of some of the FmHA programs, we have more than one definition for a rural area. They are as follows:

(*a*) The official designation of a "rural area" as it relates to the rural housing program follows:

> Section 520 of the Housing Act of 1949, as amended, states, "As used in this title, the term 'rural' and 'rural area' mean any open country, or any place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000, and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit, as determined by the Secretary of Agriculture and the Secretary of HUD." Attachment 1* is a copy of the definition of rural areas as it apears in FmHA Instruction 444.1.

(*b*) The official definition of a rural area under the business and industrial loan program is that " 'rural' and 'rural area' may include all territory of a State, the Commonwealth of Puerto and the Virgin Islands, that is not within the outer boundary of any city having a population of 50,000 or more and its immediately adjacent urbanized and urbanizing areas with a population density of more than one hundred persons per square mile, as determined by the Secretary of Agriculture according to the latest decennial census of the United States: *Provided*, that special consideration for such loans and grants shall be given to areas other than cities having a population of more than twenty-five thousand." This definition is also applicable to industrial grants of the community programs.

(*c*) As it relates to community programs, with the exception of "industrial grants" to the terms "rural" and "rural area" shall not include any area in any city or town having a population in excess of 10,000 inhabitants according to the latest decennial census of the United States.

(2) For rural housing loan purposes, we define a senior citizen as an individual who is 62 years of age or older. This is in accordance with the provisions of section 501(b)(3) of title V of the Housing Act of 1949.

(3) Section 504 Rural Housing Repair Loans:

(a) From fiscal year 1965 through fiscal year 1975, we made 309 of these loans in Iowa; 54 in Nebraska and 99 in South Dakota.

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*Retained in committee files.

(b) We do not have cumulative statistics on the number of these loans made to the elderly. Most section 504 rural housing loans, however, are made to elderly persons as an eligible borrower must be a owner-occupant with a very low income. Elderly persons use the loans to repair their homes.

(c) The outreach activities of the agency for the section 504 loan program include group information talks, agency representation at conventions and meetings with interested groups, such as church groups, issuance of information pamphlets, advertising the program through the local media, and publicity by other Federal agencies. The FmHA's delivery system, however, consists of approximately 1,760 county offices located primarily in county seat towns where housing loans are processed. This means that the local representative of the FmHA is located not too far from most rural residents.

(d) Reactivation of the grant portion of the 504 program would definitely make it more accessible to senior citizens. Many of those who would like to repair their homes do not have the resources and cannot afford to repay a housing loan.

(4) From fiscal year 1965 through fiscal year 1975 we made 791,305 section 502 rural housing loans, of which 33,415 were for senior citizens.

(5) Statistics on rental units provided for the elderly by rural rental loans. are only available for fiscal years 1972 through 1975. During that period, 2,675 out of 3,261 units in Iowa, 76 out of 292 units in Nebraska, and 685 out of 1,812 units in South Dakota were made available for senior citizens.

(6) Owner occupied and substandard housing:

(a) Information obtained from the 1970 Census of Housing shows that there are 279,296 owner occupied housing units in the rural area in Iowa, 131,307 units in Nebraska, and 83,655 units in South Dakota.

(b) We have no figures on the number of senior citizens living in substandard homes in Iowa, Nebraska, and South Dakota. The 1970 Census of Housing shows, however, that of the owner-occupied units in these three States, 39,671 homes in Iowa, 19,179 homes in Nebraska, and 22,879 homes in South Dakota lack some or all plumbing facilities.

(c) We have not defined substandard housing in our regulations, however, we consider homes without bath and plumbing facilities and overcrowded dwellings as being substandard. We have established the standards for an adequate but modest home and the requirements are contained in the following publications: HUD Minimum Property Standards (MPS) 4900–SFH; 4910.1 MFH; 4920.1 Care Type Housing, and; 4930.1 Manual of Acceptable Practices. The requirements contained therein, define the minimum level of quality acceptable in each specific condition. This, in addition to the appropriateness of the building site and the neighborhood, other minor considerations, and the acceptability of the property as a whole, determine an adequate home for loans from FmHA.

(7) A memorandum of understanding (see attachment 2*) on the use of section 8 of the U.S. Housing Act of 1937 and section 515 of the Housing Act of 1949 was signed by the Secretary of Agriculture and the Secretary of Housing and Urban Development (HUD) on June 23, 1976. In order to implement the program in compliance with the memorandum of understanding, both the FmHA and HUD must publish the required regulations to the field office; however, present instructions exist outlining the method for obtaining the combination of section 8 rental assistance payment program and section 515 loans in tandem.

The FmHA requires, in accordance with HUD minimum property standards, that FmHA financed rental projects as well as single family housing designed for senior citizens, include certain special architectural features to assist the elderly such as handrails for bathtubs, special lighting, minimum width halls to accommodate wheelchairs, nonabrasive walls and maximum gradient of 5 percent for driveways. FmHA housing regulations require that the location of rural rental projects designed for senior citizens be convenient to stores, medical services, churches and other facilities needed regularly by the occupants.

We appreciate your interest in our housing program and hope we have provided the information you requested.

Sincerely,

FRANK B. ELLIOTT.

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*Retained in committee files.

ITEM 3. LETTER AND ENCLOSURE FROM WILLIAM. H. WALKER III, ASSISTANT SECRETARY, DEPARTMENT OF AGRICULTURE; TO SENATOR DICK CLARK, DATED AUGUST 3, 1976

DEAR SENATOR CLARK: This will reply to your letter concerning planned hearings to examine the effectiveness of certain Federal programs which serve older Americans in rural areas. While I am responsible, in the Department, for the operations of the Farmers Home Administration, the Rural Development Service and the Rural Electrification Administration, I believe, from the questions you asked as they relate to the FmHA's business and industry program, the Farmers Home Administration. The attachments provide answers to the questions you asked as they relate to the FmHA's business and industry program, the community programs and the rural housing programs.

We appreciate your interest in the Department's rural development activities.

Sincerely,

WILLIAM H. WALKER III.

[Enclosure]

RURAL HOUSING PROGRAMS

Questions answered in order asked:

(1) The official definition of a "rural area," as it relates to the rural housing program is as follows:

Section 520 of the Housing Act of 1949, as amended, states, "As used in this title, the term 'rural' and 'rural area' mean any open country or any place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000, and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit, as determined by the Secretary and the Secretary of Housing and Urban Development."

Farmers Home Administration (FmHA) instructions, in defining rural area, basically repeat, in modified form, the above section 520 of the Housing Act of 1949, as amended. The FmHA instructions, based primarily on legislative history and other factors, also provides additional guidelines to the FMHA field staffs for making the necessary determination as to those areas which are rural and nonrural.

(2) All rural housing programs are available to Iowa, Nebraska, and South Dakota. Following is a list of the housing programs currently operating with the corresponding obligations, as of June 3, 1976, for fiscal year 1976. The rural housing programs are authorized in the Housing Act of 1949, as amended.

State and program	Number of loans	Funds obligated
Iowa—Sec. 502 (homeownership)	3,125	$56,937,980
Iowa—Sec. 504 (low-income home repair loans)	52	60,070
Iowa—Sec. 515 (rural rental housing)	113	14,441,120
Nebraska—Sec. 502 (homeownership)	1,534	32,306,600
Nebraska—Sec. 504 (low-income home repair loans)	4	6,830
Nebraska—Sec. 515 (rural rental housing)	3	307,950
South Dakota—Sec. 502 (homeownership)	1,342	24,393,890
South Dakota—Sec. 504 (low-income home repair loans)	12	30,250
South Dakota—Sec. 515 (rural rental housing)	52	6,411,440

(3) While there is no strong disagreement with the designation that an "older American" is of age 60 or older, the FmHA housing programs consider the "elderly" to be 62 years of age or older. This age designation goes back to the "Senior Citizens Housing Act of 1962" which specifically states the term "elderly persons" means persons who are "62 years of age or over." Furthermore, we believe the Social Security Administration and others have, for several years, used 62 years of age as the time a person becomes a senior citizen. We recommend that the age of 62 be used by all agencies as the time a person is considered to be elderly.

(4) All rural housing programs are available to the elderly. However, the three programs most widely used by that age group are the section 502 home ownership loans, the section 504 rural housing repair loans, and the section 515 rural rental housing loans. Following is a brief description of these housing programs.

OUTLINE OF RURAL HOUSING PROGRAMS—FARMERS HOME ADMINISTRATION

Type of assistance	Purpose	Terms	Who may qualify
Sec. 502—Rural housing loans (adequate housing).	To buy, build or improve or relocate homes and related facilities. To buy minimum adequate building sites. Also to refinance debts under certain conditions when necessary to help a family retain ownership of its home.	8½ percent interest for low- to moderate-income families. Eligible families may receive interest credits which may reduce the effective interest rates on the loan to as low as 1 percent. Up to 33 years to repay.	Low- and moderate-income families who lack adequate housing and related facilities and who will become the owner-occupants of a home in a rural area after the loan is closed; or a farmowner without decent, safe, and sanitary housing for his own use or for the use of his tenants, sharecroppers, farm laborers, or farm managers. Housing must be located in rural areas, i.e., any place which is not part of or associated with a nonrural area, is rural in character and has a population not in excess of 20,000.
Sec. 504—Rural housing loan.	To make minor repairs to homes to make them safe and remove health hazards to the family or the community.	1 percent interest and up to 20 years to repay. $5,000 limit.	Very low-income owner-occupants who do not have enough income to qualify for sec. 502 assistance. Applicant must be able to repay the loan.
Rural rental housing and cooperatively owned housing loans (secs. 515 and 521).	To build, improve, repair or buy rental or cooperatively owned houses or apartments that are economically designed and constructed for independent living. Eligible occupants must be low- to moderate-income families or senior citizens.	9 percent. Up to 40 yrs. except that projects for senior citizens may be up to 50 yrs. Loans to private nonprofit corporations, consumer cooperatives, State or local public agencies, and other nonprofit organizations will be limited to the development cost or the security value of each project, whichever is less. Loans to other applicants will be limited to 95 percent of the development cost or the security value of each project, whichever is less.	Private nonprofit corporations, consumer cooperatives, and State or local public agencies. Individuals or organizations operating on a profit basis, including those that agree to operate on a limited profit basis. Cooperatives owned, occupied and managed by eligible low- to moderate-income families or senior citizens.

(5) We are unable to keep a running account of the number of elderly persons under our housing programs. Data is not compiled to show the number of elderly people who satisfy their housing loans by payment in full or other methods and thereby graduate from the housing programs.

(6) The FmHA and HUD work together in many ways in an effort to provide housing for the elderly and others. Following is a list of some joint endeavors:

(*a*) On June 23, 1976, the Secretary of HUD and the Secretary of Agriculture signed a memorandum of understanding covering the combining of the FmHA section 515 rental housing loan and the HUD section 8 program. This is a way to provide subsidized rental housing in rural areas.

(*b*) The FmHA and HUD use the same minimum property standards (MPS). They work together, as needed in developing these standards.

(*c*) The FmHA utilizes and is a party to HUD's contracts with credit reporting agencies for the obtaining of credit reports.

(*d*) The FmHA and the Federal Insurance Administration of HUD worked together in the implementing of the Flood Insurance Protection Act of 1973.

(*e*) The FmHA and the Flood Disaster Assistance Administration (FDAA) of HUD have a memorandum of understanding permitting the FDAA to use FmHA inventory housing for disaster victims.

(7) We know of no way to accurately measure the current needs of the elderly for programs the Department administers in Iowa, Nebraska, and South Dakota. There is always a need for jobs, services, and better housing but statistical data is not available to enable us to answer this question in a responsible way.

COMMUNITY PROGRAM LOANS

Questions answered in order asked:

(1) FmHA is authorized to make loans for facilities for public use in rural areas and towns of up to 10,000 in population.

(2) See the following table:

	Iowa	Nebraska	South Dakota
Water and waste disposal loans	$91,773,103	$17,400,440	$28,820,990
Water and waste disposal grants	14,153,515	5,560,850	6,922,200
Community facility loans	3,868,000	1,500,000	2,566,000
Industrial development grants	784,900	368,000	423,800

(3) FmHA does not distinguish between elderly and nonelderly in administering its programs. However, we have no objection to the definition stated by the Administration on Aging.

(4) Funds may be used to construct, enlarge, extend or improve water, sewer and solid waste disposal systems, fire stations, libraries, hospitals, nursing homes, clinics, community buildings, recreation facilities, industrial parks and other community facilities that provide essential services to rural residents.

(5) FmHA does not distinguish between elderly and nonelderly in administering its programs. However, several nursing home projects have been funded in the three States mentioned.

(6) Not applicable.

(7) FmHA does not distinguish between elderly and nonelderly in administering its programs and has no specific information regarding the needs of the elderly.

BUSINESS AND INDUSTRIAL LOANS

The official definition of a rural area under the business and industrial loan program is that " 'rural' and 'rural area' may include all territory of a State, the Commonwealth of Puerto Rico and the Virgin Islands, that is not within the outer boundary of any city having a population of fifty thousand or more and its immediately adjacent urbanized and urbanizing areas with a population density of more than one hundred persons per square mile, as determined by the Secretary of Agriculture according to the latest decennial census of the United States: *Provided*, That special consideration for such loans and grants shall be given to areas other than cities having a population of more than twenty-five thousand."

Records indicate that under the business and industrial loan program, the following activity in each of the states from inception through June 30, 1976:

IOWA

Twenty-four loans amounting to $18,888,500 have been obligated. The projects that would provide services for the elderly that funds have been obligated for are one hospital and two nursing homes. The State Office is in the process of evaluating an additional nursing home application at the present time.

SOUTH DAKOTA

Twenty-two loans in the amount of $5,955,500 have been obligated. No specific projects that cater to the elderly have been financed. The community programs division has been able to fill this State's needs for the elderly for hospitals and nursing homes.

NEBRASKA

Six loans amounting to $4,740,000 have been obligated. The community programs division has been able to fill this State's needs for the elderly for hospitals and nursing homes.

We are unable to forecast the need for additional hospitals and nursing homes and do not have any data on the number of elderly in Iowa, Nebraska, and South Dakota.

ITEM 4. LETTER FROM SAMUEL R. MARTINEZ, DIRECTOR, COMMUNITY SERVICES ADMINISTRATION, WASHINGTON, D.C.; TO SENATOR DICK CLARK, DATED AUGUST 10, 1976

DEAR SENATOR CLARK: Thank you for your recent letter concerning the field hearings on the rural elderly that you plan to conduct during August in Iowa, Nebraska and South Dakota.

We are pleased to provide you with the information you requested from the Community Services Administration. Our Headquarters response is being coordinated with the CSA Region VII and VIII Offices that administer programs

in Iowa, Nebraska and South Dakota, respectively. Our answers have been provided in the same sequence as your questions.

(1) CSA defines a rural Community Action Agency (CAA) as one that serves an area in which the household population is 50 percent or more "rural," based on the definition of the Bureau of the Census. If an area is less than 50 percent "rural" and contains no place with a household population of 10,000 or more, it is classified by CSA as "rural," too.

(2) CSA's legislation defines an "elderly poor American" as one who is 60 years of age or older, except in one section of the Headstart, Economic Opportunity, and Community Partnership Act of 1974. Section 223 of that Act uses age fifty-five (55) years and older for employment purposes and employment opportunity "as regular, part-time and short term staff in all component programs."

(3) The CSA funds 18 CAA's in Iowa, 9 CAA's in Nebraska and one statewide CAA in South Dakota. The geographical areas covered by each CAA or delegate agencies and the number of agencies having elderly service components are being provided to your office by the CSA Region VII and VIII offices.

(4) The description of services being provided to the elderly poor by the CAA's in the aforenamed States, the number of elderly served, and the level of funding in fiscal years 1975 and 1976 are also being provided to your office by our regional offices. Additionally, descriptions of information and referral and outreach services which assist the elderly in the more rural areas are being included in the regional reports.

(5 and 6) The answers to these two questions will be reports provided by our regional offices.

(7) The CSA and the Congress have long recognized that the needs and the provision of services to assist the elderly poor cannot be met alone by the CAA's and SOS projects with their limited resources. Instead, CSA sees as its mission and function at the local, State, and Federal levels to be a catalytic agent which generates and mobilizes other sources of funding and to be of assistance in the formation of coalitions of agencies and joint funding efforts which meet the growing and unmet needs of our Nation's elderly poor. The Congress of Seniors Organizations located in South Dakota, is a good example of how we see the CSA best using our limited funding resources to assist the elderly poor.

(8) The President's budget for fiscal year 1977, included a request for the SOS program in the amount of $10 million. In the light of both the administration and the congressional budgetary ceilings, it does not seem practical at the present time to support a higher congressional appropriation for the SOS program. To a certain extent all of the programs funded and administered by CSA benefit older poor citizens, for our goal is to enhance the opportunities and lives of all the poor. However, because of the increasing and special needs of the elderly poor, CSA is supporting a number of research and action projects which we hope through their implementation and replication will diminish the impact of poverty on their lives.

(9) As you know, the CAA programs are designed exclusively for the poor as a whole, whereas the SOS programs focus on the elderly poor. Basically speaking, SOS programs provide the elderly poor with another means of obtaining information and assistance. While AoA's congressional mandate is to be responsible for programs for all the elderly poor in the Nation, CSA uses the SOS program through its CAA network to provide service delivery programs to the elderly poor. For example, in cases of emergencies or national disasters, SOS programs provide the means to meet the personal and special needs of the stricken elderly poor.

(10) We believe the ultimate value of our SOS program has been to improve the quality of life for individual elderly poor men and women, and we thank you for giving CSA an opportunity to express our effort to help them.

Sincerely,

SAMUEL R. MARTINEZ.

ITEM 5. LETTER AND ENCLOSURE FROM FAYE G. ABDELLAH, SPECIAL ASSISTANT TO THE UNDER SECRETARY, HEW; TO SENATOR DICK CLARK, DATED JULY 16, 1976

DEAR SENATOR CLARK: The enclosed report is in response to your request that our office assist the Special Committee on Aging in preparing for field hearings on the status of rural, older Americans in Iowa, Nebraska, and South Dakota by providing information on several federally funded programs in those States. The report was formulated with the collaboration of Mrs. Helen Lazenby and

Mr. Bruce Edemy of the Social Security Administration and Dr. Jerry Solon of the National Institute on Aging.

I trust that this information is sufficient for your current needs. Please do not hesitate to contact this office in your future preparations for hearings in other States.

Sincerely yours,

FAYE G. ABDELLAH.

[Enclosure]

(1) *Question.* What is the official definition of a rural area in your agency?

Answer. For purposes of classifying the older population by place of residence, this office accepts the definition of a rural area as utilized by the Public Health Services' National Center for Health Statistics (NCHS) in its 1971 National Health Survey. The NCHS definition geographically separated the population into persons residing in urban areas, inside a standard metropolitan statistical area (SMSA), and persons residing in rural areas, outside a SMSA. The U.S. Office of Management and Budget considered two primary steps of factors in establishing the boundaries and titles of SMSA's: First, a city or cities of specified population which constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with contiguous counties which are metropolitan in character.

(2) *Question.* Do you agree with the designation—as in Administration on Aging programs—that an "older American" is of age 60 or older?

Answer. Depending upon the program area involved, we believe the answer to this question may be either yes or no. In service administration or benefit programs, such as the Administration on Aging, the Social and Rehabilitative Services, and the Social Security Administration, it may become necessary to select an age at which eligibility for services or benefits begin. When, for example, legislative or administrative authority dictates that services are to be made available only to a population, specifically defined by age, the operating agency must accept and adhere to a prescribed definition. In the research and policy development areas, however, a greater flexibility in formulating concepts about age is permissible and desirable. Thus, in the latter areas, a sensitivity to the invalidity of choosing one time at which old age begins is important, and the term "older American" may take on a functional definition in which the individual is defined with reference to physical, physiological or mental capacities.

(3) (a) *Question.* How many persons in these three States are receiving long-term care services under the Medicare program?

Answer. Information was obtained on the number of admissions to skilled nursing facilities (SNF's) under the Medicare program during 1974 and 1975. Since Medicare for long-term care patients covers only services in a SNF and coverage may not be extended past 100 days for any one admission, we believe the following information presents a fairly accurate picture of the actual numbers of persons in long-term care facilities in the three States who received Medicare reimbursement.

State	Total number medicare enrollees	SNF admissions
1974:		
Iowa	362,613	3,934
Nebraska	191,170	2,239
South Dakota	84,407	815
1975:		
Iowa	365,076	3,943
Nebraska	192,971	2,219
South Dakota	85,294	679

(3) (b) *Question.* How many persons are receiving reimbursable home health services under the Medicare program in these States?

Answer. Since 1971 the Social Security Administration (SSA) has not tabulated information on the numbers of persons receiving reimbursable home health services under the Medicare program. The most relevant information attainable from SSA, in response to your question, pertains to the total number of bills paid for home health services under title XVIII, part A, hospital insurance, and part B, medical insurance, during 1974 and 1975 and to the number of bills paid for every thousand Medicare enrollees. This information does not reflect the actual number of persons receiving home health services, since one individual may have been responsible for more than one bill. The following statistics were provided:

State	Total aged enrollees	Total home health service (bills paid)	Home health services per 1,000 enrollees (bills paid)
1974 HOSPITAL INSURANCE (PART A)			
Iowa	362,613	29,653	82
Nebraska	191,170	18,428	96
South Dakota	84,407	5,505	65
1974 MEDICAL INSURANCE (PART B)			
Iowa	357,458	17,570	49
Nebraska	187,042	13,048	69
South Dakota	82,688	3,578	43
1975 HOSPITAL INSURANCE (PART A)			
Iowa	365,076	41,701	114
Nebraska	192,971	27,593	143
South Dakota	85,294	6,425	75
1975 MEDICAL INSURANCE (PART B)			
Iowa	360,405	22,903	64
Nebraska	189,940	14,483	76
South Dakota	83,723	3,405	41

(3) (c) *Question.* Can your office provide the Committee with a listing of home health agencies and day care centers for the elderly in these States, particularly those serving rural areas?

Answer. A list* of the home health agencies in Iowa, Nebraska, and South Dakota is attached. However, the Department of Health, Education, and Welfare's only responsibility, to date, for funding day care centers has been through Section 222(b) of P.L. 92-603 which authorized expenditures of monies for demonstration projects, none of which is located in Iowa, Nebraska, or South Dakota.

ITEM 6. LETTER AND ENCLOSURE FROM ARTHUR S. FLEMMING, COMMISSIONER ON AGING, HEW; TO SENATOR DICK CLARK, DATED JULY 17, 1976

DEAR SENATOR CLARK: This is in response to your inquiry of June 22, 1976 in which you asked me to prepare a summary on rural areas and the effectiveness of certain Federal Programs for the States of South Dakota, Iowa, and Nebraska.

To answer your first question concerning the official definition of a rural area, the Administration on Aging issued IM-73-28, April 16, 1973 to the State agencies on aging as a guideline to determine a sparsely populated rural area. This guideline said in part:

"If the project area of an award has boundaries essentially coterminous with those of any community (city, town, borough, village, etc.), whether incorporated or unincorporated, that has a population of less than 2,500 such project area may be considered a sparsely populated rural area. However, if an award is made to an area larger than such community and the average population density of the whole project area is less than 100 persons per square mile, then such project area may also be considered a sparsely populated rural area. However, if such larger project area contains one or more communities having a population greater than 2,500, then, the elderly outside of those communities must be served at least in proportion to their numbers within the entire project area."

The responses to the remaining questions are contained in the attached chart.

If I can be of any further assistance please do not hesitate to contact me.

Very sincerely and cordially yours,

ARTHUR S. FLEMMING.

[Enclosure]

*Retained in committee files.

RURAL AREA AGENCIES, TITLE VII AND MODEL PROJECTS

Questions	South Dakota	Iowa	Nebraska
1. Percent of area agencies located in rural areas	Single PSA [1]	50 percent	66 percent.
2. Geographical area these area agencies are mandated to serve	Total State	59 percent (58 counties)	29 percent (27 countries).
3. Elderly served by these agencies in rural areas	66,007	225,000	61,000.
4. Areas within State not served by area agency	The total State is covered because it is a single planning and service area.	No rural areas are denied coverage.	The complete State is considered rural and at present do not cover 43 percent of the elderly.
5. Total number of nutrition projects located in rural areas	12	6	7.
6. Total sites operated by rural nutrition projects	24	81	46.
7. Total number of elderly served by these sites	2,166	26,461	6,943.
8. Percentage of meals served by these sites which are home delivered	18 percent	9 percent	14 percent.
9. Number of projects which allow food stamps for congregate or home delivered meals	H.D.—7; Cong.—7.	H.D.—6; Cong.—7.	H.D.—7; Cong.—7.
10. Number of rural areas within the State which have requested a nutrition project, but denied because of lack of funding	None	None	None.
11. Number of AOA model projects funded	None	1	1.
12. Special outreach and/or information and referral operations	80 percent of elderly have access to I. & R.	100 percent of elderly have access to I. & R.	65 percent of elderly have access to I. & R.
13. State programs related or coordinated with Older Americans Act	Transportation, title XX.	Transportation	Transportation.
14. The effectiveness of South Dakota as a single planning and service area	It is not feasible at this time to ascertain the effectiveness of the single agency operation in meeting the needs of older persons in rural areas. An adequate response to this question would require an extension evaluative study. It is, however, the experience of the Administration on Aging that the effective administration of programs under the Older Americans Act in a State designated as a single planning and service area is dependent upon the characteristics of the State and its older population. Serving older persons in rural areas is emphasized both in States that are designated as a single planning and service areas and in those where there are planning and service areas with area agencies on aging. Therefore, each request by a State for designation as a single planning and service area must be reviewed on its individual merits. Primary consideration is given to the size of the State, its topography, the size and distribution of elderly population as well as to capacity of the State agency to administer the program. This latter factor, State agency capacity, is often a major consideration when assessing the effectiveness of one structure versus the other. All these factors and their interrelationship are weighed when considering whether the single planning and service areas with area agencies on aging is the most effective means of meeting the needs of the older persons in the State. The framework for this perspective is based upon sec. 301 of the act and on the intent of Congress as explicated in the reports of the Senate Committee on Labor and Public Welfare and the House Committee on Education and labor.		

[1] Single planning and service area has 1 area agency which has responsibility for the complete State.

Note: Special significance to rural elderly. Iowa—Project provides a means of part-time employment for the 60-plus person. Nebraska—Project provides for the winterizing of homes.

ITEM 7. LETTER AND ENCLOSURE FROM M. KEITH WEIKEL, COMMISSIONER, SOCIAL AND REHABILITATION SERVICE, HEW; TO SENATOR DICK CLARK, DATED JULY 27, 1976

DEAR SENATOR CLARK: I was pleased to learn in your June 23 letter about the forthcoming hearings scheduled for August by the Special Committee on Aging in Iowa, Nebraska, and South Dakota.

In your letter you requested specific information concerning the Medicaid programs in these States as they might affect the rural elderly population. Each of these questions is addressed in detail below.

What is the official definition of a rural area in your agency?

Although Social and Rehabilitation Service/Medical Services Administration has not officially adopted a definition of rural areas *per se*, we are essentially in agreement with that developed by the Office of Rural Health Initiatives (HEW/HSA). This office defines rural areas as those geographical areas which are not included within a standard metropolitan statistical area, i.e., under 50,000 persons or are not listed as an urbanized area or as unincorporated places in the current *County and City Data Book*, tables 4 and 5 (U.S. Department of Commerce).

Do you agree with the Administration on Aging (AoA) designation that an "older American" is of age 60 or older?

Congress has mandated that for a person to be eligible for Medicaid, he must be 65 or over and either be receiving "old-age cash assistance" or, in those States having medically needy programs such as Nebraska, fall within a financial range not to exceed 133 percent of the States welfare income limits. Age 60 or older as the basis for dispensing AoA grants in no way conflicts with these requirements.

How many persons in each of these States are eligible for Medicaid? How many of these are elderly? How many in rural areas? Could the committee be provided with descriptions of each State's Medicaid plans?

Current Medicaid eligibility data is not routinely available from the States although figures collected for a recent special study by the HEW regional office indicate that in fiscal year 1976 the total number of eligible in Iowa and Nebraska were 138,776 and 56,437, respectively. Of these the number of aged eligibles in Iowa was 6,695 and in Nebraska, 12,293. The most reliable figures for South Dakota is an unduplicated *recipient* count for fiscal year 1975 which totaled 41,966 persons with 11,540 of these elderly.

No information is presently available on the number of Medicaid elderly living in rural areas of these States. Enclosed is a current summary of Medicaid services by State which describes in general the scope of benefits offered in each State.

I hope this information is useful to you during the hearings and if we can be of additional support as they progress, please feel free to contact me.

Sincerely yours,

M. KEITH WEIKEL.

[Enclosure]

MEDICAID SERVICES STATE BY STATE,

JUNE 1, 1976 1/

* BASIC REQUIRED MEDICAID SERVICES. Every [illegible] must cover at least these services for at least everyone [illegible] outpatient hospital services; other laboratory and X-ray services; [illegible] services for individuals 21 and older; early and periodic screening, diagnosis, and treatment [illegible] under 21; family planning, and physician services. Federal financial [illegible] available [illegible] to expand their Medicaid programs by covering additional services and/or by [illegible] people eligible for medical [illegible] not for financial assistance. For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Services provided only under the Medicaid [illegible] and treatment program for individuals under 21 are not [illegible] on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

● offered for people receiving federally supported financial assistance

+ offered also for people in public assistance 2/ and SSI 3/ categories who are financially eligible for medical but not for financial assistance

Additional services for which Federal financial participation is available to States under Medicaid:

FMAP 4/	BASIC* REQUIRED MEDICAID SERVICES SEE ABOVE	State	Clinic services	Prescribed drugs	Dental services	Prosthetic devices	Eyeglasses	Private duty nursing	Physical therapy and related services	Other diagnostic, screening, preventive and rehabilitative services	Emergency hospital services	Skilled nursing facility services for patients under 21	Optometrists' services	Podiatrists' services	Chiropractors' services	Care for patients 65 or older in institutions for mental diseases	Care for patients 65 or older in institutions for tuberculosis	Care for patients under 21 in psychiatric hospitals	Institutional services in intermediate care facilities	
74	●	Alabama		●		●	●				●	●	●				●		● 5/	AL
50	●	Alaska					●				●	●	●			●		●	● 5/	AK
60		Arizona																		AZ
75	+	Arkansas	+	+	+	+					+	+			+	+	+	+	● 5/	AR
50	+	California	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+ 5/	CA
55	●	Colorado		●		●			●		●	●		●		●		●	● 5/	CO
50	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+		+	+ 5/	CT
50	●	Delaware	●	●					●					●		●	●		●	DE
50	+	D.C.	+	+		+	+		+	+	+	+	+	+		+	+	+	+ 5/	DC
57	●	Florida		●							●					●	●		● 5/	FL
66	●	Georgia	●	●		●				●		●		●		●	●		● 5/	GA
50	+	Guam	+	+	+	+	+		+		+	+	+							GU
50	+	Hawaii	+	+	+	+	+		+	+	+	+	+						+	HI
68	●	Idaho	●	●							●	●	●	●	●				● 5/	ID
50	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	IL
57	●	Indiana	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●	IN
57	●	Iowa		●	●	●	●		●		●	●	●	●	●				● 5/	IA
54	+	Kansas	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+ 5/	KS
71	+	Kentucky	+	+	+	+			+		+	+				+	+	+	+ 5/	KY
72	●	Louisiana	●	●		●				●	●	●			●	●	●	●	● 5/	LA
71	+	Maine	●	+		+			+	+	+	+		+	+	+		+	● 5/	ME
50	+	Maryland	+	+		+	+				+		+			+	+		+ 5/	MD
50	+	Massachusetts	+	+		+	+	+	+	+	+	+	+	+		+	+		+ 5/	MA
50	+	Michigan	+	+		+				+	+	+		+	+	+	+	+	+ 5/	MI
57	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	MN
78	●	Mississippi		●	●							●				●	●		● 5/	MS
59	●	Missouri		●	●						●		●			●	●		● 5/	MO
63	+	Montana	+	+	+	+	+	+	+	+	+	+	+	+		+		+	+ 5/	MT
56	+	Nebraska	+	+	+	+	+	+	+		+	+	+	+	+	+	+		+ 5/	NB
50	●	Nevada	●	●	●	●	●	●	●		●	●	●	●	●	●			● 5/	NV
60	+	New Hampshire	+	+		+	+	+	+	+	+	+	+	+	+	+			● 5/	NH
50	●	New Jersey	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	NJ
73	●	New Mexico	●	●	●	●	●	●	●		●	●	●	●					● 5/	NM
50	+	New York	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	NY
68	+	North Carolina	+	+	+		+			+		+	+	+	+	+	+	+	+ 5/	NC
58	+	North Dakota	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	ND
54	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	● 5/	OH
67	+	Oklahoma		●	+									+		+		+	+ 5/	OK
59	●	Oregon	●	●	●	●	●	●			●	●	●	●	●	●	●	●	● 5/	OR
55	+	Pennsylvania	+	●	●	●	+				+	+	+	●	+	+		+	+ 5/	PA
50	+	Puerto Rico	+	+	+				+	+	+						+			PR
57	+	Rhode Island		+	+	+	+						+	+		+			● 5/	RI
74	●	South Carolina	●	●	●	●	●		●		●	●	●		●	●	●	●	● 5/	SC
67	●	South Dakota	●	●		●	●		●		●	●	●	●	●				● 5/	SD
70	+	Tennessee	+	+		+					+					+	+	+	+ 5/	TN
64	●	Texas		●	●		●				●		●	●			●		● 5/	TX
70	+	Utah	+	+	+	+	+	+	+		+	+	+	+	+	+		+	+ 5/	UT
70	+	Vermont	+	+		+					+	+		+		+		+	+ 5/	VT
50	+	Virgin Islands	+	+	+	+	+													VI
58	+	Virginia	+	+			+		+		+	+	+	+		+	+		+ 5/	VA
54	+	Washington	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	WA
72	+	West Virginia	+	+	+	+	+	+	+			+	+	+	+	+	+		+	WV
60	+	Wisconsin	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	WI
61	●	Wyoming										●	●						●	WY
●	21	●	13	21	12	14	12	5	10	5	18	18	15	14	10	14	11	8	25	
+	32	+	29	30	22	27	24	14	22	17	25	25	23	23	18	27	19	21	25	
	53	Total	42	51	34	41	36	19	32	22	43	43	38	37	28	41	30	29	50	

Intermediate Care Facilities (ICF): P.L. 92-223 transfers the ICF program to Medicaid (Title XIX) as an optional service, effective 1-1-72. States may at their option include institutions for the mentally retarded, both public and private. See footnote five.

1/ Data from Regional Office reports of characteristics to State programs and State plan amendments.
2/ People qualifying as members of families with dependent children (usually families with at least one parent absent or incapacitated).
3/ People qualifying as aged, blind, or disabled under the Supplemental Security Income program.
4/ FMAP - Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from July 1, 1975, through June 30, 1977, are rounded.
5/ Including ICF services in institutions for the mentally retarded.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — Social and Rehabilitation Service — Medical Services Administration

Division of Program Monitoring

(SRS)-76-24801*

ITEM 8. LETTER FROM ROBERT FULTON, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, HEW; TO SENATOR DICK CLARK, DATED JULY 28, 1976

DEAR SENATOR CLARK: Thank you for your letter of June 22 on behalf of the Special Committee on Aging requesting information about Federal programs for older Americans in rural areas. Please accept my apology for the delay in responding.

You ask specific questions concerning programs in Iowa, Nebraska, and South Dakota. In response to your first question, this agency has no official definition of a "rural area." Since title XX is a Federal-State program that is State administered or supervised, States decide what services will be offered in the dif-

ferent political subdivisions according to the specific needs in those areas. In other words, rural areas reflect rural interests, urban areas reflect urban interests.

Contrary to the Administration on Aging, this agency, under the titles of the Social Security Act, classifies an "older American" as one who is age 65 or older.

States are not required to accumulate and report precise data on age breakdowns of social service recipients. However, for your upcoming committee hearings, I requested staff in the Social and Rehabilitation Service Denver and Kansas City Regional Offices, to compute rough estimates regarding the percentage of title XX funds that are used for social services for the aged. In Nebraska, approximately 16 percent of the title XX funds are used for services to the aged; in South Dakota, 11 percent and in Iowa, 15 to 20 percent.

All three States provide the following title XX services to Supplemental Security Income recipients: health related programs, home management services, meal programs, and transportation services. Nebraska also provides adult day care services.

Title XX programs are coordinated with programs under the Older Americans Act through joint working agreements between the State title XX agencies and the State commissions on aging. This allows the agencies to work closely together when determining the needs of the aged and the programs that will be provided. In South Dakota, the State Office on Aging is under the umbrella of the State title XX agency. Therefore, South Dakota sees no reason to sign a joint working agreement.

Revisions to section 228.61 of the title XX regulations allow the States to establish any method or methods, including income declaration without documentation, when determining title XX eligibility. Nebraska and South Dakota require income documentation while Iowa requires only declaration of income.

I trust this information is helpful to your committee. Please let me know if I may be of further assistance.

Sincerely,

ROBERT FULTON.

ITEM 9. LETTER FROM LOUIS M. HELLMAN, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, HEW; TO SENATOR DICK CLARK, DATED AUGUST 11, 1976

DEAR SENATOR CLARK: This is in further response to your letter of June 22 requesting information about the Health Services Administration's (HSA) role in serving the elderly in rural areas.

Within HSA there are several programs which serve rural areas, including the health maintenance organization (HMO), the emergency medical services (EMS), the community health centers (CHC), the migrant health, the national health service corps (NHSC), the health underserved rural areas, and the home health programs. Health service delivery programs for rural areas are coordinated through the Public Health Service's (PHS) rural health initiative (RHI) under the guidance of a PHS-wide rural health coordinating committee. The RHI is an administrative effort combining existing health resources of the Department to improve the delivery of health care to health underserved rural areas.

We shall respond to the specific questions you asked in the order presented to us in your June 22 letter.

(1) HSA has explored and is using several definitions of "rural." The RHI initially defined rural as nonstandard metropolitan statistical area (non-SMSA) counties. Data subsequently received from the Department of Agriculture indicates that approximately 38 percent of the rural population live in SMSA counties. Accordingly, we reviewed the definition we used for rural, i.e., non-SMSA, and found that it would be more appropriate to define rural as non-SMSA *or* those areas not listed as urbanized areas *or* unincorporated places (places having 25,000 or more inhabitants) in the *County and City Data Book 1972*, tables 4 and 5, U.S. Department of Commerce, Bureau of the Census, Social and Economic Statistics Administration, Washington, D.C. 1973.

HMO regulations published in the *Federal Register*, October 18, 1974, defines a rural area as any area not listed as a place having a population of 2,500 or more in Document #PC (1)–A, "Number of Inhabitants," table VI, "Population of Places," and not listed as an urbanized area in table XI, "Population of Urbanized Areas" of the same document (1970 Census, Bureau of the Census, U.S. Department of Commerce).

The EMS program defines rural areas as those areas other than urbanized areas as defined by the Bureau of the Census.

Enclosed for your information is a copy of a paper* prepared by HSA in September 1974 which examined several other definitions of rural in use.

(2) The Older Americans' Act title VII (nutrition program) requires that beneficiaries be "60 and over." Title III of the same act, however, requires that for the purposes of planning, each State should determine the age of an older person in accordance with a thorough needs assessment. Our position is that each State should determine the age in accordance with need. Farm area residents have higher incidences of chronic disability conditions, therefore, if by lowering the age (e.g., 55) individuals would have better access to health care through transportation systems, sponsored by the Administration on Aging (AoA), we would support that action. By intervening at the beginning stages of a chronic disability there is both a cost savings and slower development of disease progression. Nebraska has determined that an older person is "55" because of certain disabling conditions and is eligible to participate in a transportation system to health facilities authorized by the State AoA agencies.

(3) The NHSC assigns health professionals to critical health manpower shortage areas (CHMSA's) rather than to medically underserved areas (MUA's). Designations of CHMSA's for the States of Iowa, Nebraska, and South Dakota are enclosed. Also enclosed are lists of areas designated as MUA's. These designations are used by the CHC and HMO programs.

The PHS NHSC scholarship program was established in 1974 and the first recipients eligible for placement were assigned this year. Twenty-two scholarship recipients have been available for placement nationally through the NHSC. The remainder of the scholarship recipients who have completed their training have been assigned through the Bureau of Health Manpower and the Indian Health Service. One scholarship recipient has been placed in Faulk County, S.Dak., through the NHSC. It is estimated that 149 scholarship recipients will be available in 1977 for placement in NHSC designated CHMSA's, and this number will continue to grow as more of the recipients complete their education. The NHSC's placement of health professionals is not limited to recipients of scholarships. In addition to the physician placed through scholarship obligations in South Dakota, three M.D.s and one nurse practitioner (N.P.) were recruited and assigned to South Dakota. Also, five M.D.s and one physician extender (P.E.) were recruited and assigned to shortage areas in Iowa. The NHSC has only the one nurse practitioner serving within the three States at the present time. She is assigned to Onida (Sully County), South Dakota, and is working with a NHSC physician. Many nurse practitioners are employed by communities, however, we do not have any statistics available on such paraprofessionals. The NHSC assignees are as follows:

Iowa: 1 M.D. in Eldora County, 1 M.D. in Lyon County, 1 P.E. in Lyon County, and 3 M.D.s in Tama County.

South Dakota: 2 M.D.s in Faulk County (includes the scholarship assignee), 1 M.D. in Sully County, 1 N.P. in Sully County, and 1 M.D. in Roberts County.

(4) Iowa received $45,000 for a planning grant in fiscal year 1975 under section 1202 of P.L. 93–154 (the Emergency Medical Services Systems Act of 1973). This planning project covered a population of 339,000 (253,000 rural and 86,000 urban) in the northwestern part of the State. The 1976 appropriations for P.L. 93–154 stated that if a State and/or locale had not received monies in fiscal year 1975 under either section 1203 or section 1204 those locales were ineligible for fiscal year 1976 implementation monies. The lack of funding under these sections in 1975 precluded the operational funding of this region in fiscal year 1976. It is estimated that 42,000 or 12.4 percent of the population in this region are age 65 and over.

Nebraska has received 2 years' funding for grants under section 1203 of P.L. 93–154, fiscal year 1975, $1,236,836 and fiscal year 1976, $1,547,391. These grants cover EMS regions comprising 80 percent of the State's population and 60 percent of its land area. Of the land area covered, 80 percent of the area is rural to wilderness. The rural population in this federally funded EMS region totals 443,030 of which 65,952 (14.9 percent) are over 65. Current data being obtained from EMS facilities in Nebraska reflects only time-patient loading characteristics. Age is not now being collected for usage, but a standard ambulance form will be introduced this year which will report age of utilizing patients.

*Retained in committee files.

South Dakota received $90,000 for planning grants in fiscal year 1974 under section 1202 of P.L. 93–154. Two additional grants under section 1203 have been awarded, fiscal year 1975, $556,484 and fiscal year 1976, $714,519. These two operational grants cover 100 percent of the State and its population. Ninety-two percent of the State is estimated to be rural, 21.1 percent of the population are over 65, 55 percent of the population is classified as rural and 18 percent of the population actually live on farms. It is estimated that 42,000 rural elderly have access to the Federal service programs.

(5) At the present time the names and locations of operational or developmental HMO's in the three States mentioned are:

Iowa: None.

Nebraska: Community Health Care Association, Lincoln; Missouri Valley Group Health, Inc., Omaha.

South Dakota: Health Care, Inc., Mitchell; Rosebud Sioux Tribe, Rosebud; Western South Dakota, Rapid City.

(6) HSA has not conducted a total health needs assessment for the elderly, however, our home health program has made an assessment as to those counties within your investigation area that *do not* have home health services. It is the intention of the Under Secretary to hold regional public meetings on the status of home health care in five cities (New York, Atlanta, Chicago, Dallas, and Los Angeles) as to the needs of the chronically disabled and the elderly.

We have also enclosed for your information a list of health service delivery projects presently being supported by programs administered by the Bureau of Community Health Services, HSA.

Copies of this correspondence are being forwarded to Holman R. Wherritt, M.D., Regional Health Administrator in our Kansas City Regional Office, and to Hilary H. Connor, M.D., Regional Health Administrator in our Denver Regional Office, so they will be aware of your interest. If they can be of further assistance to you in your field hearings, their addresses are: Holman R. Wherritt, M.D., Regional Health Administrator, Department of Health, Education, and Welfare Region VII, 601 East 12th Street, Kansas City, Mo. 64106, 816–374–3291; Hilary H. Connor, M.D., Regional Health Administrator, Department of Health, Education, and Welfare, Region VIII, 19th and Stout Streets, Denver, Colo. 80202, 303–837–4461.

If we can be of further assistance, please let us know.

Sincerely yours,

LOUIS M. HELLMAN.

ITEM 10. LETTER AND ENCLOSURES FROM JAMES B. CARDWELL, COMMISSIONER OF SOCIAL SECURITY; TO SENATOR DICK CLARK, DATED AUGUST 27, 1976

DEAR SENATOR CLARK: With further reference to your inquiry of June 23, I am enclosing some material relevant to the questions which you posed in your letter.

(1) While the Social Security Administration does not officially define an area as urban or rural, we can indicate the rural status of counties by using census data (see table C). Residents of less populated areas are served by contact stations on specified days of the month. Toll-free lines are also available and district offices have a liberal policy on accepting collect telephone calls.

(2) Information for items 2(a), 2(b), and 2(c) are shown in the enclosed tables C, D, and E, respectively. While we do not know the number of beneficiaries residing in rural areas, we show in table C a breakdown of the number of beneficiaries by the rural status of the counties in which they reside. (For detailed county data on beneficiaries, see enclosed tables A and B for Iowa, Nebraska, and South Dakota.)

(3) Information for items 3(a), 3(b), 3(c), and 3(d) is shown in the enclosed table F, which summarizes information shown in the enclosed table 4, the research and statistics note No. 8, and the advance release of supplemental security income (SSI) data—March 1976. We do not have information with respect to item 3(e). We are referring your letter to the Social and Rehabilitation Service of the Department of Health, Education, and Welfare for any information which they may have with regards to this item.

(4) Information with respect to the medicare program is as follows:

(*a*) Tables 4.a.1–4.a4 show enrollment and utilization data for both the hospital insurance (part A) and the supplementary medical insurance (part

B) programs, and by aged (65 and over) and disabled. Data on enrollment are shown, as of January 1, 1975, in table 4.a.1. Table 4.a.2 shows the number of part A admissions to inpatient hospitals and skilled nursing facilities (SNF's) in fiscal year 1975, with a separate breakout for persons with chronic renal disease (CRD) who are under 65 years old but are not qualified as disabled under medicare. (These people are covered under medicare on the basis of their chronic renal disease only.) The number of admissions may be greater than the number of persons served since a person may have more than one admission to a health care facility. Table 4.a.3 shows the number of home health agency (HHA) visits for fiscal year 1975. Table 4.a.4 gives the approximate number of persons aged 65 and over using all types of part B services for calendar year 1974 by metropolitan and non-metropolitan area of residence. (Such a breakdown is not available for disabled persons.)

(*b*) With reference to your question on physician assignment rates under medicare, the physician decides on a case-by-case basis whether or not to accept assignment. He may submit assigned claims for one type of service and not another, for one patient and not another, or for a patient or service on one occasion and not on another. The percentage of physicians who accept assignment is unknown. However, the percentage of claims assigned is shown below. Assignment rate data is available only on a part B carrier basis. (A carrier is a health plan administering medicare part B on local level.) In the case of the three States in question, one carrier serves each State in its entirety (Iowa-Blue Shield, Nebraska-Mutual of Omaha, and South Dakota-Blue Shield). The available data do not permit a rural-urban breakdown.

Percent of claims assigned	Iowa	Nebraska	South Dakota
Total	41.0	41.8	38.8
Net [1]	34.9	37.6	32.6

[1] Excludes claims made by hospital-based physicians and group prepayment plans (GPPP's).

(*c*) Currently there is no reliable data on payments made to paramedical personnel (physician extenders). These people work under the direct supervision of a physician who submits claims for medicare reimbursement on their behalf. The physician is under no obligation to identify them or how much of his total reimbursement they are receiving. A program experiment, not as yet fully operational, has begun, whereby physicians who agree to participate in the experiment will begin identifying their physician extenders, the services they render, and the amount they are reimbursed by him. All claims for medicare payments will still be made by the supervising physician under his identification number. As of April 1976, there were 10 physicians' practices in Iowa which have shown interest in the experiment, 3 in Nebraska, and 5 in South Dakota.

(*d*) As of December 1975, data regarding the number of health care facilities participating in medicare for the three States are as follows:

	Iowa	Nebraska	South Dakota
Part A:			
Inpatient hospitals	173	123	60
Beds	17,293	9,828	3,511
SNF's	32	16	10
Beds	921	1,014	326
HHA's	64	12	21
Independent labs	14	7	6
Outpatient physical therapy	1	.....	.....
Part B.—Groups, clinics: [1]			
General practice groups	53	1	31
Clinics [2]	32	1	2
Group practice prepayment plans	.....	.....	.....

[1] Number of groups is approximate since a group may have more than 1 identification number. (These numbers are assigned by carriers.) For example, a group or clinic with more than 1 office or branch may have a separate ID number for each location. Also, the figures here represent only those groups or clinics which have received medicare reimbursement.

[2] A clinic is a group of physicians with at last 2 specialties.

We are unable to provide you with separate data on health care facilities in "medically underserved" areas. However, you may wish to contact Dr. Daniel F. Whiteside, Director, Bureau of Health Manpower, Public Health Service, for any information that he may have available. His address is: National Institutes of Health, Room 5C02, 900 Rockville Pike, Bethesda, Md. 20014.

You may also be interested in several publications which contain data on health resources availability. These are:

(1) *Health Resources Statistics—1975*, Public Health Service, Health Resources Administration, National Center for Health Statistics, Rockville, Md. 20852.

(2) *Distribution of Physicians in the United States, 1973*, vol. 1, region, State, county; vol. 2, metropolitan areas; American Medical Association, Center for Health Services Research and Development, 535 N. Dearborn Street, Chicago, Ill. 60610. (This publication includes data on counties with no active physician in patient care.)

I hope this information will help to satisfy your needs.

Sincerely yours,

JAMES B. CARDWELL,
Commissioner of Social Security.

[Enclosures]

TABLE C.—ALL BENEFICIARIES AND THOSE AGED 65 AND OVER FOR IOWA, NEBRASKA, AND SOUTH DAKOTA, BY RURAL STATUS OF COUNTY OF RESIDENCE, END OF 1975

Rural status of county of residence [1]	All beneficiaries	Those aged 65 and over
Iowa:		
All counties	470,003	341,195
Counties which are:		
100 percent rural	47,001	35,822
50 percent or more rural but not 100 percent	180,753	134,699
Under 50 percent rural	242,249	170,674
Nebraska:		
All counties	241,168	178,058
Counties which are:		
100 percent rural	49,104	38,410
50 percent or more rural but not 100 percent	55,380	42,387
Under 50 percent rural	136,684	97,261
South Dakota:		
All counties	113,364	80,344
Counties which are:		
100 percent rural	39,055	28,640
50 percent or more rural but not 100 percent	13,704	9,531
Under 50 percent rural	60,605	42,173

[1] Based on Census Bureau classification.

TABLE D.—SOCIAL SECURITY OFFICES IN IOWA, NEBRASKA, AND SOUTH DAKOTA, 1976

	Iowa	Nebraska	South Dakota
District or branch offices	21	10	6
Contact stations [1]	99	67	68
Institutional contact stations [1]	8	4	0
Enterprise toll free lines [2]	22	10	0
WATS lines	0	1	0

[1] A contact station is a space in some local government or other office which serves as a social security office on a prearranged number of days during the month.

[2] All offices have a liberal policy on accepting collect telephone calls.

TABLE E.—ESTIMATED AVERAGE MONTHLY BENEFIT AMOUNTS FOR SPECIFIED BENEFICIARY GROUPS IN IOWA, NEBRASKA, AND SOUTH DAKOTA

Beneficiary group	December 1975	June 1976
Iowa:		
Retired worker without dependents	$197	$212
Aged couples	345	370
Aged widow	197	212
Nebraska:		
Retired worker without dependents	194	208
Aged couples	335	360
Aged widow	194	208
South Dakota:		
Retired worker without dependents	184	198
Aged couples	314	338
Aged widow	187	201

TABLE F.—SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENT DATA

	Iowa	Nebraska	South Dakota
Recipients of federally administered SSI payments, June 1976:			
Total	28,943	15,823	8,803
Aged	15,807	8,193	5,332
Monthly amount of State supplementation:			
Individuals	$55.20	[1]	[1]
Couples	$54.20	[1]	[1]
Living arrangements of aged recipients, March 1976 (percent):			
Owns households	80.1	80.0	82.2
Another person's household	9.2	7.3	8.3
Medicaid institution	10.7	12.7	9.5
Recipients receiving concurrent OASDI benefits, December 1975:			
Total	17,400	8,800	5,100
Aged	12,500	6,200	3,900
Recipients living in nonmetropolitan areas, December 1974 (percent):			
Total	NA	NA	NA
Aged	74.6	72.8	91.3

[1] No State supplementation.

TABLE 4A–1.—ENROLLMENT AS OF JAN. 1, 1975

	Iowa	Nebraska	South Dakota
HI and/or SMI:			
Total	389,220	204,392	91,288
Aged	366,680	193,673	85,766
Disabled	22,540	10,719	5,522
HI:			
Total	387,060	203,128	90,601
Aged	364,520	192,409	85,079
Disabled	22,540	10,719	5,522
SMI:			
Total	379,794	198,534	88,295
Aged	359,142	188,896	83,293
Disabled	20,652	9,638	5,002

TABLE 4A–2.—NUMBER OF HI (PART A) ADMISSIONS, FISCAL YEAR 1975

	Iowa	Nebraska	South Dakota
Inpatient hospital:			
Total	147,060	82,500	37,352
Aged	136,737	77,381	35,207
Disabled	10,077	4,941	2,124
CRD only [1]	246	178	21
SNF:			
Total	3,954	2,172	773
Aged	3,802	2,124	751
Disabled	151	48	21
CRD only [1]	1	0	1

[1] Under 65 but not qualified as disabled under medicare—coverage is on the basis of chronic renal disease only (no other disabling conditions).

TABLE 4A–3.—NUMBER OF HHA VISITS, FISCAL YEAR 1975

	Iowa	Nebraska	South Dakota
HI and SMI:			
Total	59,368	40,761	10,265
Aged	54,211	38,544	9,665
Disabled	5,148	2,218	600
HI:			
Total	37,148	25,525	6,160
Aged	34,161	24,273	5,870
Disabled	2,988	1,253	290
SMI:			
Total	22,220	15,236	4,105
Aged	20,060	14,271	3,795
Disabled	2,160	965	310

TABLE 4A-4.—APPROXIMATE NUMBER OF PERSONS 65 AND OVER RECEIVING ANY TYPE OF SMI (PART B) SERVICE, CALENDAR YEAR 1974

	Iowa	Nebraska	South Dakota
Total	282,948	143,956	59,568
Metropolitan areas	147,379	74,982	31,027
Nonmetropolitan areas	135,569	68,974	28,541

ITEM 11. LETTER FROM JAMES L. YOUNG, ASSISTANT SECRETARY, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT; TO SENATOR DICK CLARK, DATED JULY 13, 1976

DEAR SENATOR CLARK: Secretary Hills has asked me to acknowledge your letter of June 23, 1976, and coordinate the Department's response to your request for certain information dealing with older Americans in rural areas.

With respect to your first question, this Department does not have an official definition of rural area, since, by and large, our programs are available to all eligible users regardless of the type of location. Section 520 of the Housing Act of 1949 does define rural area for the purposes of eligibility for Farmers Home Administration programs.* We have in the past occasionally used this definition for statistical purposes, but changes in this definition have made it less useful, particularly as a result of the addition of part (3) to section 520 in 1974, which expanded the definition to include places between 10,000 to 20,000 population if they are determined to have a "serious lack of mortgage credit."

For the purposes of providing the information requested in items 3 through 6, where appropriate, we intend to provide such data for non-metropolitan areas which we define as being outside of Standard Metropolitan Statistical Areas (SMSAs) rather than "rural." Data maintained within the Department is normally identifiable on an SMSA basis, whereas identifying the specific location of a project and then determining the population of the community in which it is located would require an extensive effort. I am informed that we would have considerable difficulty in obtaining much of the desired data by July 15, 1976, if it were necessary to utilize any other area of definition.

With respect to your second question, our housing legislation consistently defines elderly as one who is 62 years of age or more. The Department believes that there remains substantial unmet needs among those currently defined as elderly, and that an expansion of elderly housing demand through a reduction in the age standard is not warranted.

Please be assured that we will make every effort to supply you with the remaining information requested within the July 15, 1976, date you indicated.

We are pleased to be of assistance in your efforts in examining Federal activities in these areas and will be glad to be of further assistance in other hearings you are planning.

Sincerely,

JAMES L. YOUNG.

ITEM 12. LETTER AND ENCLOSURES FROM JAMES L. YOUNG, ASSISTANT SECRETARY, HUD; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR SENATOR CLARK: This is in further reply to your letter of June 23, 1976, requesting certain data concerning older Americans in rural areas.

The following responds to questions 3 through 6, which were not addressed in our initial response:

3. (*a*) How many persons in these States are receiving section 8 rental assistance?

*Section 520 reads as follows: ". . . the terms 'rural' and 'rural area' mean any open country, or any place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000 and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit, as determined by the Secretary and the Secretary of Housing and Urban Development."

(*b*) How many of these could be classified as rural elderly?

The following represents actual occupancy through June 1976, as reported by the respective HUD Field Offices in a telephone survey done for this purpose:

State	Total number of households receiving sec. 8 assistance	Number considered elderly outside SMSA's [1]
South Dakota	65	20
Iowa	567	85
Nebraska	345	0

[1] Standard metropolitan statistical areas.

(*c*) What offices are responsible for administering the section 8 program in these States?

The Omaha, Nebr., area office has responsibility for administering the section 8 program in Nebraska, and the Des Moines, Iowa, insuring office administers the program in that State. The Denver regional office is responsible for administering the program in South Dakota. I have enclosed a listing of the full address of these offices for your information.

(*d*) Does the Department work jointly with Farmers Home Administration in meeting rural needs?

The Department and the Farmers Home Administration (FmHA) have executed a memorandum of understanding to encourage and facilitate the greater use of section 8 housing assistance for families in newly constructed projects financed under the FmHA Section 515 Rural Rental Housing program. We are drafting regulations for a joint program to implement this memorandum. A central aspect of the program is that owners will deal only with FmHA in developing projects and FmHA will certify to HUD that the proposed project is in compliance with the program requirements. We have agreed that we will set aside not less than 4,000 units for FmHA through September 30 and, subject to congressional authorization, not less than 10,000 units in subsequent fiscal years.

A copy of this memorandum of understanding signed by Secretary Butz and Secretary Hills is enclosed for your information.[1]

4. (*a*) How many units of public housing are located in each of these States?

(*b*) How many of these units are located in rural areas, and how many of these rural units are occupied by elderly persons?

PUBLIC HOUSING UNITS IN IOWA, NEBRASKA, AND SOUTH DAKOTA AS OF JULY 1975

State	Total units		Units located outside SMSA's			
	Programed	Under management	Under management	Occupied	Elderly occupied	Percent elderly
Iowa	3,890	2,927	1,730	1,718	1,505	88
Nebraska	9,436	8,609	3,473	3,312	3,110	91
South Dakota	4,998	3,713	2,368	2,234	778	35

5. What other Federally subsidized or assisted housing (i.e., 202, 221, 231, 236) for the rural elderly is available in these States. May we have a listing of rural projects in each State?

Enclosed is a detailed listing of multifamily subsidized housing available for elderly occupancy under HUD programs in nonmetropolitan areas in the three States.

6. What is the need for rural housing for the elderly as assessed in the housing assistance plans of the communities in these States?

I have enclosed a complete listing of the estimated number of elderly households in need of housing assistance as reported in the housing assistance plans submitted to HUD by the nonmetropolitan communities in the three States.

I hope you find this information useful in your coming hearings. If you require more detail on the information provided or further information, please do not hesitate to contact me.

Sincerely,

JAMES L. YOUNG.

[Enclosures]

[1] Retained in committee files.

ADDRESSES OF HUD FIELD OFFICES HAVING JURISDICTION OVER SECTION 8 PROGRAM IN IOWA, NEBRASKA, AND SOUTH DAKOTA

Iowa: Mr. Nate Ruben, Director, Department of Housing and Urban Development, 210 Walnut Street, Des Moines, Iowa 50309. Telephone (515) 284–4512.

Nebraska: Mr. Guy J. Birch, Area Director, Department of Housing and Urban Development, Univac Building, 7100 West Center Road, Omaha, Nebr. 68106. Telephone (402) 221–9301.

South Dakota: Mr. Robert C. Rosenheim, Regional Administrator, Department of Housing and Urban Development, Federal Building, 1961 Stout Street, Denver. Colorado 80202. Telephone (303) 837–4881.

SUBSIDIZED HOUSING AVAILABLE FOR THE ELDERLY UNDER HUD INSURED OR DIRECT LOAN PROGRAMS OUTSIDE SMSA'S IN IOWA, NEBRASKA, AND SOUTH DAKOTA, AS OF DEC. 31, 1975

State and project name	Place	County	Amount	Units
IOWA				
Sec. 202:				
Eventide Lutheran Home for the Aged	Denison	Crawford	367,000	51
Rotary Club	Eagle Grove	Wright	398,000	43
Prairie View Home	Garner	Hancock	885,000	76
Good Shepherd Retirement Apartments	Mason City	Cerro Gordo	1,374,000	93
Golden Buckle Home	Rockwell City	Calhoun	345,000	42
Do	do	do	140,000	12
Sunset Retirement Home	Spencer	Clay	515,000	51
Sec. 202/236: Golden Buckle	Rockwell City	Calhoun	583,300	48
Sec. 221 MR rent supplement:				
Jans Manor	Indianola	Toma	701,600	60
Courtview Apartments	Carroll	Carroll	575,500	56
Suncrest Village	Newton	Jasper	679,200	60
Sec. 236:				
McBurney Apartments	Belmond	Wright	372,200	32
Bluff Towers	Council Bluffs	Pottawamie	1,137,000	70
United Manor	De Witt	Clinton	560,200	48
Franken Manor	Sioux Center	Sioux	404,700	31
SOUTH DAKOTA				
Sec. 202:				
Morningside Manor	Alcester	Union	518,169	52
Wesley Acres, Inc	Mitchell	Davison	400,000	45
Do	do	do	494,000	38
Pioneer Memorial Manor	Spearfish	Lawrence	274,000	23
Sec. 221 MR rent supplement:				
Pierre Senior Citizens Home	Pierre	Hughes	450,500	40
Carver House	Wagner	Charles Mix	132,000	12
Sec. 236: Village Green	Yankton	Yankton	394,000	32
NEBRASKA				
Sec. 202: North Platte Odd Fellow Housing	North Platte	Lincoln	1,515,000	120
Sec. 202/236: Norfolk Housing Inc	Norfolk	Madison	1,635,000	92
Sec. 221 MR rent supplement: Valentine Housing	Valentine	Cherry	248,800	24
Sec. 236:				
Home Creek Manor	Gering	Scotts Bluff	685,400	40
Good Samaritan Society	Hastings	Adams	1,699,400	106
Tabitha Village	Lincoln	Lancaster	1,923,900	128

Elderly households in need of housing assistance as reported in 1975 housing assistance plans

Iowa:	*Number*
Akron	46
Albia	225
Ames	672
Arnold Park, Okoboji, W. Okoboji, Milford	49
Auburn	16
Bloomfield-Davis Counties	270
Burlington	435
Calumet	11
Carroll	29
Centerville	303
Charles City	266
Clinton	1238
Colfax	37
Fairfield	352
Fort Madison	420
Ft. Dodge	355

Grinnell	155
Iowa City	660
Iowa Falls	626
Jewell Junction	3
Keokuk	114
Leon	38
Mason City	1302
Missouri Valley	55
Moravia	55
Muscatine	715
Oelwein	102
Onawa	156
Oskaloosa	305
Ottumwa	408
Villisca	35
Winterset	171
Woodburn	43
Nebraska:	
Atkinson	35
Cedar Rapids	34
Crofton	41
Elgin	15
Fairbury	100
Falls City	120
Franklin	74
Grand Island	236
Hartington	35
Hastings	3820
Kearney	157
Loup City	85
Norfolk	494
North Platte	762
Omaha Indian Reservation	13
Scottsbluff	80
Talmage	11
Verdigre	20
Wilber	15
South Dakota:	
Astoria	7
Cheyenne River Reservation	50
Crow Creek Reservation	9
Dallas	17
Ft. Pierce	29
Garden City	23
Henry	8
Lower Brule Reservation	14
Menno	80
Mitchell	15
Monroe	22
Pine Ridge Reservation	300
Rapid City	213
Sinai	5
Sisseton	39
Sisseton Reservation	92
Toronto	3
Waubay	30
Yankton Reservation	24

ITEM 13. LETTER FROM RICHARD W. VELDE, ADMINISTRATOR, LAW ENFORCEMENT ASSISTANCE ADMINISTRATION; TO SENATOR DICK CLARK, DATED JULY 16, 1976

DEAR SENATOR CLARK: This is in response to your letter requesting information for field hearings to be held by the Special Committee on Aging.

I will respond to your questions in the same numerical sequence in which they were presented in your letter.

(1) The Law Enforcement Assistance Administration does not have an official definition of a rural area, and would use the definition of the Bureau of Census in developing any surveys.

(2) Inasmuch as the Administration on Aging is the agency with the expertise on this subject, we would be inclined to agree with their definition that an "older American" is of age 60 or older.

(3) Although studies have been conducted which show the crime rate on the basis of age, there have been no studies conducted comparing crime rates between rural and urban elderly residents.

(4) At present there are no programs in the three States which deal exclusively or to a large degree with the crime problem affecting rural, elderly residents.

Based on provisions of section 303(a) of the Crime Control Act of 1973, funding under LEAA programs gives priority attention to high-population areas rather than small communities or rural areas. Section 303(a) reads as follows:

"No State plan shall be approved as comprehensive unless the Administration finds that the plan provides for the allocation of adequate assistance to deal with law enforcement and criminal justice problems in *areas characterized by both high crime incidence and high law enforcement and criminal justice activity.*" (Emphasis added.)

It should be pointed out, however, that there are several requirements in the Crime Control Act, as amended, which have a favorable impact on smaller towns and rural areas.

Among the requirements of the Crime Control Act of 1973 (P.L. 93–83) are:

Section 203(c) which provides that the state planning agency must make at least 40 percent of planning funds available to units of local governments so that they may participate in the formulation of the comprehensive State plan.

Section 303(a)(2) requires that the State pass Federal action funds through to local units of governments and that the State assist localities in meeting match requirements.

Section 303(a)(3) mandates that every State plan must adequately take into account the needs and requests of the units of general local government in the State and encourage local initiative in program development. in addition, funds must be allocated between the State and localities in a balanced manner.

Section 303(a)(8) provides for a system of review whereby units of general local government can challenge allegedly adverse State decisions.

All of these congressional mandates are reflected in our guidelines and in the administration of the LEAA program.

I have enclosed a copy of the statement of Judge Henry McQuade, LEAA's Deputy Administrator for Policy Development, before the House Subcommittee on Housing and Consumer Interests Select Committee on Aging. A review of the enclosure will indicate that the entire LEAA program benefits older Americans at least indirectly, for its goal is to enhance the safety of all citizens. Mr. McQuade's statement includes a brief description of several research and action projects, supported by LEAA because of the recognition that senior citizens have special needs.

For your further information, I have also enclosed a copy of the latest National Crime Panel Survey Report entitled "Criminal Victimization in the United States, a Comparison of 1973 and 1974 Findings." I trust you will find both enclosures useful and informative.[1]

Your interest in this matter and the programs of the Law Enforcement Assistance Administration is appreciated.

Sincerely,

RICHARD W. VELDE.

ITEM 14. LETTER FROM JEANNA D. TULLY, DIRECTOR, OFFICE OF REVENUE SHARING, DEPARTMENT OF THE TREASURY; TO SENATOR DICK CLARK, DATED JULY 23, 1976

DEAR SENATOR CLARK: Thank you for your letter dated June 21, 1976, requesting information on the use of revenue sharing funds specifically in the categories of health and social services for the poor or aged.

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[1] Retained in committee files.

As a member of my staff discussed with David Harf of your staff, the Office of Revenue Sharing does not collect specific data on the expenditure of revenue sharing funds. As you know, the State and Local Fiscal Assistance Act of 1972 provides that funds allocated to local governments must be spent within several general priority categories. Additionally, these funds must be spent in accordance with local law.

The Office of Revenue Sharing does not have an official definition of rural area. Revenue sharing funds are allocated to general purpose governments as determined by the Bureau of the Census, Department of Commerce. The Office of Revenue Sharing does not specify which individuals fall into the "poor or aged" category for the purpose of spending general revenue funds to benefit that group. The flexibility of the program allows local governments to make those distinctions as necessary.

We are unable to provide a county-by-county breakdown of funds spent in entitlement period 5 or planned for entitlement period 6. We are able, however, to give you aggregate amounts for all counties within each of the states you mentioned. Accordingly, we have prepared an aggregate report for counties by State for actual uses in entitlement period 5 and a breakout by types of government, including counties, for entitlement period 6 planned uses. This data is enclosed.[1]

I am also enclosing for your information informal notes located in our files concerning expenditures for older Americans in Dubuque, Iowa, and Clay County, Iowa.[1] In addition, we believe that general revenue sharing funds may have been used for the benefit of the aged in Sioux Falls and Huron, S. Dak., as these jurisdictions specifically listed social services as a category of expenditures. Please accept this information as unverified inasmuch as the revenue sharing act does not require specific information of this nature.

I hope that the enclosed data will be of interest to you and the committee. Please feel free to call on me if at any time I may be of assistance to you or your constituents.

Sincerely,

JEANNA D. TULLY.

ITEM 15. LETTER FROM ODELL W. VAUGHN, DEPUTY ADMINISTRATOR, VETERANS' ADMINISTRATION; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR MR. CHAIRMAN: This will respond to the request of Senator Clark for answers to nine questions propounded in connection with field hearings to be conducted relative to the care received by older Americans in rural areas. For your convenience, the questions have been repeated, followed by the pertinent answers.

(1) What is the official definition of rural area in your agency?

The Veterans Administration feels that every veteran or beneficiary has the right to equal service; and, therefore, this Agency does not have an official definition of a "rural area". For general working purposes, particularly with regard to our outreach efforts, we have tended to classify anything outside of the Bureau of the Census list of Standard Statistical Metropolitan Areas as a rural area. This has in no way affected our service to beneficiaries in these areas.

(2) Do you agree with the designation—as in Administration on Aging programs—that an "Older American" is of age 60 or older?

Some veterans' benefits have certain provisions in law which refer to age, such as benefits relating to minors or disability pension. However. the figure 60 should not be used as a yardstick age for all items relating to Older Americans. As to health care, the chronological and physical ages may not be the same, e.g., a veteran may need nursing home or domiciliary care at age 50. These activities are considered as Extended Care or health care facilities for the "Older American Veterans."

There should be flexibility enough in the age designation for "Older Americans," so the justifiable need of the individual is taken care of.

(3) Are there any VA supported or affiliated hospitals, nursing home, or home care programs located in the hearing States which serve a significant rural elderly population?

The following VA and VA-supported facilities and programs serve a significant rural elderly population in the States of Iowa, Nebraska, and South Dakota:

[1] Retained in committee files.

	ADPC [1]	Operating beds
IOWA		
VA hospital, Des Moines		362
Community nursing home care program	42	
VA hospital, Iowa City		360
Community nursing home care program	63	
Hospital based home care program	18	
Iowa Veterans Home, Marshalltown:		
Nursing home care	375	
Hospital	24	
Domiciliary	175	
VA Hospital, Knoxville		703
Nursing home care unit		200
Community nursing home care program	6	
NEBRASKA		
VA Hospital, Grand Island		172
Nursing home care unit		42
Community nursing home care program	4	
Nebraska Veterans Home, Grand Island:		
Nursing home	349	
Domiciliary	200	
VA Hospital, Lincoln		207
Community nursing home care program	16	
VA Hospital, Omaha		444
Community nursing home care program	33	
SOUTH DAKOTA		
VA Hospital, Fort Meade		389
Community nursing home care program	9	
VA Center, Hot Springs		232
Domiciliary		511
Community nursing home care program	6	
South Dakota State Veterans Home, Hot Springs:		
Nursing home	30	
Domiciliary	94	
VA Center, Sioux Falls		249
Nursing home care unit		57
Community nursing home care program	16	

[1] Average daily patient census.

(4) What efforts have been made in the hearing States to acquaint the elderly rural veteran with the availability of VA information and referral services?

In the States of Iowa, Nebraska, and South Dakota, several programs are in operation which have been used to inform the elderly rural veteran. Among these are:

VA mobile vans, manned by veteran benefits counselors.—Vans were in Nebraska in June of 1975 and July 1976, in South Dakota in July 1975 and May 1976, and in Iowa in April 1975 and August 1976. The vans are preceded by intensive publicity in local newspapers and on radio stations. They reach into the most remote small towns and have proved to be an effective means of reaching rural veterans.

Toll-free telephone service.—Toll-free (FX and WATS) telephone service is now available to 90 percent of the Nation's veterans. Benefits information and assistance are provided by means of VA telephone units in each regional office. This service is available in all of Iowa and South Dakota and in part of the State of Nebraska. It has proved to be the most effective medium to assist the aged in rural areas.

Vet reps on campus.—There are now almost 1,300 vet reps on college campuses nationwide. While their primary function is to assist veterans who are enrolled in educational programs, they have frequently been used to provide outreach to individual veterans, especially the aged, in areas of the States in which they work and live.

VA information service.—By means of news releases, pamphlets, radio and TV announcements, the VA information service reaches into all areas of the Nation. Many small hometown newspapers regularly carry VA news release items.

In addition, the VA provides itinerant veterans benefits counselors, who go wherever the need arises, VA counselors who visit Federal and State prisons, VA field attorneys working in the guardianship program, and community service specialists in certain selected VA regional offices. The Veterans Administration is grateful to the veterans service organizations, such as the American Legion,

Veterans of Foreign Wars, Disabled American Veterans. American Red Cross, and AMVETS, who have provided much valuable assistance in providing veterans' benefits information to the aged in these States.

The Veterans Administration has also designated representatives of the Department of Medicine and Surgery and the Division of Veterans Assistance to each of the 10 Administration on Aging Regional Committees. The regional committees serve all States in the task of carrying out the VA's information and referral responsibilities as they have been spelled out in the working agreement between the 14 Federal agencies and the Administration on Aging. Part of the VA's commitment is to acquaint all elderly veterans with the availability of VA information and referral services. Also, to see that each information and referral office has access to VA information and referral service, each VA hospital and/or outpatient clinic and the Department of Veterans Benefits, Division of Veterans Assistance Offices have been designated liaison representatives to each Administration on Aging Area Office to serve the information and referral programs under their jurisdiction. (This provides service at the local level where the "Older American Veteran" is.)

(5) Are any VA day treatment mental health facilities serving elderly rural residents of the hearing States?

Medical District No. 23 includes Iowa, South Dakota, and Nebraska. There is one day treatment center in this medical district located at VA hospital, Des Moines, Iowa. The day treatment center sees approximately 60 people per day. This generates about 15,000 outpatient visits per year. Of the 60 patients seen at the day treatment center, 5 can be considered elderly, 1 in his early 80's, 4 are over 60 years of age. None of these patients are living in rural areas.

(6) What VA social work services, including telecare, are directed toward the elderly rural veteran of the hearing States? What are the names of the affiliated hospitals?

Social work service has a long tradition of providing a wide range of services to the older veteran and to his wife and widow. This is due in part to the fact that the veteran population is essentially an aging population and because medical science and technology have made it possible to live longer than ever before. The challenge to social work has been to help older veterans live meaningful and useful lives within the limits of their health problems and their disabilities. The complicating factor in achieving this goal has been the lack of adequate social services and social supports for older veterans in the community, and the need to locate and develop a variety of reseources including income maintenance, ambulatory health services, housekeeping and other personal services, such as meals on wheels, transportation, recreational opportunities, etc.

Social work service provides a full range of services either directly or through referral to community agencies for veterans requiring discharge planning and followup assistance. Services include evaluation and counselling visits to veterans placed in nursing homes, State homes, personal care homes, their own homes or other special living situations. VA social workers are active in the development of community resources and the coordination of services veterans may require in order to achieve a satisfactory adjustment in the community. All VA hospitals have extensive field visitation programs through which social services are provided directly to the veteran in his own home.

Volunteers are being utilized in 3 hospitals to provide Telecare services to veterans with special needs who live in isolated areas. One additional hospital will have a formal Telecare program operational in 6 weeks. All programs are operating under the auspices of social work service.

The following hospitals are affiliated for graduate training in social work: VAH Des Moines, VAH Iowa City, VAH Knoxville, VAH Omaha, VAH Lincoln, VAH Grand Island, VAH Hot Springs, VAH Ft. Meade.

(7) What, if any, of the following programs are operational and serving elderly rural veterans in the hearing States: rehabilitation medical services; dietetic and nutritional programs; nursing service; or voluntary service programs?

All of these programs are operational and serving rural veterans in VA Hospitals and VA Centers in Iowa, Nebraska, and South Dakota.

(8) Have any findings resulted from your GRECC research program which are of significant interest to the rural elderly?

The geriatric research, education, and clinical centers are involved in ongoing research efforts which are of interest to rural elderly. The research is not limited, however, to just elderly people living in rural areas. Some of the early research involvements include:

Three GRECC's are engaged in demographic health needs assessment studies of their surrounding communities. Results from this work enables better long-term planning of health services, particularly for the elderly population.

Controlled research is being conducted comparing the normal and pathological states of the cardiopulmonary system in the elderly.

Research efforts at another GRECC are making possible the early diagnosis of senile dementia.

Research is being conducted in the area of nutritional effects upon development in the aging brain.

Work carried on at another GRECC has resulted in the first successful growth of human arterial smooth muscle cells which revealed significant species differences in lipoprotein uptake between human and rat cells. This finding has implications for future research in cellular aging.

Additional research is being conducted on diseases often associated with the aged: osteoporosis, diabetes, and arthroscerosis.

(9) Can you recommend any alterations in your pension and compensation programs which would enable them to better serve the rural veteran?

We have no specific recommendations on this point. Veterans' benefits are the same for all, regardless of area.

We trust that the above answers are responsive to your inquiries.

Sincerely,

ODELL W. VAUGHN.

Appendix 3

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM JOYCE LEANSE, DIRECTOR, NATIONAL INSTITUTE OF SENIOR CENTERS; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR SENATOR CLARK: I am pleased to be able to assist the Special Committee on Aging with its preparations for field hearings on older Americans living in rural areas. Not all of the questions you addressed to us could be answered with information from the National Institute of Senior Centers Senior Center Research Project, but I hope the enclosed information will be useful.

The attached summary of data relies on two NCOA publications, the 1974 "Directory of Senior Centers and Clubs" and the "Report of Senior Group Programs in America," and on the in-depth survey questionnaires which were used to prepare the report. Pages from both books have been copied and enclosed for use with the summary. If the committee staff would like an additional copy of the directory or the report, please do not hesitate to ask. I have also enclosed copies of materials which describe some innovative programs designed to serve the rural elderly.[1]

If you have any questions about the summary or if you need additional information, please call me or Valinda Jones of the Public Policy Department, who prepared our response. I look forward to the results of your upcoming hearings and to working further with the committee.

Sincerely,

MRS. JOYCE LEANSE.

[Enclosure]

(1) The exact number of senior centers and clubs in the United States or in any particular State cannot be determined from the senior center research project data. Although an extensive effort was made to identify and elicit responses from as many adult group programs as possible (as described on pages 3–6 of the report), 9,448 organizations of the 17,930 on the basic mailing list did not respond to the initial questionnaire. Of the 8,442 responses, only 4,870 of those that wanted to be listed in the directory met the three criteria for inclusion. To be included, an organization had to offer a program directed at older adults, meet on a regular basis at least once a week and provide some form of education, recreation or social activity.

Consequently, the listings in the directory represent the minimum number of senior centers and clubs in a region. The following chart (based on information from the director) shows the total number of listed centers and clubs, the average age membership, the average daily attendance and the range of membership totals for organizations in the three States (see pages 407 and 437 of the directory). Comparable national averages are listed on page ix of the directory.

State	Total listed centers	Average membership	Number responses	Average daily attendance	Number responses	Range of membership
Iowa	62	160.2	46	58.8	45	16–7,023
Nebraska	63	170.9	42	36.2	51	2–8,000
South Dakota	57	116.6	47	35.3	47	10–1,300

The directory lists the centers and clubs alphabetically by towns and cities within each State. That information is also attached (pp. 409–415, Iowa; pp. 429–435, Nebraska; pp. 453–459, South Dakota). A summary of the percent of centers in rural and urban areas can be found on pages 13 and 14 of the report.

[1] Retained in committee files.

(2) The National Institute of Senior Centers Senior Center Research Project did not attempt to determine funding sources for construction or alteration of facilities because, at the time the surveys were conducted (fall 1973–fall 1974), there were no active Federal programs of assistance for such activities. Title V of the Older Americans Act was not funded until this year when $5 million was appropriated for the Fiscal Year 1976 transitional quarter. Title I of the Housing and Community Development Act of 1974 (enacted August 22, 1974) allows grants for construction and alteration of publicly sponsored senior centers, but it was not an active program when the questionnaires were distributed. Pages 17–19 of the report include a general description of facilities.

The initial surveys and the in-depth questionnaires tried to determine general funding sources and the proportion of Federal, State, and local funds used by centers. Unfortunately, many of the centers did not respond completely to the questionnaires, particularly to the questions concerning financing. The proportion of Federal and other funds on the average in each State is noted on pages 408 and 438 of the directory. Pages 14–17 of the directory summarize the detailed funding information on a national basis. Additional information on funding patterns in Iowa, Nebraska, and South Dakota can be obtained from the in-depth questionnaires. The difficulty is that the number of in-depth questionnaires from each of the three States is too small to be statistically reliable (10 from Iowa, 7 from Nebraska, and 11 from South Dakota). However, the data might be useful in making some broad generalizations about funding resources. The combined data show that each program relies on several funding sources—the only exceptions being the smaller clubs that indicated a sole reliance on dues and fees.

According to the ten in-depth questionnaires from programs in Iowa, only three received financial assistance from sources other than dues, fees, or individual contributions (a "kitty" was listed by several). (Most of the respondents to the in-depth questionnaire in that State considered themselves clubs rather than centers which might explain the reliance on membership contributions.) In these three programs, funds from title III of the Older Americans Act (OAA) were listed twice; from the Office of Economic Opportunity (OEO) once; from adult social services, once; and from a city tax levy, once. Local organizations, such as the United Fund, were listed by all three.

In Nebraska, only one program of six responding to that question used Federal funds (OEO) and that also relied on local in-kind support. Of the other five programs, unspecified, state funds were listed as a revenue source once; unspecified local funds, twice; local revenue sharing funds, once; and dues, fees or money-raising projects, such as bake sales, were listed several times.

Five South Dakota programs out of nine responding to the question used Federal money. Four of these used title III OAA funds; one used Department of Labor funds. Local unspecified funds were listed five times and, again, dues, fees, projects and other membership contributions were also listed by most of the respondents.

(3) Pages 25–33 of the report summarize the findings on activities and services nationwide. For each center that provided details, the directory lists types of services and notes how often and when centers meet (see pages 409–415; 429–435; 453–459). A comparison of services and frequency of meetings can be made by States and by regions from the information listed on pages ix, 407, and 437 of the directory. Organizations noted whether they held sessions in the morning, afternoon or evening in the initial survey. The frequency of full-day sessions (mornings and afternoons—evenings were infrequent and so not considered here) in centers in Iowa, Nebraska, and South Dakota is noted below.

State	Total centers	With full-day sessions	Average full-day sessions per week
Iowa	62	22	4.5
Nebraska	63	32	4.4
South Dakota	57	16	4.6

The report suggests two standards by which multipurpose programing can be determined (see p. 25). The first is to count those groups that offer three or more nonspecific services; the other is to count those that offer the so-called three basic services (recreation, education, information, and referral or counseling). The following chart is based on information obtained from directory listings.

State	Total	3 or more	Percent	3 basics	Percent
Iowa	62	46	74	29	47
Nebraska	63	42	67	28	44
South Dakota	57	52	74	20	35

A similar chart, also based on the directory listings, shows the number of centers offering health services and, from these, the number offering health screening.

State	Total	Health services	Health screening
Iowa	62	3	1
Nebraska	63	5	1
South Dakota	57	13	4

Information on outreach programs was sought in the in-depth questionnaires, but responses were sporadic and inconclusive. A major difficulty in obtaining information is that two in-depth forms were used—one for organizations that considered themselves clubs and the other for self-designated senior centers. Only centers were asked about outreach efforts in any detail, so the number of responses is negligible. (The small number of in-depth questionnaires from each State must also be kept in mind.)

In Iowa, three outreach programs were identified from six responses to that question; in Nebraska, two outreach programs from five responses; and in South Dakota, five from eight responses. The data on the number of contacts made per month and the number of outreach workers used are too scanty to be useful. Thirty is a rough average of contacts per month through all three States. When compared with the national averages on page 39 of the report, this figure demonstrates the likelihood that the small number of responses has made the information unreliable.

(4) The senior center research project did not attempt to obtain descriptions of innovative programs and, unfortunately, correspondence to the National Institute of senior centers from Iowa, Nebraska, and South Dakota has not included many descriptions of programs which might be useful to your committee. The few that might be of interest have been copied and attached.[1]

ITEM 2. LETTER AND ENCLOSURE FROM JUDITH ASSMUS RIGGS, DIRECTOR, OFFICE OF GOVERNMENT RELATIONS, LEGAL SERVICES CORP.; TO SENATOR DICK CLARK, DATED JULY 19, 1976

DEAR SENATOR CLARK: This letter is in response to your request for information on legal services for the elderly in the states of Iowa, Nebraska, and South Dakota. It is provided as background for field hearings on the effectiveness of federal programs serving the rural elderly in those three states.

As you know, the Legal Services Corporation is a private nonprofit corporation established by the Legal Services Corporation Act of 1974 (Public Law 93-355) to provide legal assistance in noncriminal matters to persons who cannot afford to employ an attorney. The corporation makes grants to local legal services programs that previously received funds from the Office of Economic Opportunity and its successor agency, the Community Services Administration. From 1971 through 1975, Federal funds for legal services remained at the same level. As a result, there was no expansion of service and, in fact, many programs were forced to cut back services as a result of inflation. Congress has just enacted an appropriations measure for fiscal year 1977 that provides an increase in funding to enable the corporation to begin expansion of services to the vast areas of the country where the poor are still without any legal assistance at all.

Programs in Iowa, Nebraska, and South Dakota that receive grants from the Legal Services Corporation.

The corporation supports four programs serving eight counties in Iowa, three programs serving four counties in Nebraska (and one county in Iowa), and two programs in South Dakota, one that is limited to a single county and one that

[1] Retained in committee files.

serves a largely native American population in a 15-county area in the central part of the State. Several of these programs are in cities of substantial size—Des Moines and Omaha-Council Bluffs, for example—and serve a predominantly urban client population. Others serve a mix of rural and small city clients. Only two programs could be described as principally serving rural populations—Panhandle Legal Services in Scottsbluff, Nebr., and South Dakota Legal Services in Mission, S. Dak.

There is attached to this letter a list of the programs in the three states, the addresses of their main offices, the counties they serve, and their current level of funding from the corporation.

Number of elderly served.

The corporation does not have data on the number of rural poor over age 55 in the three States. According to 1970 census figures available to us, the number of rural poor over age 65 in Iowa is 43,321; in Nebraska, 24,743; and in South Dakota, 14,946. Obviously, we reach only a small fraction of that population.

None of our programs in the three States serve the elderly exclusively. The percentage of clients over age 65 varies from program to program, from as low as 5 percent to as much as 15 to 20 percent. The programs do not keep separate records on the number of clients over age 55, but if the group aged 45 to 64 is included, then the percentage of older clients increases significantly.

In most programs, the percentage of clients who are over age 55 is less than the percentage of the eligible population that is elderly. This is due largely to the transportation difficulties poor elderly people have, especially in rural areas. In addition, the elderly tend to be less aware of the fact that legal services are available and do not understand how the programs could be helpful to them.

Those programs serving a relatively high proportion of elderly clients are the ones that have engaged in aggressive outreach efforts. For example:

The director of the Legal Aid Society of Polk County (Iowa) regularly visits senior citizens centers and speaks during their meal programs. In addition, he lectures to the State welfare agency's adult protective workers around the State on the problems of the elderly.

Black Hills Legal Services, Inc. (South Dakota) has a wide-ranging program for senior citizens, including presentations in senior citizens centers and monthly newsletters published especially for senior citizens.

South Dakota Legal Services uses paralegals as well as attorneys to visit nursing homes and the elderly in their own homes to advise and assist them with their legal problems. For example, the program recently canvassed the elderly, to inform them of a South Dakota law providing special tax rebates and to help them fill out the forms needed to obtain the rebate.

Unfortunately, few of our programs have the additional resources required for adequate outreach and community education activities. Title III of the Older Americans Act is being utilized effectively by some local programs to supplement Corporation funds in order to reach the elderly in need of legal assistance. Those efforts through the Older Americans Act must be continued and expanded.

Nature of the legal problems of the elderly.

Accordingly to program directors in the three States, most of the legal problems of their elderly clients are routine and not all that different from those of other clients. However, these problems are particularly serious for older persons and often affect their very livelihood. This most common set of problems relate to their ability to obtain government benefits and services to which they are entitled—social security, SSI, medicare and medicaid, and food stamps. A second set of problems are health-related, including insurance, medical bills, and nursing home problems. The elderly also come with property and personal tax problems, and for help with wills, conservatorships, and problems associated with the death of a spouse. To a lesser degree than younger clients, they need assistance with housing and consumer problems.

The majority of these problems are resolved without litigation. In many cases, the client simply needs information on benefits available to him or her, and assistance in filling out forms. Many matters can be resolved through negotiation. The following are examples of how legal services programs represent elderly clients:

When property taxes rose as much as 45 percent in Polk County last year, the Legal Aid Society representing 2,300 elderly persons in individual protest hearings. The vast majority of those cases, 1,500 in all, were won and another 300 are on appeal.

In South Dakota, a legal services attorney represented a poor elderly client who needed life-sustaining drugs costing $80 a month. Since the State medicare plan did not include payment for drugs, the elderly had to rely on county relief. The county had set an arbitrary limit of $50 a month on payment for drugs. Negotiations failed, a successful suit was filed, and that limit was removed, providing relief not only for the particular client but for all of the elderly in similar situations.

In Iowa, a legal services attorney represented a 91-year-old woman in an eviction proceeding. Friends agreed that the loss of her home would destroy all that bound her to life. The court delayed the eviction and the attorney was able to persuade the landlord to let the woman remain.

The need for legal services for the elderly.

Evidence of the need for legal services among the elderly poor is overwhelming. In Iowa, when the State's commission on aging set up a WATS line for the elderly, the bulk of the calls were about legal matters. As a result, the commission has awarded a small grant to the Polk County Legal Aid Society and refers calls there. Often, the program can take care of the problems simply by giving the callers information, and sometimes by writing a letter for them. In other situations, they refer them to a local attorney who can help.

In Nebraska, the most recent needs assessment conducted by the State's commission on aging identified legal services as a priority among the rural elderly in three out of the four areas reporting. The Panhandle Community Action Agency in Gering, Nebr., conducted a separate five-county survey of needs of the elderly, which showed that home health services were the greatest need and legal services the second. In each of the counties, more than 70 percent of those responding to the question, "Is there a need for legal services?" said yes. In some counties, the response was as high as 89 percent.

We understand that you will be holding hearings in all three of the States during August. Representatives of legal services programs, including paralegals and the elderly clients themselves, as well as staff attorneys, program directors and board members, could provide useful testimony about the need for legal assistance and the benefits when it is available. Perhaps even more important, since those attorneys and paralegals work directly with elderly persons who find it difficult to obtain services and benefits available under Federal programs, they can offer useful insights into the way those programs are serving senior citizens.

I am enclosing letters[1] some of our programs sent in response to our request for information. If you need any further information, or if we can be helpful in identifying potential witnesses for your hearings, please let us know.

Sincerely,

JUDITH ASSMUS RIGGS.

[Enclosure]

Legal Services Corporation funded programs in Iowa, Nebraska and South Dakota

Program and area served	*Annual funding level*
Iowa:	
Legal Aid Society of Polk County, 102 East Grand Ave., Des Moines, Iowa (515) 282–8375; Polk County	$308,000
Dubuque Area Legal Services Agency, 630 Fischer Bldg., Dubuque, Iowa (319) 588–4655; Dubuque, Delaware, and Jackson Counties	75,900
Hawkeye Legal Aid Society, 114 East Prentiss, Iowa City, Iowa (319) 351–6570; Johnson, Jones, and Washington Counties (on referral from county bar association)	77,880
Black Hawk County Legal Aid Society, 708 First National Bldg., Waterloo, Iowa (319) 235–7003, Black Hawk County	99,000
Total Iowa funding	560,780

[1] Retained in committee files.

Nebraska:	
Legal Aid Society of Lincoln, Inc., 800 Anderson Bldg., 12th and O Sts., Lincoln, Nebr. (403) 435–2161; Lancaster County	90,400
Legal Aid Society of Omaha-Council Bluffs, Inc., 7th floor, Farnam Bldg., 1613 Farnam St., Omaha, Nebr. (402) 348–1051; Sarpy, Douglas Counties, and Pottawattamie County, Iowa	277,700
Panhandle Legal Services, Inc., 701 East Overland, P.O. Box 605, Scottsbluff, Nebr. (308) 632–4734; Scotts Bluff County	66,000
Total Nebraska funding	434,100
South Dakota:	
South Dakota Legal Services, P.O. 727, Mission, S. Dak., (605) 856–4444, 15-county area in central South Dakota	290,758
Black Hills Legal Services, Inc., 714 4th St., Rapid City, S. Dak., (605) 342–7171, Pennington County	74,800
Total South Dakota funding	365,558
Total funding in 3 States	1,360,438

ITEM 3. LETTER FROM HARVEY C. DAVIS, ACTING DIRECTOR, MATURA ACTION CORP.; TO SENATOR DICK CLARK, DATED AUGUST 12, 1976

DEAR SENATOR CLARK: Matura Action Corp. has been working with and is an advocate for the low-income elderly since 1966. In the last 10 years changes have been made in public attitude toward the elderly. More affirmative thought is going into the well-being of the elderly.

Even with this progressive change in the attitude toward the elderly, some more assertive changes need to be incorporated into the programs. For instance, in housing, HUD's low-income housing has been eliminated or cut back so drastically that many of our towns and cities that had hopes of a program have been dropped and the elderly are then forced to find other means of housing. Also in the housing that has been established, the housing authorities are encouraged to keep running in the black so HUD will not have to subsidize the program. When this happens, the really low income elderly are sometimes passed over as residents because their 25 percent payment would make their contribution for the rent a little over $25 per month for the rent—and with very many of these in a housing complex, it runs in the red. HUD encourages them to eliminate running in the deficit.

Transportation for the elderly is another area that has made some progress the past 10 years, especially in Madison County.

In the other counties that Matura Action Corp. is funded, the area agency on aging has used title III of the Older Americans Act to furnish transportation. This has been a help. Matura Action Corp. has submitted a proposal to the State department of transportation for the coordination of transportation systems. This would be a boon to the area, but some of the boards of supervisors are reluctant to enter into the agreement, although they know there is a need, because it might become so popular they might be forced to contribute to the program. It is my belief that rural public transportation is going to have to be subsidized by the State, Federal, and the agencies purchasing services for the program. The elderly would benefit from this coordination of transportation systems.

Matura's network of neighborhood centers have been a home-away-from-home for the elderly. In most of the counties in our area, these need to be kept in existence by Matura and supplemented by moneys made available by the Older Americans Act. Matura was helping the elderly long before the Older Americans Act designated regional AAA. Out of our centers we also sponsor 16 other projects for the elderly in other smaller towns in the areas.

The title VII nutrition program of the Older Americans Act has been a valuable asset to our area. I have some constructive criticism: In some instances, the wealthy tend to monopolize some nutrition sites and the low-income will not attend

because of this; and in other instances, the low-income elderly are patronizing the nutrition program in large percentages and now the middle-income and above have some hesitancy to take advantage of the program.

I do not have a solution for this problem, although I think it was created in the recruiting phase of the program. I am concerned about the low-income elderly participating in the program and will use Matura's outreach and encouragement for the elderly poor to participate.

Thank you.

HARVEY C. DAVIS.

ITEM 4. LETTER AND ENCLOSURES FROM DAVID L. ADAMS, HUMAN AGING COORDINATOR, DRAKE UNIVERSITY, DES MOINES, IOWA; TO SENATOR DICK CLARK, DATED AUGUST 30, 1976

DEAR SENATOR: I was pleased to receive your request of August 11, 1976 for copies of my research on the rural elderly. I regret that I missed the hearings you held in Iowa, but am very pleased that you got to talk with Woody Morris and with Governor Blue.

I am enclosing copies of those articles which seem most directly relevant to your inquiry. Three of these apply specifically to the small town rural elderly of Missouri and have been done in conjunction with Dr. C. T. Pihlblad of Columbia, Mo.[1] We will soon issue another series based on a restudy of his sample done in 1973–74. The fourth was done for the Gerontology Society and applies to the general concept of rural elderly in America. It may be of particular use to you.

If I can be of further assistance to you, please feel free to contact me.

Sincerely,

DAVID L. ADAMS.

[Enclosure]

WHO ARE THE RURAL AGED?[2]

By David L. Adams, Ph. D., Drake University

In accepting the offer to write this paper, the task of defining the rural aged and of setting the pace for contributions which follow seemed fairly easy and straightforward. After all, there have been several studies of rural and small town elderly done in the past 15 years and while publications in this area are not as voluminous as those in urban aging, they at least offer a high degree of consistency in defining the study sample. Basically, the rural elderly are those persons aged 65 and older who reside in areas of less than 2,500 population density.

The assumption which underlies this demographic definition of the rural aged is that the social persons so named rather suddenly came into existence at the age of 65 and in the locations where they are found. Perhaps this is a necessary assumption, for it does underlie most of the gerontological research of the past 30 years. The theories of aging—subculture (Rose, 1962), role (Phillips, 1957), and disengagement (Cummings and Henry, 1961)—all presume that the variables necessary to explain the elderly are to be found in their current environments and social persons. Even the lifestyle theory (Williams and Wirths, 1965) is limited to existing, rather than preexisting styles of life. There is one approach, however, which is concerned with both past and present environments—the life-course frame of reference (Youmans, 1969).

This approach indicates that a full understanding of human aging requires that the cultural expectations and abilities associated with older age be compared with those of earlier stages of life. It also indicates that to function effectively, a given society must provide the means by which a person can move in an orderly fashion from one status position to another, and the society must provide the motivations for individuals to fulfill the roles of each position.

Consider, for example, the individual who has lived a lifetime in a highly urbanized area, who has achieved considerable class, status, and power in a bureaucratic structure, who has maintained a lifestyle and a value system commensurate with this position, and who at the age of 65 leaves this lifestyle for the quiet countryside of the Ozark foothills of Missouri (Oliver, 1971). By the

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[1] Retained in committee files.

[2] Published by the Gerontology Society, November 1975.

demographic definition, he would be considered rural aged and there would be nothing to distinguish him from the successful store owner who has spent a lifetime in the region—but surely they cannot be considered "rural" aged in the same qualitative sense of the term. Without the earlier environmental history of the respective individuals, we would be lacking valuable information for explaining much of the variance in their current values and life styles.

The "aged" portion of this definition is also subject to qualitative inconsistencies. For instance, the successful grocery store owner mentioned above might be 75 years old, but still puts in 10 hours a day, 6 days a week at the store. He is still treated and greeted by his customers and friends as he has always been. He has come to be defined in terms of functional age, as ageless. His urban counterpart, while 10 years younger, is structurally defined as a retired old man. Consequently, while the store owner is rural, he is not aged—and his younger counterpart while aged, is not rural.

These examples illustrate the weakness of considering only the current characteristics and environments of the rural aged and emphasize the necessity of further inquiry into the past history of the rural aged and their social worlds. Central to this life-course approach are the dual concepts of social role and socialization. The roles provide for the orderly movement through the life cycle as mentioned by Youmans. Socialization provides the continuing motivations to assume these roles. As used here, socialization is considered a lifetime process of modifying adaptive mechanisms, but its foundation is in childhood socialization—the language, values, expectations, and other patterns of environmental adaptation acquired during the younger years. With respect to the current generation of rural aged, their basic socialization occurred in a period which preceeded the instantaneous communication and value exchanges made possible by automobiles, radios, telephones and television. Consequently, change in their social world was slower and social roles were less abstract or ambiguous than is the case today.

In 1942, a role theory approach to understanding adjustment to present and future roles was proposed which included the following requirements for successful adjustment (Cottrell, 1942):

(1) The clarity of such future roles.
(2) Emotionally intimate contact with persons in such roles.
(3) Practice of the role through play or other activity.
(4) The completeness of the shift in responses and expectations of others to the individual in his new role.

All of these factors were more evident in rural America of 1920 than they are today. Consequently, the rural aged were socialized not only to a different society, but also to a different pattern of socialization and speed of expected social change. They were raised to expect that future roles would remain relatively clear and unchanged during their lifetimes and that societal response to them would be towards the total individual (functional worth) rather than towards some social characteristic of the individual (structural definition).

The difference in orientation to one's social world which such a role expectation affords is vividly described by Parsons:

> . . . the (urban) father does not work in the home and his son is not able to observe his work or to participate in it from an early age. Furthermore, many of the masculine functions are of a relatively abstract and intangible character such that their meaning must remain almost wholly inaccessible to a child. This leaves the boy without a tangible meaningful model to emulate and without the possibility of a gradual initiation into the activities of the adult male role. An important verification of this analysis could be provided through the study in our own society of the rural situation. It is my impression that farm boys tend to be "good" in a sense in which that is not typical of their urban brothers. (Parsons, 1942)

If we substitute for the word "good" other descriptive adjectives—such as neighborly, family oriented, independent, etc., the relationship or comparison remains basically the same. The rural environment of the early 1900's produced a social animal well equipped for survival in a society which existed at that time, but less well prepared for a society which was to change quite drastically during the lifetime of that social animal. The remainder of this discussion represents an inquiry into the nature of this change—especially that directly related to "rural" and to "agedness." It is based on the assumption that the rural aged of contemporary America are not simply old people who happen to live in rural places—they are rural people who have aged while their environments have become progressively less rural.

RURAL ENVIRONMENTS

One of the easier methods of tracing changes in the rural scene is through the U.S. census information—not simply the enumerations, but also the changes in definitions over time. For instance, in 1900 the census definition of rural was basically all places of less than 4,000 population density. By 1910 this definition had been changed to 2,500 population. Thus something about the nature of human social environments had changed sufficiently to cause the Census Bureau to question the validity of the earlier indicator and to reduce the size of the place necessary to be considered "rural." The definition of rural was further subdivided in 1930 with the introduction of the concept of rural-nonfarm. In other words, not only the size of a place but also the occupational structure was considered a useful component of the definition. This subdivision suggested two types of rural people—the farmers and the small towners—with the latter being less rural than the former. The most recent development in this changing definition of rural environs occurred in 1960 with the concept of the metropolitan rural areas. Basically, such areas are those which would otherwise be considered rural, but which are located within the county boundaries of a standard metropolitan statistical area. The significance of this change is that an individual could now be a fully occupied agricultural producer, yet not be considered truly rural due to the proximity of a high population density. The rural areas became relegated to those farms which were at some distance from all major and many minor urban areas.

Each succeeding redefinition of rural served to maintain a degree of isolation or segregation of rural persons from those considered urban. The isolation is a product of both geographic distance and of social difference. The social difference is maintained by the occupational homogeneity of rural peoples who are conceived as agricultural producers for urban consumers. Thus the image of old age as consummatory phase of life (Parsons, 1963) which fits the urban aged may not be so applicable to the rural environments. As will be seen in later papers, this social difference accounts for considerable variance in the social environments and expectations of rural and urban aged.

Another major impact of the redefinitions has been the maintenance of a constant rural population size for the past 70 years—those years during which the rural aged gained their status as the aged. This constant population size is often ignored in the presence of the more frequently cited declining proportion of the rural population. During the period 1920 to 1970, the population of the United States increased by 97 million from 106 to 203 million. But during the same time period, the rural population (farm and nonfarm) remained almost unchanged with 52 million and 54 million respectively.

To correct for the slight error due to changing census definitions during this time, the data has been standardized according to the 1960 definition of nonmetropolitan rural (Robinson, 1965). This information is provided in table 1 and figure 1 and indicates that the constancy of rural population remains. Practically all of the population growth in this country in the past seventy years has taken place in the urban areas and their suburbs—the metropolitan rural areas. In fact, the nonmetropolitan rural population peaked in 1940 and has declined since then to a level below that of 1900. This suggests that as the rural aged leave the farms, they are not being taken over by younger generations, but seem to be passing into the conglomerates of agribusiness. Thus even in nonmetropolitan rural America, the impact of urban styles and values of life are being felt.

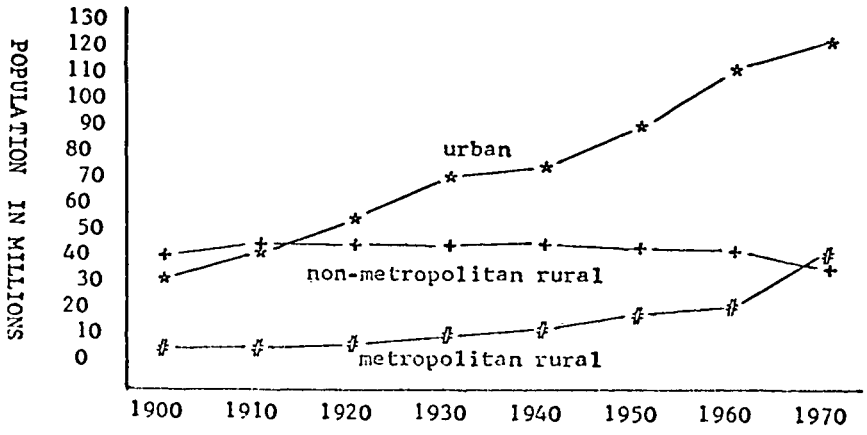
TABLE 1.– RURAL POPULATION OF THE COTERMINOUS UNITED STATES BY METROPOLITAN AND NONMETROPOLITAN STATUS, 1900–70 [1]

[In millions]

Year	Population				Percentages		
	Total	Urban	Metropolitan	Nonmetropolitan	Urban	Metropolitan	Nonmetropolitan
1900	75.7	30.4	5.4	40.5	39.5	7.1	53.4
1910	91.6	42.3	6.7	43.3	45.5	7.3	47.2
1920	105.3	54.5	8.2	43.3	51.1	7.8	41.1
1930	122.3	69.4	10.7	43.2	56.0	8.7	35.3
1940	131.0	74.9	13.0	44.3	56.3	9.9	33.8
1950	149.9	90.4	17.9	43.1	59.4	11.9	28.7
1960	177.7	113.4	24.7	41.2	62.9	13.9	23.2
1970 [2]	203.2	123.0	42.7	37.5	60.6	21.0	18.4

[1] Source: Warren C. Robinson, 1965.
[2] Source: 1970 Census of the United States, U.S. Bureau of the Census.

CHART 1. URBAN AND RURAL POPULATION OF THE COTERMINOUS UNITED STATES BY METROPOLITAN AND NONMETROPOLITAN STATUS, 1900–70



AGE AND SEX ENVIRONMENTS

The rural environment is only half of our consideration here—the other half deals with the aging environment of the American character. That is, not only have the rural aged gained their present status by growing older in the past 70 years, but also the structure of the American population has grown older. Further, the differential impact of mortality on men and women is sufficiently great to cause us to consider rural aged men and rural aged women separately in this section.

Given the phenomena of the migration of youth from rural to urban environs, plus the above cited fact of the stable rural farm population during the past 50 years, it would seem logical to conclude that the rural population has "aged" more rapidly than the urban segments of the population. In fact, it might seem that the 50 million in rural areas today are the same 50 million who were there a half century ago—and consequently are all rural aged. However, the census data supports such a proposition only partially.

It is a well known fact that he "aged" proportion of the American population has increased from about 4 percent in 1900 to about 10 percent today. If the above stated hypothesis were correct, then the rural population would be expected to account for more of this increase than the urban population. However, the data in table 2 indicate that both urban areas and rural farm areas have increased at about the same rate from 1930 to the present.

TABLE 2.– PERCENTAGE OF UNITED STATES POPULATION OVER AGE 65 BY RURAL AND URBAN STATUS, AND BY SEX, 1930–70

1970 distribution and location of aged	Census year				
	1930	1940	1950	1960	1970
Males:					
4 percent rural nonfarm	6.3	7.2	7.8	11.2	11.7
26 percent rural farm	5.7	7.1	8.2	8.8	9.2
68 percent urban	4.8	6.3	7.6	8.2	8.1
Females:					
5 percent rural nonfarm	6.6	7.4	8.3	13.1	15.3
20 percent rural farm	4.5	5.9	7.0	9.0	10.0
75 percent urban	5.4	7.3	9.0	10.1	11.3

Source: U.S. Bureau of the Census, 1930–70.

In each of the census years, there have been about 1 percent more males over age 65 in rural farm areas than in the cities while the reverse was true for females—a higher proportion in the cities than on the farms. For both sexes, how-

ever, the proportion over 65 in the rural nonfarm areas has grown much more rapidly than either rural farm or urban areas. For males, 12 percent of the rural nonfarm population is over age 65 compared with 8 percent and 9 percent in urban and rural areas. For females, the figures are 15 percent, 11 percent and 10 percent respectively. Our first inclination would be to interpret this higher rural nonfarm figure as supportive of the thesis that the rural population has aged faster than the urban population. However, when we realize that only 5 percent of all aged reside in rural nonfarm areas, compared to one-fourth in rural farm and 70 percent in urban areas, then the impact of this higher proportion is seen to be relatively small.

There are three possible explanations why the static population of rural areas, even with its outmigration of youth, has not "aged" faster than the more dynamic and growing urban areas. First, the rural families tend to be larger thereby holding down the proportion over age 65. The rural aged will differ from the urban aged because of this family differential in ways described later by Powers. Second, the life expectancy of rural people has traditionally been lower, thus reducing the number of people reaching the status of rural aged. This is considered in later papers by Oliver and Taietz. Finally, there has surely been some rural to urban migration by the elderly—if not from the farm to the cities, then at least from rural farm to rural nonfarm or small town environments. This is discussed in the following paper by Pihlblad.[1]

It was mentioned above that mortality, and therefore aging, has had a differential impact on rural aged men and women. For the country as a whole, the sex ratio has declined from 104 men per 100 women in 1920 to only 95 m/w in 1970. This information is presented by age and place of residence in table 3 and clearly illustrates that the decline has been the greatest in farm areas, going from 139 in 1930 to only 93 in 1970 for persons aged 65 and over. In other words, there has been a drastic change in the sex composition of the rural aged during the lifetime of the current generation. While we frequently think of the change in urban aged sex composition over the past 50 years as a trend from aged couples to urban widows, the trend during the same time in rural areas has been from rural widowers or bachelors to rural couples. If this trend continues, the implication is that more and more rural widows will be faced with the decision to remain on the land and try to farm it themselves, or to join the flow of rural widows to the nearby small towns.

TABLE 3.—SEX RATIO OF THE U.S. POPULATION OVER AGE 65 BY RURAL AND URBAN STATUS, 1930-70

Location of aged	Census year				
	1930	1940	1950	1960	1970
Rural nonfarm	101	100	97	80	71
Rural farm	139	134	128	104	93
Urban	86	82	80	76	67

Source: U.S. Bureau of the Census, 1930-70.

In concluding this section on the trends in rural aging, we have reason to believe that the rural aged may need more adjustment to their old age than do the elderly in general. Not only have they witnessed an aging of their social environment, they have seen a rural way of life to which they were socialized give way to an urban way of life for which they may not be prepared. As children they lived in a very young world which contained few older people—both in absolute size and in proportion. Because they were few in number and because of their rural environment, we have reason to believe that the rural aged of 1920 possessed a relatively high degree of status and respect (Cowgill and Holmes, 1972). It was this image of old age that the children who became today's rural aged envisioned for themselves. But as they grew older, they found themselves surrounded by an increasingly larger number of persons like themselves. This may function to provide them with a larger peer group with whom to interact, but it is generally dysfunctional to the extent that it lowers the status of the aged and affords them less respect than they were socialized to expect.

[1] Retained in committee files.

It has been the contention of this paper that the rural aged were the products of one culture, the participants of another. Unlike the urban aged who had only to learn to be "old," the rural aged had additionally to learn to be "urban." Of course, it is a matter of argument concerning the impact of the rural-urban differences on the individual's social environment. Here we have emphasized that difference. But it should be pointed out that as early as 1920 the spread of urban life styles and values to rural areas had already been observed and described as "rurbanization" (Galpin, 1920). Charles J. Galpin used this word to indicate the changing nature of community relations—especially as they dealt with family, friends, work, and government. He felt that easy and rapid communication between rural and urban areas was responsible for "rurbanization":

> Locality groups have tended to enlarge their boundaries . . . This trend has been fostered most of all by the development and diffusion of rapid means of travel and communication, especially the automobile and good roads.

Forty years after this initial invasion was described, Richard Dewey surveyed the work of eighteen authors of books and articles dealing with rural-urban sociology, looking for items believed "to be the basis for distinguishing ruralism from urbanism" (Dewey, 1960). Although he found five variables or concepts which had some degree of agreement, he ultimately concluded that "It may occur to one that, if this be all that there is to the rural-urban continuum, it is of minor importance for sociology." The five variables which he considered relatively unimportant were: (1) Homogeneity/heterogeneity; (2) intimate/impersonal social relations; (3) familiarity/anonymity; (4) simple/complex division of labor; and (5) "symbols of status which are independent of personal acquaintance." He continued by saying these should not be eliminated from sociology, but they should "be considered with the more important cultural facts, form and content, which are the sociologist's stock in trade."

While Dewey may be describing a very accurate account of rural-urban lack of difference in 1960, we cannot help but believe him guilty of shortsighted reductionism by the implication that rural-urban differences have always been relatively unimportant. It is likely that there will be little difference between rural aged and urban aged of tomorrow, for as the children of today they are being exposed to nearly identical cultural roles, expectations, and values. But this should in no way negate the differences to be found among the rural aged and the urban aged of today.

In conclusion, the rural aged are a product of a unique combination of social, historical, and technological events. Perhaps because of this they will be more difficult for the practitioner to deal with—being more difficult to reach both geographically and socially. Further, given the transitory nature of the rural aged character, perhaps the practitioner would be well advised to build service delivery programs designed to fulfill the needs of coming generations of aged, rather than attempting to construct specialized and temporary programs for this generation. This is not meant to suggest that we should fail to attempt to satisfy the needs of the present generation of rural aged, but neither should we conclude that delivery systems which are "successful" today will continue to be successful with future generations of elderly who will be healthier, better educated, more active, and more demanding of fair treatment.

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Appendix 4

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing in Winterset, Iowa, on August 16, 1976, concerning "The Nation's Rural Elderly," I would have said:

The following replies were received:

OPAL BURGER, WINTERSET, IOWA

Our parking facilities are very inadequate here at the center.

MARJORIE DRORBAUGH, CRESTON, IOWA

The CSA needs more funding to carry out its work to help keep the rural elderly better informed of programs that will help them to live a better and more comfortable life.

VERNON R. FEE, ST. CHARLES, IOWA

I am opposed to the withholding tax proposed by IRS Commissioner Alexander. He has asked the Senate Finance Committee for authority to withhold 20 to 30 percent of all interest and dividends. The attorney for the American Bankers' Association has estimated that savings amounts alone would generate 75 million pieces of paper. Alexander claims the IRS cannot afford to compare bank reports with individual tax returns. He says the Treasury loses more than $1.5 billion in revenue each year. This is bureaucracy at its best—unable to carry out an existing law, it accuses the people of tax evasion and then asks for another law to make private business their tax collector. If the IRS plan is followed, it will really fall heavy on widows, retirees, low-income families, and those living on fixed incomes. At the end of the year, the Government would have to return all it collects from those on low incomes. The added burden of paperwork will end up costing the taxpayers money.

I am opposed to the 3-day-week congregate meal program to take effect on October 1 in St. Charles. Our group has an outstanding record and, with an expansion of the program generally, I think it unwise to cut back on the existing program.

VERNE M. HIGENS, WINTERSET, IOWA

We have been carrying hospital-health-medical insurance, also life, in case we are stricken with a long-term illness, such as cancer, stroke, diabetes, or some long illness that requires intensive care. Then we found out our little savings account had dwindled to $108 at a bank here. So I wrote to A. E. Smith, director, Madison County Department of Social Services, 110 W. Green, Winterset, Iowa 50273. A lady called yesterday and told us to drop most of our insurance. I have wanted to carry insurance to provide coverage in case of a long illness or death as we have no money, no real estate, no farm to sell or live on, no business to sell on retirement, and no big pension coming. I know I could have worked after I was 65 and that would have helped me a lot and saved the Social Security Administration a lot of money. I did have a job here in Madison County as a night

watchman for Gendler Stone Products Co. and I was getting over $300 per month. I was cut off that income right after my birthday November 29, 1968, when I became 65.

So then I finally got social security and an old-age pension—both amounted to about $160 a month, so you can see what mandatory retirement has done for me.

I would like to ask if you could get $100 more for me from social security or from something else. I was forced to retire from the post office here July 11, 1975, with only 5 years' service and only 18 hours per week, so my funds and pension fund never accumulated so we could live in retirement.

I still could be working at the post office and getting money to provide all the needs, but we are being denied all this by certain laws that have been made in Congress to deprive people like us from having money to live on. I just called the hospital here and semiprivate rooms are $59 per day and $63 for private rooms. The insurance we carry pays, $1,000 per month to persons under 65, but only $500 per month to those over 65. But we pay the same premiums that those under 65 pay, so our benefits are only one-half of those under 65. We are not able to have all the medical care we need either because of no money to pay bills or office calls.

It is too bad that people here in Madison County such as us are being denied by law the right to have medical care and money to provide it. I am asking the Committee on Aging and Congress to enact some legislation to provide money for the people and let's keep more money in the United States where it belongs and take care of us who do the voting for Members of Congress and all other elective poeple. I asked the welfare department if they would buy me two new pairs of overalls to help out and so far they have refused. And that name is A. E. Smith, director (same address as before). Why not write him a letter and ask if would do this much for me—please. Thank you. I sure hope you can do something for us right away. We need it now.

We do have a car that runs, but no money to buy gasoline nor new license for 1977.

We have borrowed $800 since May 1976 just to pay bills and live on, and now I wonder how I will repay it all. And yet I have been told by one lady in the Madison County Welfare Office back in 1972 that I could have only $117 per month while my wife was in a nursing home on medicaid. They say when I am over 65 I do not need money.

ALMA MCKINNEY, WINTERSET, IOWA

I think they should do with less help in the office. with so much visiting they can't do their work with so many around. Louise Forsyth, her daughter, Mary, her mother Neva McKebbin, her Aunt Neola, and Louise's husband too. I think the one who runs the van could pick up more at a time instead of running with one or two at time. One other thing—when the clothing room opened again, they have 2 days with volunteer helpers—one or two come one-half day. The office ladies come in, go through the clothes in boxes before we can hang them up—they want to get their pick what they can use first. I don't think that's a good rule. Two other ladies have their job—Betty Berry, Teresa Brittain. They take care of their job. I go eat meals twice a week. I think they ought to have a set price—some get by with a dime or some just sign their name and go sit down. I think this money they are getting should be spent very carefully. How lucky we are to have people do this. I enjoyed your talk, and am looking forward to hear you again.

MRS. WILBUR SAVILLE, MT. AYR, IOWA

You were asking what some of the problems confronting senior citizens are. One thing that often causes a hardship to people on social security is when people who have medicare and Blue Cross insurance go to a doctor in larger cities, they have to pay cash for the doctor's services, and then wait to collect their money from the insurance company. This can really put them in a bind until time for their next social security check or the insurance money is refunded.

Another problem is the homemakers services. More money needs to be appropriated so they can provide enough help for people unable to do all of their own work. Now these services are only provided for a few of those needing help.

Also, the congregate meals program needs enough money so they can provide meals each day instead of two or three times a week. And the same thing is true for the problem of transportation in these minibuses. More buses are needed, especially equipped so that crippled people can get into the buses easier.

YVETTE WILSON, WINTERSET, IOWA

I have a job that didn't exist 2 years ago because of title III transportation, an act to help older Americans. I am a part-time van driver and the transportation secretary at the multipurpose center in Winterset. I also serve in other capacities there to directly serve and help the senior citizens, a most rewarding occupation. However, I have some misgivings about the Older Americans Act and all the other legislation which makes free services available to an ever-growing segment of our population. Because of increased advances in medical technology, Americans are living longer and, because of the declining birth rate, older people are becoming a larger percentage of the population. It is true that 40 percent of rural older folks live below the national poverty level, but this is just a statistic.

Except for increased need for medical care and its proportionately higher cost for older people, most older persons can live more easily under the poverty level than can young or middle-aged Americans who are raising and educating children, acquiring possessions needed to run a home, who require more calories from food (therefore needing more food) and need more clothing to meet the work-a-day world. Most senior citizens these days, especially in rural areas, don't require a lot of clothes because they aren't real active and don't wear out or soil the things they have. They have already had a lifetime to acquire all the material things they truly need, and many own homes bought and paid for years ago. There are exceptions in many cases, I know. I really believe though that a great many of these poverty level people don't even want the services available to them. Take the new transportation system for example: In this county of over 11,000, about 2,631 are eligible to ride the van. However, in 1976 only 212 different individuals in the county have used it once or more. Two good friends, both over 60, say they won't because, although they feel it is a good thing for some few, it doesn't justify the money spent and therefore, indirectly, the increase in taxes they and younger people of America have to pay. Even though I benefit personally from this particular program, I agree with them.

Why should we have medicare, transportation, congregate meals, reduced college tuition, reduced admittance prices to many activities, low-income housing, home health care, etc., for 60-plus people and not for the general population? It is clearly discriminatory. I know it is true that more special funds are becoming available for other age groups; for example, money for summer recreation for low-income children 8–13 (we have a program out of this center) and man-power, which helps finance jobs and education for poor young adults, but here again, all the "programs" I know about all deal with the poor, the cost of which middle income persons are carrying. I work because with four school-age kids we can't get along on his income alone, yet he makes too much to make our boys eligible for reduced price school lunches or summer recreation or winterization of our home, or reduced costs of child care for our youngest while I work. Something's wrong somewhere. Sure, these programs produce jobs for folks my age (I'm one), but I just get paid the minimum wage, as does the outreach worker here who is buying a house and raising three teenage boys on her bimonthly take-home of $175. In her case, she could make more on unemployment or welfare. I sure don't have the answers, but I do have a lot of questions. I know mandatory retirement at age 65 is for the benefit of young and middle-aged families, but a great source of human potential is literally discarded. I don't know one of the senior citizens I am acquainted with that I don't think is worthy of government help, and I'm happy for those who have benefited by it, but the contradictory attitudes I've just described still keep running through my mind and I feel we are slowly becoming a total social society, and I'm against that.

OPAL WOODS, TRURO, IOWA

We, the undersigned, would like to have the congregate meals program continue the 5 days per week. Although some of us can't attend every day nor can we meet our 25-per-day quota, we hope this service will not be discontinued as we feel there is a real need for it in our community: Mr. and Mrs. J. L. Morse, Effie B. Spencer, Veda Johnson, Frank Weitt, Enid Dudney, Margaret Winter, Daisy Barnes, Lula Smith, Alta Rhynd, Peggy Looner, Leea Snyder, Phyllis Lorenzen, Jessie Hiatt, Mildred Hazen, Gletha Lytton, Grace Perry, Mary Fenimore, Bernice Brant, Wylma Roby, Georgia Jones, Ralph Jones, Evelyn Kephart, Alvin Kephart, C. R. Woods, Opal Woods, Edith Youmans, Ruby Camp, Cleo Creger, Mabel S. Torbet, Helen Durbin, Ethel Seamans.

MARION W. YOUNG, DES MOINES, IOWA

After working in the social service field for the past 2 years as an information and referral specialist, I feel that the elderly's two biggest unmet needs are housing and handyman-chore service. Much was said at this hearing about housing, but I was surprised that handyman-chore was not mentioned (unless it was mentioned by the last panelist—I had to leave before he spoke).

Surely, people need their grass cut, weeds pulled, and certain minor repairs, such as putting in light switches and replacing washers in leaky faucets. What elderly person can pay the prevailing wages for these services?

Also, I would like to see some type of coordination between the funding agencies that allocate funds to titles III and VII of the Older Americans Act and title XX of the Social Security Act. Title XX can do anything that titles III and VII can do, except there is a means test for title XX.

My real concern is this: Most of the agencies that channel funds down to the service providers are interested in only allocating funds and the programs they fund. Personally, I think the commission on aging and the area agencies should assume the role as advocate for the elderly and, through a cooperative effort with other community resources, see that all services are delivered.

I am 61 years old!

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THE TRAGEDY OF NURSING HOME FIRES: THE NEED FOR A NATIONAL COMMITMENT FOR SAFETY

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

HOUSE SELECT COMMITTEE ON AGING

AND

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SENATE SPECIAL COMMITTEE ON AGING

NINETY-FOURTH CONGRESS

SECOND SESSION

HELD JUNE 3, 1976

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CONTENTS

APPENDIX

THE TRAGEDY OF NURSING HOME FIRES: THE NEED FOR A NATIONAL COMMITMENT FOR SAFETY

THURSDAY, JUNE 3, 1976

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
SELECT COMMITTEE ON AGING,
and
U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittees met, pursuant to call, at 9:30 a.m., in room 318, Russell Building, Hon. Cluade Pepper, chairman of the House Subcommittee on Health and Long-Term Care, and Hon. Frank E. Moss, chairman of the Senate Subcommittee on Long-Term Care, jointly presiding.

Subcommittee members present: Representatives Pepper of Florida, H. John Heinz III of Pennsylvania, and William S. Cohen of Maine; and Senators Moss of Utah, Charles H. Percy of Illinois, and J. Glenn Beall, Jr., of Maryland.

Also present: Hon. William J. Randall, chairman of the House Select Committee on Aging, and member, ex officio, of the Subcommittee on Health and Long-Term Care.

OPENING STATEMENT OF SENATOR FRANK E. MOSS

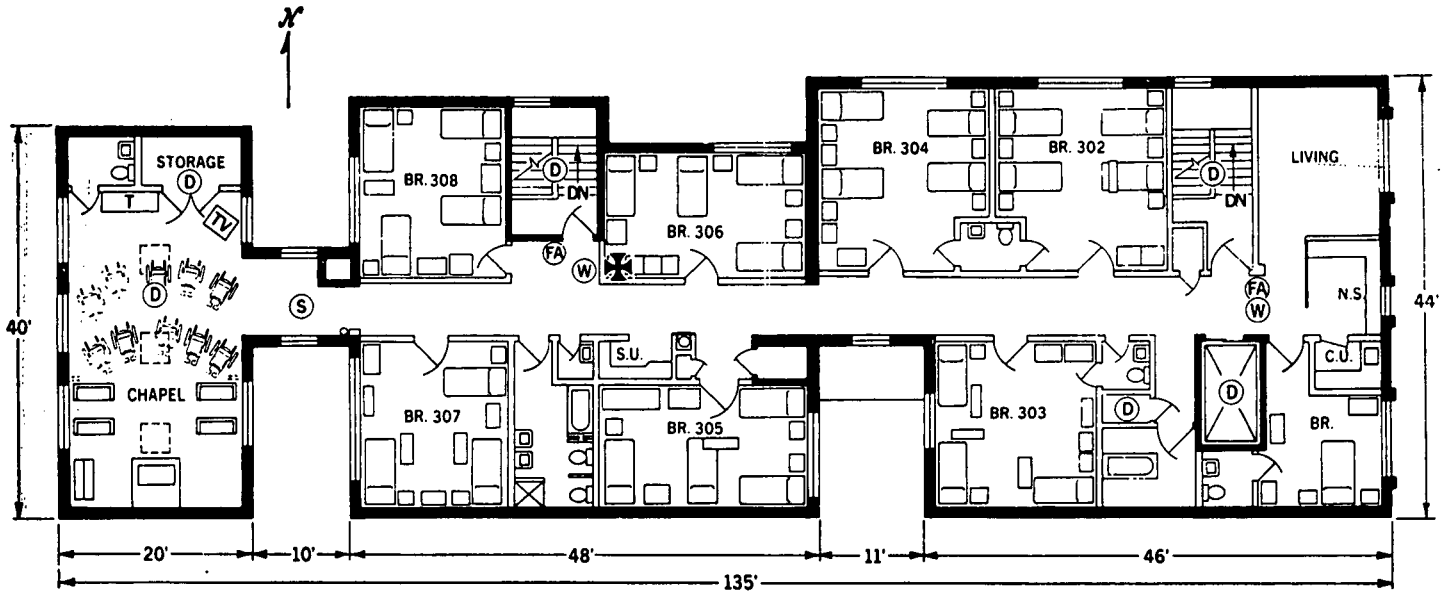
Senator Moss. The hearing will come to order.

This is a joint hearing of the Senate Subcommittee on Long-Term Care and the House Subcommittee on Health and Long-Term Care chaired by Representative Claude Pepper, and we have the Senator from Illinois as the ranking minority member on the Senate committee, Senator Percy. We hope there will be others who will be able to join us as we proceed.

We are here to probe the causes and implications of the two recent nursing homes fires in Chicago which claimed 31 lives earlier this year.

Since we are going to be talking about two fires today, I just want to take a moment to describe each fire with the hope of minimizing confusion.

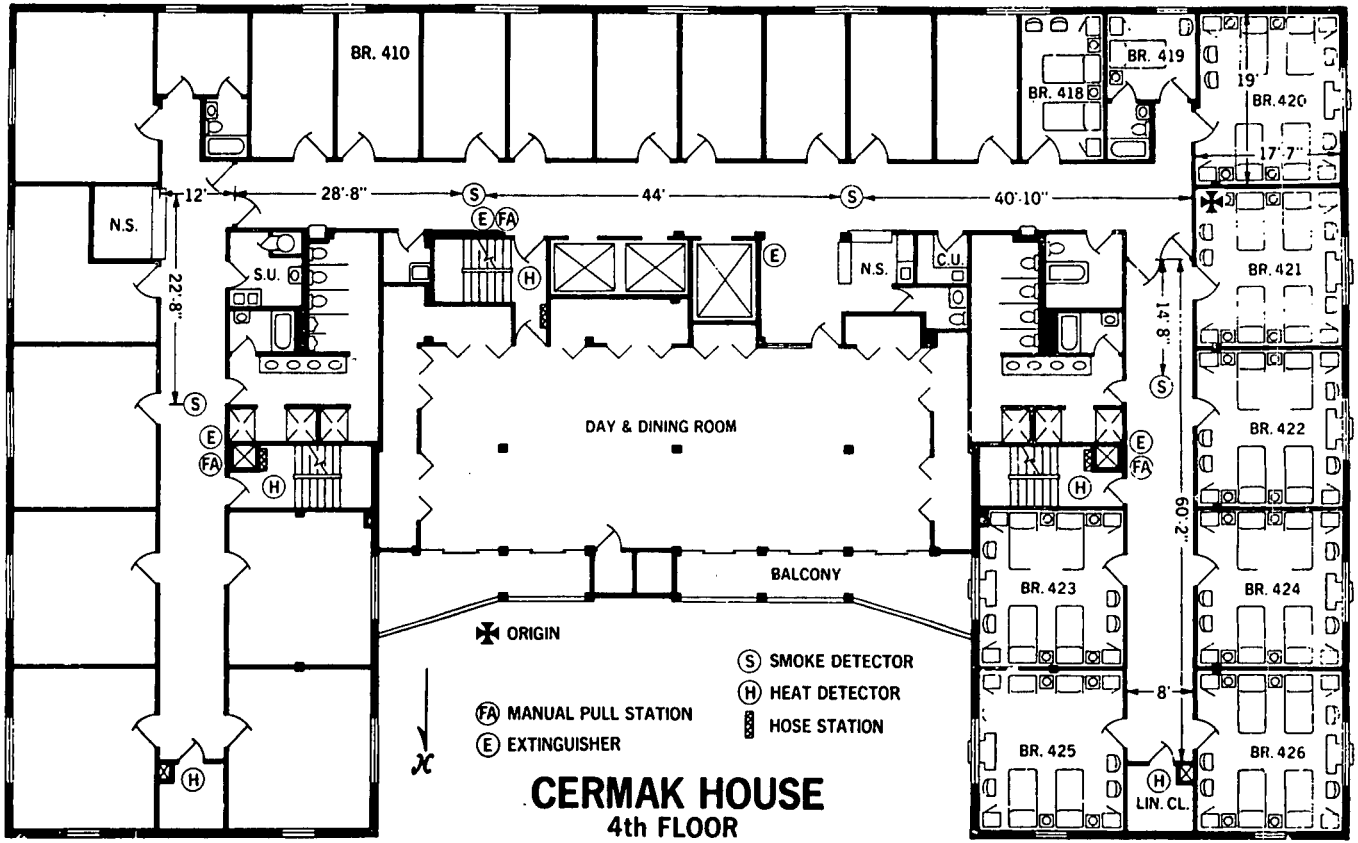
The first fire occurred in the Wincrest Nursing Home at 11:40 a.m. on January 30, 1976. This home was of modern design, basically a steel and concrete structure. It is said to have been in substantial compliance with the existing Federal fire safety standards for nursing homes: The Life Safety Code of the National Fire Protection Association. Arson was the alleged cause of the fire. The reaction of the fire department was swift, arriving at the scene 3 minutes and 40 seconds after receiving the initial alarm.



ORIGIN
(FA) MANUAL PULL STATION
(W) PRESSURIZED H_2O EXT.
(D) HEAT DETECTOR
(S) SMOKE DETECTOR

WINCREST NURSING HOME
THIRD FLOOR
CHICAGO, ILL.

SOURCE: NATIONAL FIRE PROTECTION ASSOCIATION



CERMAK HOUSE
4th FLOOR
CICERO, ILLINOIS

SOURCE: NATIONAL FIRE PROTECTION ASSOCIATION

Senator Moss. You will note by the floor plan on display here that the fire reportedly started in a patient's wooden clothing wardrobe on the third floor of the home. The contents of room 306 were totally incinerated but the fire did not spread to adjoining rooms. Employees trying to battle the fire left the door to the room open so that dense smoke filled the hall, the open rooms, as well as the chapel at the end of the corridor. Twenty-three of the home's 83 patients died in the fire. Most of them were attending religious services in the chapel at the time the fire broke out. Significantly, the chapel is at the end of a "dead end" corridor; patients had to be moved in the direction of the fire to be evacuated.

On February 4, 1976, a second fire occurred at Cermak House Nursing Home in Cicero, Ill., a modern 9-story 618-bed concrete-and-steel nursing home. The fire began at 6:30 a.m. in room 421, on the home's fourth floor. The fire department responded promptly but eight patients died, most from smoke inhalation. The exact cause of the fire is undetermined; the best theory is that it was the result of electrical failure. In this fire, as in Wincrest, most of the fatalities occurred because of a dead end corridor. Again, this means that patients had to be evacuated in the direction of the fire. Cermak House, like Wincrest, was allegedly in substantial compliance with all Federal and State fire standards for nursing homes.

These two tragedies raise a series of inevitable questions:

Why did 31 patients die in nursing homes that were ostensibly in compliance with existing Federal and State fire safety standards?

Does the existing Federal standard, which is in compliance with the Life Safety Code, adequately protect patients?

Should every nursing home receiving Federal medicare and medicaid funds be required to provide automatic sprinkler protection regardless of construction type?

Should smoke detectors be required in every facility as the first line of defense against fire?

Should the Congress enact greater controls with respect to the kinds of furnishings that may be used in nursing homes? Put differently, does it make sense to require operators to build homes of concrete and steel and yet to allow them to furnish such homes with highly flammable nightstands, wardrobes, chairs, wastebaskets, and the like?

In this connection, I want to find out why the Department of Health, Education, and Welfare has not fulfilled the promise they made to me after the January 1970 Marietta, Ohio, nursing home fire to issue appropriate flammability standards for carpeting installed in nursing homes.

I want to know why, 9 years after the enactment of the Flammable Fabrics Act, the Department of Commerce has not promulgated effective flammability standards to protect consumers. After our hearings on the Marietta fire 6 years ago, I was promised that such standards would be forthcoming. Unfortunately, both the Commerce Department and HEW continue to rely upon the anemic "pill test," a test of questionable value which provides limited protections to consumers in general and almost none to nursing home residents.

I want to know why there is little or no emphasis within the Department of Commerce or HEW on the question of smoke generation and the toxicity of burning gases. We have raised this question in the

hearings we have held on several of the major nursing home fires, and yet, little seems to have been accomplished on this score.

I hope that we can have some of these questions answered today.

I am very pleased that Representative Pepper, the chairman of the House Subcommittee on Health and Long-Term Care, is here on this joint hearing. I will ask if he has any opening remarks.

OPENING STATEMENT OF REPRESENTATIVE CLAUDE PEPPER

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

I wish to thank you and your subcommittee for accepting our invitation to join with us in today's hearing. You and your staff have, over the past several years, developed tremendous expertise in the area of nursing home fire safety, and we are privileged to be able to work together. Today's hearing is our second joint effort, the first having been at Senator Moss' invitation on the subject of proprietary home health care on October 28 this past year. I also am very grateful that Senators Moss and Percy were kind enough to agree to the delay of this hearing until today because of my recent operation.

Our Subcommittee on Health and Long-Term Care of the House Select Committee on Aging is very pleased to meet with your subcommittee to consider the vital matters of safety of people all over America who are patients in nursing homes against the danger of fire, although the circumstances necessitating today's hearing are unfortunate.

Thirty-two defenseless elderly persons died and 50 were injured in two fires in nursing homes in the Chicago area earlier this year, with multiple deaths and injuries in earlier fires elsewhere across the country.

The tragedy of the recent fires mandates congressional and executive action. It is shocking to learn that so many deaths and injuries occurred in the two Chicago fires this year, and several earlier fires elsewhere, even though the buildings were supposedly fire-resistant and were in substantial compliance with the Federal fire safety requirements. Evidence to date from Chicago fire officials and others indicates that sprinklers throughout the facilities would have avoided the multiple deaths which occurred. Current Federal life safety standards are simply inadequate.

In addition, bureaucratic tangling between the Departments of HEW and HUD—which have joint authority to approve federally assisted loans for the construction of sprinkler systems—has resulted in the approval of not a single loan anywhere in the country.

Prompt action by the Congress and the executive branch is needed to make certain that repetitions of the Chicago tragedies—which we now learn were clearly avoidable if adequate standards were in effect—do not recur.

At our request, the General Accounting Office has conducted a study on the Chicago fires. The GAO report, just completed, has concluded that "Federal fire safety requirements do not insure life safety in nursing home fires." GAO's recommendations for action include requiring all nursing homes to be fully protected with an automatic sprinkler system and expediting and publicizing Federal loan procedures for sprinkler construction. I hope our joint committee will consider the possibility of loans by HEW to nursing homes which need financial assistance in order to provide sprinklers for the safety of their people,

loans that could be amortized over a reasonable period of time. In addition, some of them may require grants, and I hope our committee will study that possibility.

I hope these matters will be carefully studied with an eye both to introducing legislation and to urging Secretaries Mathews and Hills to implement the administrative recommendations.

The General Accounting Office will be a principal witness today, and I want to express our deepest gratitude to them for their prompt completion of their study in time for today's hearing. Their study will be released for the first time at this hearing. I particularly wish to thank Alan Zipp of GAO for his thorough and dedicated service in the preparation of the background work and report itself. I understand that Alan gave up a Florida vacation to complete the report and to be with us today.

The testimony of the General Accounting Office will be followed by other leading national experts in nursing home fire safety both from the executive branch and other organizations.

Following our hearings, I intend to introduce legislation upgrading nursing home fire safety standards. The hearings will be vital to letting us know just what needs to be done.

I am grateful to you, Chairman Moss, and I would like to introduce my distinguished colleague on our committee, Mr. Heinz, of Pennsylvania.

I am going to have to go back over to the Capitol for an event there and if Senator Moss is not able to stay, I understand Senator Percy will stay until we can return.

Senator Moss. Thank you very much, Congressman Pepper, for that very fine statement and for the great leadership you have exercised in the House committee, the counterpart committee on which Senator Percy and I serve.

I now recognize the senior Senator from Illinois who is interested doubly in these two unfortunate events because they occurred within the boundaries of the State which he so ably represents in the U.S. Senate.

OPENING STATEMENT OF SENATOR CHARLES H. PERCY

Senator PERCY. Mr. Chairman, before Congressman Claude Pepper leaves, I would like to thank him very much indeed for ordering the GAO report. I certainly agree with you it is an excellent job. We welcome your participation, Congressman Pepper, not because I am a native of the State of Florida but because of our common deep interest in this problem. I certainly welcome Congressman John Heinz here as well.

Mr. Chairman, there is little I can add to the analysis you and Claude Pepper have made, other than that I happened to be in Chicago on January 30. I went to the nursing home at Wincrest after I heard the radio report.

The fire department officials who led the fight at the time of the fire were still there. I would like to express my appreciation to the owners of the home, to the Chicago Police and to the fire department who spent several hours with me going through the still smoldering room where the fire began to let me examine firsthand what had happened.

I frankly went out because I expected to see exactly the same thing that you and I have seen on so many occasions in Chicago—dilapidated old converted apartment hotels bought up cheaply and written off, rented to operators who were bilking a tremendous return on investment out of elderly patients.

I was stunned when I saw the building at Wincrest. It was an outstanding facility. This irony is what makes it all the more tragic for the family and friends. The Wincrest Nursing Home and the Cermak House Nursing Home were in substantial compliance with all Federal, State, and local laws and regulations. They are excellent facilities. They are modern and well constructed, constructed of fire-resistant materials.

We immediately sent for the inspection records. The records we looked at indicated that fire drills and tests of evacuation procedures had been carried out at least by the staff.

What I think we should ask of our witnesses today is whether or not it is feasible in long-term care facilities to have any fire drill procedures, that is, evacuation procedures that could be used by the patients themselves.

Certainly, the staff here had, by the records, been well trained. When the fires were discovered alarms were turned in or automatically activated and the fire departments of Chicago and Cicero responded promptly and acted professionally. The fires were largely confined to the rooms in which they originated.

Yet, 23 persons died in the Wincrest fire and eight died in the Cermak House fire. These persons died of smoke inhalation. They died not because rules and regulations were being flaunted by operators and administrators concerned only with profits. They died in spite of what appear to be honest and well-meaning efforts by staff and operators alike to provide a safe and secure environment for the frail and infirm.

I did notice, and I am sure we will bring out in testimony today certain mistakes in judgment that were made at the time. I think it is best for our witnesses to bring those out themselves.

If 31 persons can die under these circumstances, how many are in jeopardy in those many facilities identified by this subcommittee and others which are not in full compliance with the law?

If substantial compliance with Federal, State, and local fire safety regulations still cannot guarantee the safety of the elderly, how can we achieve this objective? Or must we concede that it is impossible to attain?

Additional steps can and must be taken to reduce the possibility of future nursing home fires.

It seems clear that sprinkler systems are cost-effective ways of extinguishing fires before they become a risk to life. As has been noted many times before, no life has ever been lost because of fire in a sprinklered facility. The Congress must act to make sprinklers mandatory in all medicare and medicaid nursing homes.

I think we ought to ask ourselves, every Member of Congress, how would we like to have our mother and father in an unsprinklered nursing home facility.

I do not think sprinklers are the whole answer. They are not alone the answers.

We have learned from the Illinois tragedies that toxic smoke is the real killer. We must eliminate from nursing homes to the extent possible those furnishings and fabrics which are likely to produce toxic smoke. In addition, we must be sure that staff and residents alike are trained to the extent possible in fire prevention and evacuation.

If fire does break out, it must be possible to contain it by means of smoke-activated self-closing doors which seal off the affected portion of a corridor. Although some risks are involved, we should also contemplate similar devices for patient rooms. Occupants of rooms adjacent to those in which the Wincrest and Cermak House fires were isolated escaped injury and damage so long as the doors were closed.

I talked to the people in the room next to the Wincrest fire. They did not know there was a fire until the firemen actually came in and led them out of danger. Where doors were open, damage and death occurred.

Mr. Chairman, although time may have dimmed our memory of the Wincrest and Cermak House fires we can still apply what we have learned because of them before yet another tragedy occurs. The fact that we are holding these joint hearings with our colleagues from the House Select Committee on Aging means that there is hope for prompt and effective action.

The first incident I ever investigated in the Senate 10 years ago involved three astronauts who were incinerated on the pad. The Senate investigation made safety regulations the rule for all future flights, and we have not had a single accident since then. I think the same care and diligence must be applied in this case.

Surely, it is not asking too much to attempt to insure the same degree of safety for elderly Americans who reside in nursing homes. Surely, we have the will and the capacity to achieve this objective.

Thank you very much, Mr. Chairman.

Senator Moss. Thank you very much, Senator Percy. Not only have you worked long and diligently on this problem, but you have more firsthand knowledge of what happened in these two fires than any one of the committees, and we will be able to elicit more information from the witnesses that we need for our record.

I now wish to recognize Representative John Heinz from Pennsylvania who has served on the House Committee for any comments that he has to make. I must leave very briefly. Senator Percy will preside during the time I am out. I know of his deep interest and concern and knowledge about this matter. I shall return as soon as I can.

OPENING STATEMENT OF REPRESENTATIVE H. JOHN HEINZ III

Mr. HEINZ. Mr. Chairman, I thank you. Let me just take this opportunity before you leave to commend you on holding these joint hearings on the subject that is of great interest both in the House and the Senate, but most of all to our senior citizens in nursing homes.

I think you deserve a tremendous commendation for bringing this opportunity about.

I would also like to recognize the excellent work of my own subcommittee chairman, Claude Pepper of Florida who, quite correctly as Senator Percy pointed out, is the person who brought to the GAO the need to study the Federal fire safety regulations and has produced what is obviously a very timely and provocative report.

Finally, Senator Percy, I must say, listening to your comments about your firsthand experiences in the Wincrest Home in Illinois, I think that perhaps you should be both witness and chairman today, and you have a very special contribution that is usually remanded to the Congress and in particular this very serious problem.

I would like to identify myself with your opening statement about the necessity for swift and more congressional action to improve our Federal fire safety requirements for nursing homes.

The fact that this committee is jointly meeting here today under Representative Pepper and Senator Moss's leadership, really marks a decade of attention to this problem.

The efforts in particular of the Senate Committee on Aging have yielded important results. In fact, the social security amendments of 1967 which became effective on January 1, 1970, required nursing home facilities participating in medicaid programs to comply with the 1967 lifesaving code standards of the National Fire Protection Association.

This was the first time policy was taken to insure that residents of the nursing homes would be protected from the effects of fire.

Nonetheless, in the 6 years since 1970 that followed Federal implementation of fire safety codes, we have, unfortunately, learned much about the effectiveness of the provisions of this and later versions of the Life Safety Code.

Unfortunately, because most of the experience we have learned comes at the expense of the nursing homes, the stark tragedy of the 31 patients in the January and February Chicago medicare facilities brings our attention to the fact that our nursing home safety codes, while expensive to comply with and often lead to inconvenience to residents and administrators of homes still do not insure fire safety.

Both of the Cermak and Wincrest facilities were in compliance as Senator Percy pointed out with the current version of the code and were a relatively new fire-resistant construction.

Yet, despite quick action by the fire department and the nursing home staffs, a lethal environment was created for those residents.

The ethical and policy implications of these facts should not be lost on us here in Congress, nor on the executive branch, nor on the American public.

We continue to foster halfway approaches to critical problems faced by our institutionalized elderly and disabled population.

I hope today's testimony by our witnesses can lead us to a fuller understanding of what combination of safety measures can most effectively prevent the effects of fire and toxics and suffocating by-products from reaching lethal proportions as it so often does under the present Life Safety Code.

In that connection, I hope our witnesses will particularly address the question of sprinkler system and the most effective way to implement that kind of system in nursing homes.

In conclusion, Mr. Chairman, I would only add that earlier this year our House Select Committee on Aging, Subcommittee on Health and Long-Term Care issued a report on new prospects in health care for older Americans.

Mr. Chairman, this is a report that was drafted before these terrible fires in Chicago. In part, the report observed that, and I quote:

> Current regulatory practices may over-emphasize compliance of a physical plan to standards not fully appropriate to them.

It is a grim and slightly pathetic irony that even with our tendency to regulate to a certain extent by physical overkill, that is to say to require blanket application standards to all personal care institutions which are not sufficiently flexible or effective, such tragedies as Chicago are still commonplace.

Our mission today would seem to me is to point in a new direction, to determine how dollars and resources can best be allocated and permit our senior citizens and others to live a safe and active life in institutions.

I certainly pledge my full support to the efforts of this joint committee today, and I certainly believe that this is a very timely meeting of both our House and Senate Select Committees on Aging.

I would like, Mr. Chairman, at this point to recognize, if I may, another distinguished member of the House Select Committee on Aging who is here, but I also see that Senator Beall is here.

Let me advise the Chair that Congressman Cohen of Maine is here, a very valuable member of the minority on the House Subcommittee on Health and Long-Term Care, and I would hope that when the time comes the Chair will recognize him.

Senator PERCY [presiding]. We will be very happy to recognize Congressman Cohen after Senator Beall, who would like to make a brief statement.

OPENING STATEMENT OF SENATOR J. GLENN BEALL, JR.

Senator BEALL. Thank you, Mr. Chairman.

First of all, let me say that I heartily endorse the remarks that you just made relative to the necessity of improving the standards for fire protection in nursing homes. As one who spent most of his working life, prior to becoming a full-time legislator, in the insurance business—I know from firsthand experience the cost effectiveness of sprinkler systems. Of course, any fire prevention measure is cost effective when you consider the savings in lives and property that results from good standards effectively enforced.

I would like to point out that we must strengthen and expand the Federal role in the development of new standards for nursing homes. In addition, the Commerce Committee, of which I am a member, last year developed and the Senate and House passed legislation that established the new National Fire Prevention and Control Administration. This legislation gave the Federal Government a central administrative body that can undertake the research and development of new technology to prevent, detect, and control fires.

Some interesting experiments are now taking place at the National Bureau of Standards. One such area of research involves treating certain floor covering and wall covering materials with fire retardant chemicals. This concerted research effort on the part of the National Fire Prevention and Control Administration will help to make and market new fire prevention technology. This new technology should

be promptly put into place so that the public can get a greater degree of protection from fires.

I am pleased to have had a role in shaping the National Fire Prevention and Control Act and I congratulate the committee for holding this joint hearing this morning.

Senator PERCY. Thank you very much.

I now recognize Mr. Cohen of Maine.

OPENING STATEMENT OF REPRESENTATIVE WILLIAM S. COHEN

Mr. COHEN. Thank you, Mr. Chairman.

I would like to say that I join in the remarks of my good friend and colleague from Pennsylvania, Mr. Heinz.

I welcome the opportunity afforded by this joint meeting of the Long-Term Care Subcommittees of the House and Senate Aging Committees to focus attention on fire safety standards in our Nation's nursing homes.

This is not the first time Members of Congress have met to discuss the importance of fire safety in long-term care facilities. Deaths by fire are three times higher for older Americans than for the population as a whole and invalid patients of nursing homes are especially vulnerable to this threat. Recognizing the danger of this situation, the Social Security Act was amended in 1967 to require compliance with fire safety standards issued that year by the National Fire Protection Association, a voluntary, nonprofit organization formed to promote the science and improve the methods of fire protection and prevention, for purposes of reimbursement under medicaid and medicare.

Technological advances and further study led to revisions of the Code in 1967 and 1973. My State of Maine was one which recognized the value of the updated codes—particularly the 1973 Code which emphasized the use of automatic sprinklers. Maine is now one of two States in the Union in which long-term care facilities have been fully equipped with sprinklers.

As a result of mounting evidence underscoring the value of automatic sprinklers in protecting lives and property against the dangers of fire, I introduced legislation late last year with the other members of the Maine congressional delegation to update the Fire Safety Code requirements of the Social Security Act by incorporating the provisions of the 1973 Code. This legislation was subsequently attached to an omnibus social security bill and is now a part of Public Law 94–182. The provisions of that law concerning fire safety went into effect this week.

Since the Congress has placed itself in the position of mandating fire safety codes, it is unfortunate that we have not acted more promptly on the lifesaving benefits of the 1973 Code. It has taken such tragedies as the recent Chicago nursing home fires to make Congress fully appreciate its responsibility in this area.

The GAO report released to us today indicates that our past legislation has not gone far enough toward protecting lives and property from the dangers of fire. I was amazed by the report's conclusion that buildings constructed of fire-resistant materials, as required by the 1967 Code, do not insure life safety. In fact, GAO found evidence

that increased use of fire-retardant materials may increase the hazard of death in fires rather than reduce it—due to the toxic gases released when these substances catch fire. The report also notes that fire-resistant buildings are too often filled with flammable materials, such as carpets, curtains, and upholstery. In view of these findings, I commend GAO for recommending that all long-term care facilities be fully equipped with sprinklers.

The report's other disclosures on the ineffectiveness of fire-resistant and noncombustible construction, however, lead me to wonder if the Congress should not legislate that the requirement for fireproof construction also be modified as allowed by the 1973 code, when sprinklers, smoke detection, and other fire prevention techniques are used in a home.

I commend you, Senator Percy, for the long years you have devoted to the problems in this area, the books you have written concerning it and your continued demonstrated interest in this field, and I congratulate you for holding these hearings.

I believe we will be rewarded by our active participation in this hearing today, and I look forward to the testimony of our witnesses. Thank you.

Senator PERCY Thank you very much, indeed, and I appreciate both you and Congressman Heinz coming over to the Senate today for this joint hearing and for your contribution.

The Chair will call the first panel, the Reverend William Pollard, chapel reverend, Wincrest Nursing Home, Dr. Paul Hurwitz, examining physician, the Wincrest Nursing Home, Mr. Charles Chandler, administrator, Cermak Nursing Home.

Gentlemen, we would like you to make any statement you would care to make. If you would like to incorporate your full statement in the record, it will be so ordered and you can summarize your comments. Proceed as you see fit.

STATEMENT OF REV. WILLIAM POLLARD, CHAPEL REVEREND, WINCREST NURSING HOME, ACCOMPANIED BY DR. PAUL HURWITZ, EXAMINING PHYSICIAN, WINCREST NURSING HOME, AND CHARLES CHANDLER, ADMINISTRATOR, CERMAK NURSING HOME

Reverend POLLARD. Thank you very much, Mr. Chairman.

Gentlemen, my name is William Pollard and I am a member of the St. Patrick's Missionary Society. We are here in America offering mission education to the people of America, and we work in Africa and South America.

Mr. Chairman, I was born in Ireland and I was educated there. I was ordained in 1968 and spent 8 years in Kenya in east Africa, teaching and doing social work, with the Terrakani tribe in north Kenya.

Mr. Chairman, this is not my first time in America. I was here 5 years ago, and I came and did some mission education work and then stayed for 5 months and also took a flying course in Chicago and used my flying experience in Africa to help the East Africa Flying Doctors Service there.

Now, I have come back to study and offer my missionary experience to the people of America, and I have just arrived.

I was 2 weeks in Chicago and I was asked to go to the Wincrest Nursing Home to see the people in the nursing home.

I would like to summarize very briefly my experience there.

The chapel there, as you can see from this chart, is at the end of the building, and we had just come to the end of mass and a nurse had left the chapel area when a bell had sounded. I was not sure what this bell was, and I was happy to see her leave.

Well, she left immediately and I was happy to see her going out to find out what the bell was. She came back very quickly and said to me, "Father, there is a fire. It is serious."

At that stage, I took my vestments off, put them on the chair and went out into the corridor.

Could I stand here, please, sir?

Senator PERCY. Yes, of course.

Reverend POLLARD. I left the chapel area and went out here [indicating on chart].

When I came to the fire, the fire was in room 306. There were two men here standing on the threshold pointing fire extinguishers into the room. The door I have no recollection of seeing. Fire seemed to be in this area over here.

On the path of this room back toward the window here was very dense smoke. The two men were pointing two extinguishers into the small area, so I took an extinguisher from one of the men and asked him to go get another fire extinguisher, and I pointed the extinguisher here in this area where the fire was.

Very, very quickly in the space of seconds, I would say the white smoke turned to black smoke and it began to descend on us until we could no longer see the fire, until we could no longer breathe.

We retreated along the corridor to this stairwell here. The smoke covered the corridor and it was impossible to stay in the corridor with the black smoke, so we went out here to the other corridor.

I remember very well and I probably will remember until the day I die going down along this corridor and thinking about the poor people at the end of the corridor in the chapel area, and I prayed that the fire department would come quickly because I felt they were the only ones who could rescue those people at that stage.

Senator PERCY. Father, at that stage, how dense was the smoke?

Reverend POLLARD. The smoke had come down to about this area, about 4½ feet. It was totally dense. I could not see in front of me. I could not see who was with me.

I went out to the stairwell and very quickly the fire department arrived. The firemen put on their oxygen equipment and went down along here. I went back down the stairs and went over to this stairwell.

Very soon, the fire department had the fire under control and I gave absolution to the people as the firemen brought them out of the building, using this staircase.

That is my experience at the Wincrest, and if I would like to say one thing, I would like to say that the whole experience happened over a few seconds, just a few brief minutes. It was very, very quick.

Senator PERCY. Before you leave the chart, could you identify the objects?

You pointed to an area where you said the fire was.

Reverend POLLARD. Yes.

Senator PERCY. At the time you entered the room, what was that object?

Reverend POLLARD. I'm afraid I could not say because of the fire there, and it was smoke here and the fire.

Senator PERCY. Could you identify the object immediately behind the door?

Reverend POLLARD. No.

Senator PERCY. You do not know what that was?

Reverend POLLARD. No.

Senator PERCY. That is a cabinet, a wooden plywood cabinet jammed, apparently, with a number of personal effects. Did you enter the room later and examine those objects?

Reverend POLLARD. When the fire was over.

Senator PERCY. In other words, I want to know, did you know personally where the fire started?

Reverend POLLARD. Personally, before the fire and when the fire was going on, I did not know where the fire started.

I could only distinguish here [indicating] where there were names in this area here.

After the fire, I learned this—where it had started.

Senator PERCY. Could you determine whether or not there was at any time that you were there any windows open at any place on the floor?

Reverend POLLARD. No, I could not, I'm afraid.

Senator PERCY. Did you subsequently learn that a window had been opened?

Reverend POLLARD. Yes.

Senator PERCY. And which window? Would you point out to the committee what window was actually opened?

Reverend POLLARD. Not really. It was a window in the chapel, I believe.

Senator PERCY. A window in the chapel?

Reverend POLLARD. Yes.

Senator PERCY. And could you point out which window that was?

Reverend POLLARD. I'm afraid I cannot.

Senator PERCY. You have no idea which one it was?

Reverend POLLARD. No.

Senator PERCY. This was all so fast, I know, but at what instant was that window open?

Are you certain it was open while you were down there trying to use the fire extinguisher?

Reverend POLLARD. I do not know when it was open.

Senator PERCY. You are not certain from any questions you put to any of the staff subsequently at what point the window was open?

Reverend POLLARD. No.

Senator PERCY. What do you think the effect of that window was when it was opened?

Reverend POLLARD. I have no idea, Senator.

Senator PERCY. You have no idea at all?

Reverend POLLARD. None whatsoever.

Senator PERCY. You have no knowledge as to whether the window being open actually hurt or helped the situation as to whether the smoke went out or what happened?

Reverend POLLARD. I'm afraid not, no.

Senator PERCY. Before the Reverend leaves the chart, would any of the other members of the committee like to ask any questions?

Mr. COHEN. No, Mr. Chairman.

Senator PERCY. Then if you care to be seated again—does that complete your statement?

Reverend POLLARD. That completes my statement.

Senator PERCY. Dr. Hurwitz?

Dr. HURWITZ. Good morning, gentlemen. I am Paul Hurwitz and a physician from Chicago where I practice medicine.

I divide my time between school health and emergency medicine.

Wincrest Nursing Home is a small family business owned by my mother and uncle, and I have often been associated with it since childhood.

At the time of the fire, I was in my car transferring some cultures I had done for several studies for the board of education downtown.

I drove to Wincrest and arrived 10 minutes after the fire was struck out.

Though I normally have no professional responsibilities at Wincrest, I did so on that day because the attendant physician was in California.

I made certain observations at the time of the fire, however, and drew certain conclusions which members of your staff might continue the description of the fire scene which Father Pollard has already begun.

My first impression is, I crossed the police line and entered the building and there was pandemonium. The lobby and entire first floor was filled with horrified people, both police, fire and government officials, board of health inspectors, insurance adjusters and occasional family members which made it over very, very quickly and, of course, nursing home employees.

Everybody seemed to be attempting to provide service.

Miss Cassidy, the Administrator of Wincrest for 20 years, I first found in the ground floor hall looking terribly stressed, but as usual, working as competently as ever attempting to organize with vital components of the nursing home, remained so as to provide continuation of services to the uninjured residents living on the lower floors.

Incidentally, most of whom as we are going to learn later in the day, most of these people were not even aware that a fire, much less a holocaust, had occurred.

Over the next 30 minutes as they passed, additional members of our family arrived, both past and off duty current employees arrived and certainly other friends.

Each of us instinctively were attracted to those services which we know most about. Several minutes after my arrival, I spoke with Miss Cassidy and asked her what I could do, and she suggested that the best thing for me to do would be to go up and take a look at the remaining patients.

I did that and went to the second floor and then down to the first floor and found them to be peaceful and comfortable.

I was shocked by this, tragically shocked, by the order and the quiet, more or less retrospectively, which prevailed on the patient floors in gross contrast to what I had experienced on the ground floor, and in gruesome contrast to what I was soon to see when I went to the third floor.

I walked up after examining the patients, the remaining patients. I walked to the third floor via a rear enclosed stairwell to a rubble-strewn third floor.

While you are going to hear expert testimony throughout the day about observations and thoughts which pervaded from their lips on the first few minutes after the fire was out, was the terrible shame that the fire could not have been prevented, but the terrible smoke could not have been contained in room 306, which the Father has pointed out, which housed the fire.

Also, the news as Senator Percy has related to the hearing, several patients in room 304, which you can see right on the schematic there, that several patients were right next to the scene of the fire, came out after the fire was over.

Their door had been closed and they had asked if, in fact, there was a fire. I think it might be well to limit my initial comments to those I have made and suggest that I am in total agreement and in identification with the points Senator Percy offered in his opening remarks.

I think it might be well once again for whatever good it might serve to underscore the necessity of having confidence in fire retardants of these structures, their ability to compartmentalize the fire and smoke.

I think it is well to point out if we were to go right now to any nursing home and drag 30 people down from the third floor, you are going to kill a substantial number, and I think we have got to remember and remember throughout the day that evacuation is really futile. It is a waste of personnel and as the Father has pointed out so aptly important in time as this thing took place in such a short number of minutes, that we have to limit our efforts to those which will save lives and evacuation will not.

I thank you.

Senator PERCY. Thank you very kindly.

Any questions my colleagues would like to ask at this point?

Mr. COHEN. I have one, Senator.

Doctor, you stated evacuation is a waste of time, that you feel a certain number of patients would die when you would drag them down to the first floor.

What if you have a single-level nursing home?

Dr. HURWITZ. You drag them out. To move a patient without hurting them with a senile, fragile body requires two members of the staff over, you know, a couple of minutes and when you think of the chaos and the pandemonium that reigned under the circumstances, and remember you are dealing with human elements, and I am referring to staff elements, and you have to remember that people are not functioning quite on the level that they would in a drill.

Mr. COHEN. You also indicated we have to have confidence in fire-retardant materials.

My understanding is that the nature of materials is what produced the smoke.

What if you had had fire-retardant materials?

Dr. HURWITZ. That is right, that is in the room where the fire was. You have to have confidence. We have to think of the definition of the word "retardant" which slows the fire.

Mr. COHEN. Produces noxious gases.

Dr. HURWITZ. Obviously, even if you were to limit and legislate against component products to produce nothing but gases that would normally not provide ill health to a person breathing them, it is not going to be oxygen you are producing, and people will still die of carbon monoxide or oxygen deprivation.

Mr. COHEN. You do not think it would be worth while for us to investigate when other agencies are investigating the use of that material?

Dr. HURWITZ. I am not an expert in these areas.

I know what allows the human body to maintain its integrity and maintain life.

I am familiar with health education and you have to remember the pulmonary reserve capacity and the cardiac reserve capacity is markedly limited, depending on the disease process and aging.

You have to expose them to the least amount of trial and provide them with as normal an atmosphere of life-sustaining conditions as they are used to, because they are not doing a heck of a lot with what they have even when they are perfectly well.

Mr. COHEN. No further questions.

Senator PERCY. I would like to ask a question about the people in the chapel.

Was there confusion?

How would you describe the state of mind of those people as smoke poured in?

Dr. HURWITZ. I was not there.

Senator PERCY. I am addressing this question to Father Pollard.

Reverend POLLARD. I was surprised at the calm of the people in the chapel area, and when I left the fire there was quite a lot of noise from the fire itself, but I had no panic in the chapel area.

Senator PERCY. Did they know where the evacuation stairway was from the chapel?

Were they well aware of that?

Reverend POLLARD. Really, I could not answer that question. I am a visitor.

Senator PERCY. The principal problem was actually getting them out of the chapel, was it not, getting them to that stairway?

Reverend POLLARD. Yes.

Senator PERCY. Would it have been possible to just have formed a chain by hands? It is not very far down the corridor and they could lead each other down there.

Was not the principal problem one of getting them to that stairway through the heavy smoke-filled hall?

Reverend POLLARD. Possibly, but with the smoke they would not have been able to breathe anyway and the smoke got so dense that a chain would not have worked.

Senator PERCY. Were there patients in room 304 right next door?

Reverend POLLARD. I do not know.

Senator PERCY. You do not know. Did you hear whether or not, as I reconstructed the story that afternoon, there were actually patients in room 304 that did not realize there was a fire, and when the firemen came, they actually led them out to safety?

Reverend POLLARD. I heard last night that it was. That was my first time here.

Senator PERCY. Because you were actually there, I would like you to describe the smoke a little more which developed with the fire.

At what point did it rise? You mentioned before, it was about waist high.

At what point did it obscure your vision entirely?

Reverend POLLARD. The first occasion when I saw the smoke was just after the nurse had left the chapel area, and it was a small puff of white smoke coming into the chapel area.

Then, when I walked down the corridor, there was white smoke in the room itself but very quickly it turned black smoke, very dense black smoke which descended very quickly on us.

Senator PERCY. Did you have any sensation that the smoke was being pulled out into the corridor?

Reverend POLLARD. No.

Senator PERCY. In other words, the smoke originated from the fire inside of 306?

Reverend POLLARD. Yes.

Senator PERCY. It could have been confined, obviously, by just shutting that door.

Why was that door not shut, do you know, Father?

Reverend POLLARD. No, I do not know and I have no recollection of seeing a door.

Senator PERCY. You subsequently have learned that when doors were closed, the people inside those rooms actually suffered no damage; no smoke seeped into those rooms.

If that door had simply been closed and confined the fire to that one room, would that not have prevented what occurred subsequently?

Reverend POLLARD. In my mind, I am not an expert on fire, and I think you would need a fire expert, really, to answer your question.

When I got to the fire, as I have described it, I do not know whether the door would have stopped or not.

Senator PERCY. You have worked with nursing home patients.

I have always been concerned that we emphasize fire drills with children to get them to remember if there is a fire, to intuitively respond as in that drill.

I have been concerned that the fire drills are confined to the staff in nursing homes and that I know of no regular procedure for having fire drills among the residents, the guests in a nursing home.

Do you think working with older people confined to a long-term care facility that any kind of training by them about what to do in case of danger, how to quickly seek an exit, would be helpful?

Reverend POLLARD. From the point of view of a layman, I would certainly think so and being a father in education, I would deem it helpful, but whether they would react in a situation like that, I cannot say.

I think I pointed out that the sequence of events happened so quickly that it is difficult to know whether people would be able to respond from this kind of an education program.

Senator PERCY. Yes. Did the chapel have a door?

Reverend POLLARD. No.

Senator PERCY. It did not have a door?

Reverend POLLARD. It was an open space.

Senator PERCY. If it had a door and it simply could have been shut, could the tragedy then have been averted?

Reverend POLLARD. I would think so, yes.

Senator PERCY. It would have?

Reverend POLLARD. Yes.

Senator PERCY. Because the flames did not spread to the chapel at all.

Reverend POLLARD. It never left the chapel.

Senator PERCY. It was just the smoke.

Reverend POLLARD. Just the black smoke.

Senator PERCY. All we would have to do would be to shut the door.

Reverend POLLARD. Yes.

Senator PERCY. Did the open window cause the smoke to be drawn into the chapel at an accelerated rate, faster than it would have if the chapel window had not been opened?

Reverend POLLARD. I cannot answer that, I am afraid.

Senator PERCY. Dr. Hurwitz, you arrived shortly after the fire was extinguished and helped get the facility on an even keel.

With your years of experience with this home, what, in your judgment, was the most beneficial type of outside help you received?

Dr. HURWITZ. Well, it is really hard to put your finger on any one service considering the number of services at the time.

I really never thought that any one particular person provided the most benefit.

I think that retrospectively viewing the situation, frankly, when you look back at what happened, in view of the fact that all the injured were out of the building at the time, the staff and certainly Miss Cassidy needed the reassurance that the remaining patients were safe and medically sound.

I guess the member service that was provided was most important to get things moving.

Once we were sure that everybody was safe, everybody who needed evacuation was out, we could move in a little bit more orderly manner.

I guess that is my answer.

Senator PERCY. You provided followup medical care to many of the home survivors?

Dr. HURWITZ. Within the nursing home patients that were transferred, I did not see. A number were taken to the hospital.

Senator PERCY. Was there any significant medical pattern among the individuals that you treated?

Dr. HURWITZ. Well, not for a couple of days. There were a number of upper respiratory tract infections that evolved.

We see those every year, but in view of the number of drafts people were exposed to by the fire, by those who were forced to have doors and windows open for the first minutes during and after the fire, I think considering that we are dealing with a very fragile body that probably was the ideology of so many of these. They were pretty mild. I only had to transfer two to the hospital.

I think the remaining 55 patients, 2 of those, there were about 30 people who became ill anywhere ranging from nausea and only 1 patient became sick enough that they went into pulmonary edema from pulmonary pneumonia.

To me, that was the worst sequel of the actual fire incident.

Senator PERCY. Any further questions?

Mr. HEINZ. Mr. Chairman, if I might ask Dr. Hurwitz; a few minutes ago you indicated that it would be difficult and even impractical to move a large number of patients.

Dr. HURWITZ. Absolutely.

Mr. HEINZ. For evacuation.

Absent of the forms of protection and absent better ways of containing fire, whether through the closing of doors or sprinkler systems, what would be your opinion as to the benefit and feasibility of having some form of respirator for oxygen-breathing system available to the patients?

Dr. HURWITZ. The best breathing system available is the patient's lungs, and consequently, we need to provide them oxygen in the normal pattern they receive it so as not to excite them and cause the psychologic trauma which outside influences would impose.

Senator Percy mentioned a point that he and I discussed after the fire, the use of smoke protectors and door closers, one in each room and I would like to see something like that.

Not only would it make possible isolation of each of the rooms immediately and mechanically after smoke begins due to whatever cause, but even nursing home employees who might try to sneak a cigarette against the rules or certainly patients in a lot of sheltered-care facilities—we know patients smoke; they hide matches between the mattress and bedsprings and this would kind of blow the whistle on them.

We have ice cream parlors where they have the smoke detectors and it sounds a horn when someone lights a cigarette.

It has saved a lot of lives and private dwellings so far, and I think it would be a wonderful benefit.

Mr. HEINZ. My question is directed not so much toward those positive recommendations, but we are faced, for example, with a situation where the chapel had no door at the end of the corridor to protect the residents in the chapel against a fire that would not be contained.

Dr. HURWITZ. Absolutely, doors in any location.

Mr. HEINZ. Are you saying that some form of self-contained breathing apparatus should be available, in oxygen bottles such as are available on airplanes?

Dr. HURWITZ. We have to get them on the people's faces. They will not put them on themselves.

We had only a couple of minutes to work. What I discussed last night when I came in with a number of the Senate staff was the use of firehoses in the halls.

Again, this is also within the Code, how beneficial this might be. We suggested it might require two people to operate them.

We have all seen them in apartment buildings. You have to pull them off of a contraption and that would put the fire out at Wincrest. It would have cooled that storage closet and it would have put an end to the smoke.

If you could not breathe, you would be able to hold your breath and be able to cool those superheated particulate matter and it would have fallen to the floor.

I am not a fire official, just a layman.

Mr. HEINZ. Then you feel there is really no need under any circumstances to have it?

Dr. HURWITZ. We need to put out the fire.

Mr. HEINZ. I understand that. I was thinking Father Pollard had to evacuate himself because he had nothing more than his lungs to permit him to stay.

Dr. HURWITZ. Well, those fellows on the floor, if they had had a hose line there rather than going for a fire extinguisher, we could have put out the fire.

If it had happened at 4:30 in the morning, there would be no staff to handle the equipment or have the composure to do it, but it would have worked during the day shift.

Mr. HEINZ. Thank you.

Senator PERCY. One final question, Father Pollard, or Dr. Hurwitz.

Did other nursing homes in the area provide assistance with the patients?

Dr. HURWITZ. Yes.

Senator PERCY. Valuable assistance?

Dr. HURWITZ. Pardon me?

Senator PERCY. Was this valuable assistance that was rendered?

Dr. HURWITZ. Oh, sure, and especially with regard to information to family and assistance to the inspectors who were attempting to, as you did, gain immediate information on the fire scene.

Yes, it was terribly valuable. As it turned out, assistance to the remaining patients was not really necessary living in an urban setting. People do respond, you know, to such a stress, and as we had a number of past employees who had not been working for the home a number of years and those off duty, there were more than enough people aware of it. It was on radios at 4:30 in the morning.

Senator PERCY. I am very impressed that the aging are getting better organized all the time.

We have here today Marge Jones who has a 9,000 member senior citizens council in McHenry County, Ill.

I was up there recently and they are organizing effectively and well.

Can those councils and organizations be used in connection with fire prevention?

Can they help coordinate nursing homes so that they can render assistance in case of an emergency?

Can we coordinate better our overall activities to have available services of the kind that were available in this particular case and prove invaluable?

Dr. HURWITZ. Certainly, there is potential in anybody who is healthy and able.

Senator PERCY. Thank you.

We move now to Mr. Charles Chandler, who is the administrator of the Cermak House Nursing Home.

Mr. CHANDLER. Thank you, Mr. Chairman and gentlemen.

I am accompanied by Michael Stromberg.

Let me give you a little background information on the facility. It is a modern nursing home, fire-resistant construction with automatic closing and smoke barrier doors in the corridors and the corridor a smoke detection system.

Fire on the fourth floor room of the building west wing was filled with smoke and caused the death of eight residents on that floor.

The facility was built in 1973. It is poured concrete structure with 5-inch reinforced concrete floors, reinforced interior partitions.

The home is licensed by the Illinois Department of Public Health. There are 540 patients approved for Federal medicaid funds.

The fourth floor is typical of all other nursing homes and contains 26 rooms.

The west wing where the fire occurred has six, four-patient rooms.

Furniture in the rooms consist of wardrobes, beds, night stands.

Doors have a self-closing mechanism.

Fire alarm systems is of the smoke detection type which notifies the fire department and releases the smoke-type odors.

Ventilation shafts in the north end of the corridor creates a natural exhaust vent to the roof.

The building is equipped with standard pipe and hose systems being located in every stairwell.

Sprinklers are installed on the first floor only.

Now, as I go through the recap of the fire, I would like to invite your attention to the chart to my right and your left which lists the rooms, their numbers and the general position of the furniture as it was in those rooms on the morning of the fire.

At the time of the fire, it was 70 patients on the fourth floor.

Following the fire, four patients were found alive in room 426.

Four patients were found dead in room 425 and one had been removed by the fire department through the window of room 423.

At 6:44 a.m., the fire department received its first notification of the fire from the smoke detection connected with the facility. They responded promptly with engine and truck companies.

They immediately called for a second alarm and started attacking the fire with two, one-and-a-half-inch-hose lines from the building system.

At 6:55 a.m., the fire department had evacuated the patients from 423 and were fighting the fire on the fourth floor at the location of the smoke hose.

The 14 patients that occupied the west wing, other than the four who died in 425 and the four found alive in 426 and the one who was rescued by the fire department from 423, were out of the west wing at this time.

By 6:44 a.m., a human chain made up of staff personnel had been established in the center stairway from the fourth to the first floor, and by 6:56 a.m., 61 patients on the floor, other than the 9 I listed, had been passed down that chain to the first floor.

Some of the detail at 6:44—a male nurse and nurse's aide on the fourth floor heard strange noises.

In running to the area of 420, they saw flames to the ceiling of the room.

The male nurse led one patient, got her out of bed and carried her to the nurse's station and then went back to the wing. The smoke was dense. It was so dense that he tripped over a patient who was in the hallway and pulled her out. He went back a third time and could not get into the wing because of the smoke.

The other two patients that had been assigned to room 420 were not there when the nurse first arrived, but they did survive.

As to the patient in room 423 who was rescued from the window by the fire department, was in the washroom area and from that position as noted in the chart could have gone either through the corridor doors or down the west stairwell which was between the washroom and her room. She could have gone to safety.

She did not do either one and rather she went back to the room after her valuables and after the staff closed all the doors with the exception of room 421.

It also appears after the doors had been closed that patients went back in the rooms 423 and 425.

While it is a matter of conjecture because all the patients in room 425 died, one of those patients was seen at the elevator going down to the lower floors 10 minutes before the fire started and, yet, she was found near the window of room 425. That window had been broken and the door to the room open.

It can only be assumed she may have contributed to the death in those rooms.

The rooms in the west wing, 421, there were three beds.

One was rescued by staff, two were evacuated from the floor.

It cannot be determined whether staff rescued these persons.

In room 422, four residents, one death, three were evacuated from the floor, but it cannot be determined whether the staff rescued them from the room.

In room 424, four residents and one death.

Three were evacuated from the floor, but it cannot be determined whether or not the staff rescued them.

Room 426, four residents were found in the room after the fire occurred and all survived.

Room 423, four residents, one death, one evacuated by the fire department, one evacuated by the staff, found on the floor in the corridor and one evacuated from the floor and it cannot be determined whether staff rescued her.

Room 425, four residents and four deaths.

The nine people were evacuated from the floor by the human chain evacuation procedure.

Senator PERCY. Thank you very much.

Mr. Heinz, any questions?

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

You mentioned that there was a smoke detector hooked up to the fire department.

Did it also ring in the nursing home to alert nursing home personnel?

Mr. CHANDLER. Yes.

Mr. HEINZ. You were also able to establish a human chain to bring your patients out.

Did the patients who were brought out of the room seem calm, suffer any trauma or have any problems of this type?

Mr. CHANDLER. Yes.

Mr. HEINZ. Could you elaborate?

Mr. CHANDLER. At the time we had teams, doctor and nurse teams, come in from two different hospitals plus one of the house physicians enroute to the hospital, and two additional physicians.

They sent other patients, other than the ones who were obviously in bad condition, they sent other patients and staff members to the hospitals as they tried to cover every patient in the house at the time and we had patients going out in 35 or 40 minutes after the fire.

Mr. HEINZ. How much of that trauma was because of smoke or because of the excitement of the situation, the fright, as they were being moved down the stairway? There was snow on the ground.

Mr. CHANDLER. I just cannot tell you. We had a lot of water on the floor and a lot of water in the building.

Afterwards, I did not see what happened right on the fourth floor, and I did not see the human chain, but, finally, they were calm and they were waiting patiently to be saved.

At that point in time, a relatively few minutes after the fire itself, calm had been restored.

The patients that were in the lounges up on the floors remained. Volunteers and staff workers went in to them and talked to them and calmed them down, and they accepted that we had had a disaster. It was accepted.

And to go forward from here quickly now to answer your question, I cannot tell you how much because of the move, there were so many contributing factors.

Mr. HEINZ. You mentioned that there was a sprinkler system on the first floor.

Mr. CHANDLER. Yes.

Mr. HEINZ. That there was not one on the fourth floor.

Had there been a sprinkler system on the fourth floor, would it have had an effect on the kind of fire that you had?

Mr. CHANDLER. At that point in time, it would have had to have an effect, yes. It depends on what the temperature you get at the ceiling levels to set off that sprinkler head and how much gases have already been created and how much smoke of a toxic nature that had already been created, had it been sufficient at that point in time to do injury.

It would have probably confined the physical damage, yes.

As to the patient injuries, I cannot answer.

Mr. HEINZ. Thank you, Mr. Chairman.

Senator PERCY. Mr. Cohen?

Mr. COHEN. Thank you, Mr. Chairman.

Can you tell me the rationale as to why you have sprinklers on the first floor and none on the second, third or fourth floors?

What would be the rationale, the design rationale for having the sprinkler system on the first floor if, in fact, it is a four-story building and the patients on all four levels?

Why a sprinkler system on one floor?

Mr. CHANDLER. Hazard risks.

Mr. COHEN. Is not the hazard greater on the fourth floor in terms of evacuation as opposed to the first floor?

Mr. CHANDLER. Let me answer in a different way, if I may.

We have a laundry on the first floor and kitchen, fire apparatus. We have machinery and at nighttime there is less occupancy. There is more storage. It is relatively unattended and in the period usually from 8:30 in the evening until some time around 5:30 in the morning, we only have one person on the floor.

For instance, there is a complement of people going around making the rounds of the nursing floors at night.

Mr. COHEN. You indicated, I think, that you had smoke detectors in the corridors, is that correct?

Mr. CHANDLER. Yes.

Mr. COHEN. You had none in the individual rooms?

Mr. CHANDLER. No, sir.

Mr. COHEN. I guess one final followup point of Mr. Heinz and Senator Percy.

I believe Senator Percy touched on the question of whether or not it would be valuable to have periodic fire drills by residents or the personnel in the nursing home.

Would you agree with the previous witness, Dr. Hurwitz, that evacuation is a waste of time?

Let me retract. I'll ask you one question before that.

How many people were moved from 6:44 a.m. when you first heard the screams to 6:46?

Mr. CHANDLER. 6:46, I do not know.

At 6:56, 12 minutes we moved 61 patients off the floor.

Mr. COHEN. You moved 61 patients. How many of those patients who were moved out died, any?

Mr. CHANDLER. Two.

Mr. COHEN. Two of sixty-one who were moved?

Mr. CHANDLER. Yes.

Mr. COHEN. And I will ask you a question: Would you agree with Dr. Hurwitz that evacuation is a waste of time?

Mr. CHANDLER. I cannot say evacuation is a waste of time, sir.

Mr. COHEN. Particularly in this case where you saved 59 out of 61 at least from potential danger.

Mr. CHANDLER. I think there might be other alternatives that could be done that would be just as effective.

Mr. COHEN. In addition to or the exclusion of?

Mr. CHANDLER. In the threat of actual evacuation of patients.

Mr. COHEN. And what would you recommend?

Mr. CHANDLER. I would like to reserve the evacuation of patients to that time when you absolutely have to move.

Mr. COHEN. You would recommend sprinkler systems, I assume, at each level.

I would assume that you would recommend that you have smoke detectors in each room, would you not?

Mr. CHANDLER. No.

Mr. COHEN. What would you recommend?

Mr. CHANDLER. OK, I think the smoke detectors in individual rooms are a good idea.

I think smoke detectors probably are one of the best means of identifying a fire long before and possibly even before a human being can smell it because they identify the vapors and the gases.

Once an alarm is sent in, you have started the function much quicker than you would have if you wait until actually smoke or flames could be detected.

It gets extremely hot and if you had your professional firefighters en route to you, you have narrowed that gap extremely, and once they are on the scene it is a short time then when everything is under control.

As to sprinklers, I will not comment on those or the door closers, but the smoke detectors, yes.

Mr. COHEN. You have no opinion with respect to sprinklers?

That is all I have, Mr. Chairman.

Senator PERCY. Mr. Chairman, could you describe the value that you feel that smoke stop doors had in saving lives?

Mr. CHANDLER. A great deal. Those smoke doors were charred. The heat was that intense on them, Mr. Chairman.

We had a great deal of smoke in the center corridor, but if it had not been for those doors, I am afraid we might have lost everybody on the floor.

I do not know, but it appears that they saved a great number of lives. It gave a barrier from behind which the firemen could fight the fire itself.

Senator PERCY. Both fires burned material that generated toxic smoke, and in the case of the Cermak Nursing Home, the fire burned a polyurethane foam rubber mattress or mattresses and this created hydrogen cyanide gas.

Do you feel there should be regulation with respect to all kinds of materials that are used in a nursing home? Should these have the most fire retardant capability practicable?

Mr. CHANDLER. I think more testing should be done or there should be some testing.

We should know what we are facing. We should know what will and will not stop fires.

Hopefully, this would be done before legislation was passed and new regulations that would have to be complied with before we know what the results will be.

If we can find out what it is that we need to stop the flame or at least stop the lethal gases from it and then go from there, fine.

The conversations, and we have had discussions since February on this subject, many people have said they do not know what the answer is until tests are done.

I understand from the comment that was made this morning by Senator Beall that there are tests on some materials being done right now.

This could be expanded so that we know where we need to put our signals, what we need to make the materials from and what materials we need to use to make the beds and everything else proper.

I think that will give us guidance.

Senator PERCY. If you were sitting in our shoes in the House and in the Senate with the responsibility to try to insure to the greatest practical extent, that is to insure the safety of patients that are receiving benefits of Federal funds, what steps would you recommend that we take?

What steps would you take to insure that we minimize the risk of death through fire?

Mr. CHANDLER. That needs some attention. Beyond that, I think we need to speed up the testing.

In the interim, we need to assure that these things that we have today in the Life Safety Code are being followed.

I think there should be some form of interpreting those and guidelines given to us on how to interpret them, but what I am afraid of is, if we enact additional legislation before we have all of this, it will be

something else we have to comply with, and from the nursing home operators' point of view, it may or may not be the solution to it.

Senator PERCY. You are an administrator of a home that has been called an outstanding facility.

Have you visited homes that you would consider to be submarginal from the standpoint of standards that you feel should be maintained where you would be concerned about having any of your own patients?

Do you think the hazard is greater in such homes than it is in a fire-resistant building such as you operate?

Mr. CHANDLER. Yes, there probably is, depending on the type of facility we are talking about.

I have seen substandard homes in terms of building, but whether or not an individual would have any greater risk versus another one, would depend on the circumstances at the time we are talking about.

I think every fire has its own contributing factors, and all of them are different, something minute.

In this instance, there are different circumstances.

Senator PERCY. The committee thanks you very much, indeed, for your appearance today.

The Chair will now call on Mr. James D. Martin, Deputy Director, Manpower and Welfare Division, U.S. General Accounting Office.

Mr. Martin will be accompanied by Mr. Robert E. Iffert, who is an Assistant Director, Manpower and Welfare Division, U.S. General Accounting Office, and Mr. Alan Zipp, Project Manager, Manpower and Welfare Division, U.S. General Accounting Office.

I appreciate you being here very much, indeed, and you may proceed with your testimony.

STATEMENT OF JAMES D. MARTIN, DEPUTY DIRECTOR, MANPOWER AND WELFARE DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT E. IFFERT, ASSISTANT DIRECTOR, AND ALAN ZIPP, PROJECT MANAGER

Mr. MARTIN. Mr. Chariman and members of the subcommittee, I am pleased to appear here today to discuss the results of our review of Federal fire safety requirements for nursing homes, which we undertook at your request. You asked us to investigate the reasons for the severity of two nursing home fires which occurred earlier this year in the Chicago, Ill. area, and to suggest possible actions to avoid similar situations.

The results of our review are included in a report to the Congress entitled "Federal Fire Safety Requirements Do Not Insure Life Safety In Nursing Home Fires." At this time, I will summarize some of our findings, conclusions, and recommendations.

The Department of Health, Education, and Welfare (HEW) estimates that there are about 16,500 nursing homes (referred to as skilled nursing facilities or intermediate care facilities), participating in the Federal or federally assisted medicare and medicaid programs. Of these, more than 50 percent are not required to be fully protected by automatic sprinkler systems. The Federal fire safety requirements, which include the standards of the Life Safety Code, do not require automatic sprinkler systems in nursing facilities classified as 2-hour fire resistive, or one-story, 1-hour protected noncombustible. Both

76-611 O - 76 - 3

Chicago nursing homes were classified as fire resistive. As a result, automatic sprinkler systems were not required for these nursing homes to be in compliance with the Federal fire safety standards. Neither nursing home had automatic sprinkler protection throughout the facility.

CHICAGO AREA FIRES

We reviewed reports on the fires at Wincrest Nursing Home located in Chicago, and Cermak House Nursing Home located in Cicero, Ill., a suburb of Chicago. On January 30, 1976, and February 4, 1976, fires occurred at the Wincrest and Cermak nursing facilities, respectively, which resulted in the deaths of 31 patients and injuries to about 50 patients. Both institutions were intermediate care facilities participating in the medicaid program. According to reports of investigations, these deaths occurred even though (1) the nursing facilities substantially met Federal fire safety requirements; (2) the fire departments responded promptly to the alarms; and (3) the construction of the buildings adequately confined the flames to the rooms of origin.

The deaths were reported to be caused by smoke and other products of combustion rather than burns. No fatalities occurred in the rooms of fire origin. Investigators of the fires stated that sprinkler systems would have prevented deaths in these nursing facilities.

ANOTHER NURSING HOME FIRE

On February 18, 1976, within 3 weeks of the Wincrest and Cermak fires, another nursing home fire occurred. This one, at the Plaza Nursing Home in Niles, Ill., resulted in no deaths. This facility was protected throughout with an automatic sprinkler system. The fire activated one of two sprinklers in the room which extinguished the fire before the firemen arrived. The local fire chief attributed the absence of injuries and the prompt control of the fire to the sprinkler system and the prompt response by employees.

CAUSES OF DEATH

The fires at both Wincrest and Cermak burned materials which generated toxic smoke. At Wincrest, the fire burned vinyl chloride wall and mattress covers, generating hydrogen chloride gas. At Cermak House, the fire burned foam rubber mattresses, generating hydrogen cyanide gas. In addition, carbon monoxide gas was produced from combustion of the various furnishings.

At Wincrest most of the fatalities occurred in the lounge-chapel area which did not have a door and into which lethal smoke traveled. The lounge-chapel was not damaged by fire, however, the plastic covers on the ceiling light fixtures were melted by heat.

At Cermak House, the fatalities and smoke damage occurred in residents' rooms with doors open to the corridor.

COMPLIANCE WITH FEDERAL FIRE SAFETY STANDARDS

The Illinois Department of Public Health inspectors make annual health and safety surveys of intermediate care facilities. The depart-

ment's architectural section has 14 registered architects and 2 engineers who make fire safety surveys.

The Illinois Fire Marshal's office has a staff of 44 inspectors who survey skilled nursing facilities for fire safety.

In addition, the City of Chicago Fire Department makes fire safety inspections of nursing facilities within the city.

The results of recent inspections by the State agencies at both Wincrest and Cermak House indicated that both facilities were in substantial compliance with existing fire safety standards.

FEDERAL FIRE SAFETY STANDARDS DO NOT INSURE LIFE SAFETY

The deaths from these two fires show that the Federal fire safety standards do not insure life safety in nursing home fires. Thirty-one people died, as the result of fires, in nursing homes which substantially met the Federal fire safety standards.

Investigations of other nursing home fires by subcommittees of both the Senate and the House also showed that deaths occurred in nursing homes which were of fire resistive construction but were not fully protected with automatic sprinkler systems. For example, a 1970 fire in a fire resistive nursing home in Marietta, Ohio, killed 32 people because of smoke inhalation. In 1971, a fire resistive nursing home in Buechel, Ky., had a fire which killed 10 people. In 1973, a facility classified as fire resistive in Wayne, Pa., had a fire in which 15 people died.

These and other examples had been studied by congressional subcommittees and cited as the basis for their recommendations that all nursing facilities be required to be fully protected with automatic sprinkler systems.

In the opinion of Chicago Fire Department officials, sprinkler systems provide the best fire protection because they signal the fire location and immediately spray 22 gallons of water per minute on fires which activate the system. Fire department officials believe sprinkler systems would have extinguished the fires at Wincrest and Cermak and prevented deaths.

After its investigation of the Wincrest fire, a special panel appointed by the mayor of Chicago recommended that new requirements be made part of the building and fire ordinance of the city. One of these recommendations was that sprinkler systems be installed in all new and existing nursing homes and be electrically interconnected with the fire alarm system.

On February 4, 1976, the mayor of Chicago asked the city council to require all nursing homes to have automatic sprinkler systems. The ordinance was introduced only a few hours after the Cermak fire.

On April 7, 1976, this ordinance was approved by the city council and requires all Chicago nursing homes to install sprinkler systems by February 1977.

According to an HEW engineer's report on the Wincrest fire:

> The only alternative to a well trained staff is a complete sprinkler system, smoke compartments and smoke detectors.

Another HEW report concluded, as a result of the two Chicago area fires:

The facilities in each case were of fire resistive construction, but failed to provide reasonable protection. There is a need for several fire safetv measures which exceed current regulations.

According to a report by an official of the Illinois fire marshal's office. which was presented at hearings in Illinois:

The Winerest and Cermak House fires demonstrated that ignition of coverings and furnishings can turn nursing facilities into gas chambers.

NEED FOR SPRINKLERS

We believe that a strong case can be made for a requirement that all nursing facilities, regardless of construction type, be fully protected with automatic sprinklers.

In addition to the findings applicable to the two Chicago nursing homes, which were exempt from the sprinkler requirement, our review showed that: (1) Efforts by nursing home staffs to extinguish the fires and prevent the loss of lives were unsuccessful; (2) the fires created a lethal environment in a short period of time; (3) the National Fire Protection Association has no record of a multiple death fire in any nursing home fully protected with an automatic sprinkler system; (4) the National Safety Council and the American Nursing Home Association stated that automatic sprinkler systems provide the greatest "safety to life" feature available in the fire protection field; (5) after numerous fire tests by a fire safety engineering firm, it was found that with automatic sprinklers, the fire is quickly extinguished even in rooms with combustible wall paneling and ceiling tiles.

In line with previous recommendations of congressional committees, we recommend that the Congress enact legislation which will require that all nursing facilities be fully protected with automatic sprinkler systems.

THE COST OF AUTOMATIC SPRINKLER SYSTEMS

The cost of installing an automatic sprinkler system will vary with the size and type of facility, and whether it is of new or existing construction.

In April 1976, we obtained data from seven sprinkler installation companies in the Washington-Baltimore area. According to their estimates, a complete system may cost between $0.50 and $1.75 a square foot in an existing facility. Installations during 1975 in four existing nursing facilities, three in Ohio and one in Minnesota, showed costs ranging from $393 to $625 a bed, with costs per square foot ranging from $1.21 to $1.55.

Using the highest cost per bed, the monthly cost of amortizing $625 a bed over a 20-year period with a 9¼ percent interest rate is $5.57 a bed a month, or about $0.19 a bed a day.

According to the National Fire Protection Association, sprinkler heads need replacement at the end of 50 years. However, financing sprinkler system installation over a period in excess of 20 years does not seem likely. Consequently, our computation shows the monthly payment expected over the term of a 20-year loan.

SAVINGS ON FIRE INSURANCE

Although fire insurance rates vary among States, savings are possible on both building coverage and contents insurance when nursing facilities are protected by automatic sprinkler systems. We obtained information on nursing home fire insurance rates in Maryland and Washington, D.C., and found that savings of about 30 percent are possible on building coverage and 50 percent on contents insurance.

MEDICARE AND MEDICAID WILL HELP PAY FOR AUTOMATIC SPRINKLERS

Nursing facilities participating in either medicare or medicaid will be reimbursed for these programs' share of the cost of automatic sprinkler systems through reimbursement for interest and depreciation. Medicare is federally funded and medicaid is funded by Federal, State and local governments.

The actual amounts to be paid by medicare and medicaid will vary among facilities depending on the number of residents covered by the programs. According to a report from the Social Security Administration, medicare and medicaid paid over 55 percent of the national health expenditures for nursing home care during fiscal year 1975. These expenditures include services in skilled nursing facilities, intermediate care facilities and all other homes providing nursing care.

FEDERAL LOAN INSURANCE PROGRAM

In its August 9, 1972, report, the House Committee on Government Operations concluded that unless the Federal Government provided a mechanism for insuring loans for sprinkler systems, not all facilities would be able to finance such systems. The committee recommended that the appropriate congressional committees consider legislation to provide insurance for long-term loans made for the installation of sprinkler systems as a means of assisting facilities in obtaining financing.

As a result, on December 28, 1973, Public Law 93–204 was enacted, which authorized the Secretary of the Department of Housing and Urban Development (HUD), to insure loans made to nursing facilities for the purchase and installation of fire safety equipment. This law amended section 232 of the National Housing Act which is designed to provide mortgage insurance for nursing homes.

In October 1974, 10 months after enactment of the law, the Secretary of HUD and the Acting Secretary of HEW entered into an agreement for administering this section of the National Housing Act.

LOAN INSURANCE PROGRAM HAS NOT BEEN UTILIZED

According to HUD officials, there have not been any loans approved under Public Law 93–204. As of late April 1976, only one application had been received by HUD, and this was disapproved because the facility did not meet the HUD financial requirements regarding the ability of the borrower to repay the loan.

According to HEW/HUD procedures, HEW approves parts of the application and sends certain certifications to HUD before the

facility is considered for an insured loan. HUD requires that an application be submitted through a HUD approved lending institution before it will consider insuring the loan.

According to HEW officials, there has been relatively little interest in the Federal loan insurance program for fire safety equipment. They said nursing facilities did not apply or withdrew their applications, because the program offered no advantage over conventional loans and involved much more paperwork and time.

We examined the applications received in the Chicago regional office of HEW. As of September 1975, of approximately 159 inquiries into the program, only 10 applications were received by HEW. In six of the cases, HEW refused to process the applications because the nursing home owners had already started to make corrections of their fire safety deficiencies. HUD officials had taken the position that the law did not authorize them to insure loans for previously purchased equipment. A HUD official told us that if work had begun, the purchase was considered to have previously been made, and HUD would not insure the loan.

The remaining four cases resulted in the installation of sprinkler systems, but not with HUD-insured loans. In each of the four cases, HEW processing time took between 6 and 8 months. Until HEW had approved the application, the nursing facilities could not begin work, or continue processing their applications for HUD-insured loans. Two of the nursing home owners told us they became so frustrated with the time HEW was taking to process their applications that they withdrew their applications for insured loans.

LONG PROCESSING TIME CAN BE A PROBLEM

The long processing time by HEW can be a problem to nursing homes. HEW regulations provide that a nursing facility's certification will be automatically canceled within 60 days of the date established for the correction of health or safety deficiencies unless all deficiencies are corrected or substantial progress has been made in correcting the deficiencies. HEW guidelines define "substantial progress" to mean that corrections are well underway, and that there is tangible and visible evidence of progress made. If the only progress by the facility had been a loan application, according to the guidelines, this would not be substantial progress sufficient to prevent the automatic cancellation.

If the facility begins work in order to make substantial progress in the correction of its deficiencies, to avoid the automatic cancellation of its certification, HUD will not insure the loan. If the facility waits for HEW to process the application, the long processing time could result in the facility's certification being automatically canceled.

An illustration of the problems facing nursing homes is the case of a nursing facility in Minneapolis, Minn. In January 1975, the facility was cited by the State survey agency as requiring an automatic sprinkler system to be in compliance with Federal fire safety requirements. At that time, an automatic cancellation date was established as September 1975, which was 60 days after the planned correction date.

In February 1975, the facility applied through HEW for a federally insured loan to pay for the sprinkler installation. HEW approval of the loan insurance application was not received until mid-August 1975. Very little time remained for the facility to locate a lending institution, negotiate a loan, process the HUD application, obtain a sprinkler contractor, and begin work before the certification of the facility would be automatically canceled in September. The facility obtained financing through other means in order to expedite installation.

CAUSES OF DELAYS IN HEW PROCESSING

The Deputy Director, HEW Chicago Regional Office of Long-Term Care said that it is necessary that HEW engineers physically inspect the facilities before the loan insurance applications can be processed because of the HUD requirement that HEW certify that the facility will be in compliance with Federal fire safety requirements. She said that because of past experience with the quality of State inspections in Ohio and Minnesota, HEW engineers were reluctant to rely on the State life safety code surveyors. She pointed out that neither Ohio nor Minnesota use engineers or architects to make fire safety inspections. In the case of the four facilities approved by HEW for HUD-insured loans, deficiencies were found at each facility by HEW engineers which were not identified by the State inspectors.

She said also that the processing time by HEW includes the onsite inspection by HEW engineers and evaluation of architectural drawings and exhibits. In addition, HEW evaluates cost estimates from sprinkler contractors. These documents must be obtained from the facilities. In the four cases reviewed by the Chicago office, several letters were sent to the facilities requesting this information, which delayed the final approval of the applications.

HOW TO IMPROVE THE LOAN INSURANCE PROGRAM

We believe the HUD loan insurance program could be a viable source of assistance to nursing facility owners in obtaining financing for automatic sprinkler installations.

We believe the problems encountered in the loan insurance program for fire safety equipment rest both with HEW's processing procedures and HUD's position not to insure loans on projects which have already started.

In order to alleviate the difficulties encountered by HEW, we believe both HEW and HUD should evaluate the loan application processing procedures and reduce the need for HEW's detailed review and inspection.

Currently, HEW receives copies of the State inspection reports which indicate nursing facility deficiencies of the fire safety requirements. In addition, HEW receives copies of the plans of correction, which when completed, should bring the facility into compliance with the Federal fire safety requirements. Consequently, it seems that these documents could satisfy the HUD requirement that HEW certify that correction of the fire safety deficiencies should result in compliance with the Federal fire safety requirements, because medicare and medicaid certification is contingent upon the approved correction

of such deficiencies. With regard to the certification of reasonable cost estimates by HEW, it seems that this function could be more efficiently accomplished by HUD personnel, because they deal with estimating costs in other types of construction projects. The certification of reasonable cost could be made part of the HUD underwriting procedures and thereby reduce HEW's processing time.

To solve the problem experienced by nursing facilities denied loan insurance applications because work had previously started, we believe HUD should reconsider its position regarding not insuring loans for such ongoing work. Nursing facilities can be under strict time constraints to begin making corrections of fire safety deficiencies or face the possibility of cancellation of their certifications. It would seem to be in the interest of patient safety to have the corrections made as soon as possible. In some cases, work could be started while the loan insurance application is being processed.

Based on our review of the applicable laws, we do not believe HUD is prohibited from insuring loans for work in progress or completed.

In conclusion, Mr. Chairman, our review of these Chicago nursing home fires and related matters has shown that a strong case can be made for a requirement that all nursing homes be fully protected with an automatic sprinkler system. Consequently, we recommend that the Congress enact legislation which will require all nursing facilities to be so protected. We shall be happy to answer any questions that you or other members of the subcommittees might have.

Senator PERCY. Thank you very much for the testimony and for your report which has already proven to be very valuable to us.

I would like to first talk about the fire itself at Wincrest.

Why were the staffs and the fire department unable to be present and, therefore, prevent deaths from occurring?

Was it a lack of time, lack of training, something mechanical?

You can also include the Cermak House Nursing Home.

Was there a lack of familiarity with the floor plans, the physical layout where the stairways were, how they could get out?

What were some of the human factors involved here besides the physical ones?

Mr. MARTIN. I do not think there was any indication of staff panic.

I think once the staffs at Wincrest and Cermak found the fires, they attempted to put out the fires and took whatever action they could.

By the time the firemen got there, the heat and smoke were so heavy they could not get the door closed.

They started to move patients, but these are elderly patients; the average age was 80 at Wincrest and 75 at Cermak. It was not easy to move them quickly.

There was no reason to believe, as far as we had been able to find out, that the staff panicked.

It was our understanding that they responded well in the situation.

Senator PERCY. Yet, when the fire department came, they did not require a particular skill. They just led patients out of the rooms where the doors were closed. They led them out through the blackened hallway. Is it not possible for staff to do the same thing, just lead patients out knowing where the access doors are?

Mr. MARTIN. It is possible if the patients are ambulatory.

If they are bedridden, moving them down stairways is very difficult, particularly with a limited number of staff available. I think prior testimony indicates that it takes a couple of people to move some of the patients.

It is difficult to move the number of patients involved in the short time available.

Senator PERCY. Has the GAO found out what caused the smoke to move as rapidly as it did and leave the area in room 306 and fill the halls and then start moving to the chapel at the end of the hall?

Mr. MARTIN. No, sir, we did not make that determination.

Senator PERCY. You did not get into that aspect of it?

Mr. MARTIN. No, sir.

Senator PERCY. Do you feel that the training of nursing home attendants would help in evacuation once it is required?

Mr. MARTIN. I think our review and I think the opinion of experts showed that the key to saving lives in nursing homes is to have them fully protected with automatic sprinklers.

In addition, you need smoke detectors. You also need heat detectors and a well-trained nursing home staff.

These, Mr. Chairman, are the key elements in saving lives in nursing homes in fire situations.

The training that you speak of for the patients within the nursing home is also important. I think the elements I mentioned are the key in protecting patients. They should, however, certainly be familiar as to where the stairwells are and the procedures to go through in the event of fire such as closing of doors, which is a simple thing for ambulatory patients to do, but the key is automatic sprinkler systems, smoke detectors, and fire doors.

Senator PERCY. Should the staff members of a nursing home know that to open a window in a situation that feeds oxygen to a fire which might be running out of it would cause a draft and the smoke to be pulled, and should a staff member have known not to open a window?

Mr. MARTIN. I think it is reasonable to assume that part of the training of the nursing home staff should include a discussion of the impact that an open window would have on a fire; yes, sir.

Senator PERCY. You strongly recommend automatic sprinklers.

What about smoke detectors or doors which automatically close when smoke is detected?

Mr. Chandler said smoke detectors are more valuable than sprinklers.

Mr. MARTIN. I think an important element would be to tie the smoke detectors in with the sprinkler system. The detectors can then activate the sprinkler system as well as the heat.

The automatic closing doors could be a problem with elderly patients if they bump into them when they close. In some cases, they may not be able to get them open, and they could be trapped.

If you have a well-trained staff, the first thing they should do is close the doors. In that type of situation, automatic doors would not be required.

Senator PERCY. The characteristics of both of these fires is that people died, not from burns or the flames, but from toxic smoke and gases.

What can we do to minimize the possibility of death from smoke inhalation in nursing homes?

Are sprinklers sufficient, or must standards be established also for furniture and kinds and amounts of personal clothing, et cetera?

Can we do anything through tighter regulations to prevent this kind of death?

Mr. MARTIN. I think as I indicated in the testimony, there has not been a multiple death fire in a fully sprinklered home. It goes a long way to prevent this.

It is my understanding also that the National Bureau of Standards is conducting toxicological research on fabrics which can be helpful when those results are published.

I do not believe the state of the art is such now that you could eliminate all the possible fabrics that might give off toxic substances in case of a fire.

Senator PERCY. Last year, you reported that 72 percent of the nursing homes in the country, by your sample, had one or more major violations of the life safety code.

Do you have any reason to believe that things have changed and that more homes are now in compliance?

Mr. MARTIN. We have not, at least as far as I'm concerned. One of the other fellows here might want to comment on it, but we have not followed up on the report we issued in March of 1975 to determine what the situation is now; no, sir.

I do not have any knowledge that indicates change.

Senator PERCY. Last year, you reported that many States were using nurses and other unqualified people, in some cases policemen, to conduct fire safety certifications.

Has HEW acted on your recommendation on surveyor training?

Mr. MARTIN. Not to my knowledge, they have not.

Senator PERCY. Do you think followup should be made in that case, then, to see that they do?

Mr. MARTIN. Yes; it is our standard procedure, after a certain lapse of time, to follow up on recommendations to see if they have been implemented. We will certainly continue to follow up on our March 1975 report.

Senator PERCY. As we have indicated, smoke was a major problem in both the Cermak House and Wincrest Homes fires. The Life Safety Code is silent with respect to smoke standards.

Would you favor the promulgation of smoke density standards for nursing home furnishings?

Mr. MARTIN. I think we would favor that if the state of the art is such that standards could be reasonably promulgated, yes, sir.

I am not sure of the current state of the art.

Senator PERCY. Thank you.

Mr. Heinz, any questions?

Mr. HEINZ. Thank you, Mr. Chairman.

In 1972, the House Government Operations Committee, Special Studies Subcommittee, which I was privileged to serve on, wrote a report indicating the need for sprinklers.

Subsequently, another committee of Congress did enact legislation, that is, loan guarantee legislation to install sprinklers.

I note in your report a lengthy analysis of the problems that have accompanied the joint administration by HUD and HEW of that program.

Is it your belief that the program can be administered without any further changes in the law by Congress, strictly a regulatory matter that can be solved within the agencies to make these loan insurance programs workable and available?

Mr. MARTIN. Yes, sir, we believe that the principle of the guaranteed loan program is sound; that it could be used by HUD and HEW together to improve the administrative procedures processes, yes.

Mr. HEINZ. One of the things that Senator Percy touched on was the extent to which better management, things like closing doors and the use of perhaps fire extinguishers might be improved.

Do you have any specific recommendations that come out of your careful studies as to the kind of training that nursing home personnel might properly be given in order to minimize some of the problems that we have seen here today?

Mr. MARTIN. Congressman, I would like to have Mr. Zipp respond.

Mr. ZIPP. Congressman, there are measures which can be taken to train nursing home staffs in the art of fire prevention and control.

However, the staff turnover in most nursing homes is relatively high, and from a practical perspective, you simply cannot rely on staffs to control the fire and move people to save lives.

The critical point is what Senator Percy mentioned, and that is time—time is extremely important.

I have witnessed fire tests at the National Bureau of Standards where a chair was ignited with a single piece of paper. Within 5 minutes the entire room was engulfed in flame because of technical processes called flashover and other characteristics of fire.

The problem can be solved by a number of procedures which happen automatically; which notify the staff that there is a fire, which confines the fire; and which begins extinguishing the fire.

The quicker the fire is put out the less smoke there will be, the less toxic gases and the less heat. This is the issue that we have cited as the basis of our recommendation; that if the fire is extinguished very quickly, you control smoke, heat, and the other elements of combustion itself.

The fire in Niles, Ill., could have been just as deadly as the Wincrest and Cermak Nursing Home fires. There is nothing to suggest it could not have been, but there was a sprinkler system that was activated before the fire got out of control and there were no injuries, very little damage, and no deaths.

Mr. HEINZ. I think you have helped establish a point that I want to emphasize; that is, that it is relatively almost impossible for anybody to rely on the human element in the kind of fires we're talking about.

In effect, you can try and train people to be cool under pressure as you have every right to expect them to be, but when you have an emergency, when you have that very fine chap pressed into duty coming out of church service, you cannot expect the kind of human perfection that we would think might be theoretically possible, and therefore, it is very valuable, I think, to establish once and for all that we cannot rely on nonautomatic procedures here for saving

lives in nursing homes and human beings are nonautomatic, and therefore, I think the emphasis that you are placing on some of the relatively automatic sprinkler systems, smoke detection systems, is very well placed.

I wanted to make sure the record reflects your comments on the need for relying on the automatic versus nonautomatic devices.

Thank you, Mr. Chairman.

Senator PERCY. Mr. Cohen?

Mr. COHEN. Thank you, Mr. Chairman.

I have just a couple of points.

You indicated that both these nursing homes were in substantial compliance with the Federal regulations.

Would full compliance with the regulations have, in any way, reduced the deaths?

Mr. MARTIN. The inspections of the nursing homes indicated that the standards they were not in compliance with had no impact on the severity of the fire.

Mr. COHEN. No causative factor whatsoever?

Mr. MARTIN. No, sir.

Mr. COHEN. Speaking of the sources and emission of fires, could you tell us perhaps, and it has been established for the record, but what was the origin of the fire in both the Wincrest and Cermak Homes?

Mr. ZIPP. Mr. Cohen, the Cermak fire was attributed to a faulty lamp cord.

At the time of our review, the fire investigators were investigating for other causes.

The Wincrest fire on the other hand was suspected arson and without prejudicing any cases that may be pending, we do not have any substantive evidence to support any statement to the contrary.

Senator PERCY. In what object of furniture in room 306 was the fire actually set or do you know?

Mr. ZIPP. The location of the fire?

Senator PERCY. Yes.

Mr. ZIPP. It was in a wooden wardrobe.

Senator PERCY. Behind the door?

Mr. ZIPP. Yes.

Senator PERCY. And customarily, patients in Wincrest keep their personal effects in the wardrobes.

Mr. ZIPP. Yes, sir.

Senator PERCY. A lot of those I went through are plywood chests or stand-up chests holding hanging clothes and paper bags. Ordinarily they just stuff their things in there.

Mr. ZIPP. That is correct, sir.

Senator PERCY. The personal effects of the patients.

Mr. ZIPP. Yes. I might add you can regulate furnishings. However, unless everything is made of steel, for example, you are going to have combustion problems. You are going to have a fire load which is what it is classified as, and these are homes for people.

To make them institutionalized to the point of taking everything out that will burn, which I do not think is practical, indicates that something else needs to be done. With respect to the Wincrest Home, there was a problem with regard to the standards themselves regarding the length of corridor which did not require a smoke barrier.

There is a problem with the technical definition of a place of assembly where the chapel was. There were no doors to the chapel. People were trapped at the dead end.

These types of things are technical aspects of the Life Safety Code which the facility complied with, and which questions, perhaps, might be directed toward the National Fire Protection Association.

Mr. COHEN. I just have one final question, Mr. Chairman.

As I understand it, the 1973 Life Safety Code is not a mandate with respect to a single-level fire resistant home, but it does, in fact, encourage it and apparently from your statement, that encouragement has not been very strong or the nursing home community has not been terribly responsive.

From the testimony we have received so far today, it seems to me that the emphasis is that really time is of the essence, and the emphasis today in the Life Safety Code has been on fire-resistant materials.

I was wondering, is there some point in time that perhaps we have overemphasized the fire-resistant materials. We mandate that it be resistant to fire for up to periods of 1 or 2 hours when, in fact, it is minutes that are of the critical time and we should direct more attention to the smoke detectors and sprinkler systems?

Mr. MARTIN. That is a fair statement, sir. We should shift to sprinklers, smoke detectors, and heat detectors.

Mr. COHEN. And, perhaps, get away somewhat from the expensive requirements of fire-resistant materials. We still have them but not to the point where they have to resist fire up to one or two hours at a time when, in fact, that may not be necessary to save the lives when we are really talking about quick action in a matter of minutes.

Mr. MARTIN. There should be some tradeoffs of this type if you put automatic sprinklers in there.

Mr. COHEN. What would you recommend?

Mr. MARTIN. We are not experts in the field in terms of types of fabrics, in terms of how many hours it should resist or minutes it should resist.

That, sir, is better left to the experts to research.

Mr. COHEN. That is all.

Senator PERCY. Congressman Randall, we are delighted to welcome you today.

Mr. RANDALL. Thank you very much.

I commend you, Senator Percy and Senator Moss, and all of you others for this joint hearing.

I am delighted to see that these hearings are going forward.

I would suggest that we have plowed this ground before, not we on the House Select Committee but as the Special Studies Subcommittee of the House Government Operations Committee. Beginning in 1970, we analyzed 71 fires in Pennsylvania and Ohio and we wrote a report, and I think if you will dust it off, I think you will find it has the very things that Bob Weiner and Elliott Stern and your staff have discussed, that in the big Honesdale fire and the one in Ohio deaths were not caused by anybody actually burning up and being incinerated. It was all by suffocation.

The recommendation of the report was that there be a mandate that there be sprinklers and smoke detectors.

You will find in the 1971 report that it went on to recommend a loan program to provide for sprinkler systems that had some type of Federal assistance so that there was both the carrot and the stick, the stick of a Federal regulation and the carrot of a loan.

Senator, I am grateful for you recognizing me.

Senator PERCY. We appreciate your comments very much, indeed. I think we should note that the Chicago City Council has acted. Every nursing home in the city of Chicago by 1977 will be required to have a sprinkler system.

The cities around the country do not have to wait for the Federal Government to act. They can take action on their own initiative and we encourage them to do that before the Federal Government moves in.

The Chair will recognize, in the absence of Congressman Claude Pepper, his staff director, Mr. Robert Weiner, for any questions he might have.

Mr. WEINER. Thank you, Senator.

Again, we want to express our great gratitude to the GAO for their completion of the report on a very severe deadline.

Mr. Chairman, I ask that the GAO report be included in the record.

Senator PERCY. Without objection, so ordered.

[The GAO report is reproduced in the appendix, pp. 124–182.]

Mr. WEINER. Mr. Martin, as you have pointed out, the HUD loan insurance program has been a failure to date.

Why do you believe it could be a viable source of financing for nursing homes wanting to install sprinklers? How many homes might take advantage of the program if it worked based on any similar information you might have, including FHA or other loan insurance programs?

Mr. MARTIN. I have no particular knowledge on how many might take advantage of the program.

However, I think it is indicative in Chicago there were 159 inquiries to the program itself. Only 10 followed through.

We do not know why the 149 did not follow through with it. However, I think as we previously stated, that it is a sound way in principle and theory to get sprinklers into nursing homes.

However, the administrative procedures and the length of time of 6 or 8 months it takes HEW to process paperwork has really, in effect, turned off the nursing home operators from coming to that program for a loan. They can go elsewhere and get a loan quicker.

We think those administrative procedures should be cleaned up and the time shortened and that this should be made known to nursing home operators. If this happens, it is possible they would come into the program and make it viable.

Mr. WEINER. Thank you. Would direct Federal loans rather than loan insurance be more effective for them?

Mr. MARTIN. There is certainly a possibility that it might be.

We have no reason to know whether or not at this point in time loans could not be insured adequately.

A direct loan should cut down on some of the paperwork and processing time in going through a bank and HUD.

For example, if there were HEW direct loans, it would not require two procedures. You would not go through the lending institution procedure. You would not go through the current procedures with HEW and HUD.

Senator PERCY. If anyone is having trouble in hearing Mr. Martin, would you raise your hand?

Mr. Martin, would you please pull that microphone up?

Mr. WEINER. Mr. Martin, how much time do you think is appropriate to phase in the sprinkler system required for the nursing homes?

Mr. IFFERT. I am a little reluctant to speak to the time frame. We think it should be relatively short, perhaps 2 or 3 years.

We have amortized the cost of installation over 20 years. We have a long-term view of the desirability of our recommendation in that you will be providing protection not only to the present generation of nursing home residents but also to future generations in the next 50 years.

Mr. WEINER. You reported that the cost of automatic sprinklers was about 19 cents per bed per day.

Would you elaborate on your computation and discuss the possible savings from insurance reductions and medicare-medicaid reimbursement to the facilities?

Mr. IFFERT. Well, through September 1975, there have been four nursing home applications for insured loans that have been sent to HUD, although in each case the applicant withdrew before the application was processed by the lender. The installation of sprinkler systems was accomplished but not with HUD insured loans.

For these four facilities, there were three in Ohio and one in Minnesota, the estimated cost that was approved by HEW as being reasonable under competitive bid ranged from $393 to $625 per bed, and with cost per square foot ranging from $1.21 to $1.55.

These costs per square foot were very close to information we obtained from seven sprinkler installation companies in the Washington-Baltimore area.

Using the highest cost per bed, $625 and amortizing that over a 20-year period with a 9¼ percent interest rate as the average comes out to 19 cents a bed, a day.

Mr. COHEN. Is that for new construction or existing buildings?

Mr. IFFERT. That is existing buildings.

New construction is less expensive, sir.

Mr. WEINER. Does that include the possible savings from insurance reductions and the medicare-medicaid reimbursement?

Mr. IFFERT. No.

Mr. WEINER. So that would be less still.

Mr. IFFERT. Through medicare reimbursements, the program pays part of the cost.

I do not think it is a savings. Medicare and medicaid are paying their share.

Mr. WEINER. You recommended that Congress require HEW to establish specific waiver of standards which must be met before a sprinkler waiver is issued.

Would you elaborate on why you believe such a requirement should be placed on HEW by statute? In other words, why specific waiver requirements?

Mr. ZIPP. I can respond to that question.

We found in 1975 that there were significant problems with the granting of waivers from the sprinkler requirement.

As a matter of fact, we found that 79 percent of the nursing homes we visited did not meet HEW standards for a waiver designed to insure that there would be no adverse effect on patient health and safety.

HEW had established standards only for wood framed facilities to insure that a waiver of the sprinkler requirement would not result in an adverse effect on patient safety. Seventy-nine percent did not meet these requirements.

We pointed out to HEW, in our report, of the need for establishing standards for other types of construction. This recommendation was not accepted by HEW.

We feel that in rare cases there will be situations which may exist that would create such an unreasonable hardship on a nursing home, that the installation of a sprinkler system would not be practicable.

In those rare cases, we believe that a waiver should be considered. In view of the current waiver provisions of the Social Security Act, we believe standards should be established to meet the congressional requirement that no adverse effect will result from such a waiver. We also believe that since the Department of Health, Education, and Welfare has not established standards as we suggested, we believe that a requirement by statute should be placed on them to establish those standards.

Mr. PEPPER. I believe you said that both the Wincrest and the Cermak Homes were in substantial compliance with existing life safety requirements.

Could you detail the firefighting equipment and the fire-resistant construction they did have?

Mr. MARTIN. Let me give you an answer in terms of the equipment that was available at Wincrest and Cermak at the time of the fire.

Senator PERCY. Could you please speak into the microphone, Mr. Martin?

Mr. MARTIN. At Wincrest, at the time that the fire occurred, they had four alarm boxes, heat and smoke detectors, fire extinguishers, emergency lighting, solid core doors and fire-resistant construction.

At Cermak, they had four boxes for alarms, smoke detectors, fire extinguishers, fire hoses, a public address system, solid core doors, sprinklers on the first floor, vertical pipes to the other floors, but they did not have sprinkler systems installed, and it was also fire-resistive construction.

Mr. PEPPER. Mr. Martin, in other words, these homes were in compliance with present requirements?

Mr. MARTIN. Yes, they were in compliance with the present requirements.

Mr. PEPPER. So the fact that these fires occurred, which was a tragic loss, indicates that the present requirements of Congress are not adequate to protect people against fire.

Mr. MARTIN. There is a strong case they do need one additional item, an automatic sprinkler system.

Mr. PEPPER. Are you able to tell us further that if nursing homes were protected by automatic sprinklers that multiple death fires would not occur?

Mr. MARTIN. According to the National Fire Protection Association, there have not been any multiple death fires in nursing homes fully protected with automatic sprinkler systems.

Mr. PEPPER. Are you able to express an opinion from your study of this subject as to whether any other fire protection device, other than a sprinkler system by itself or with other equipment, does have an equal record of preventing death by fires to patients?

Mr. MARTIN. Not to my knowledge, sir.

Mr. PEPPER. So I would conclude that it is your opinion after a study of this subject that the existence of adequately installed and proper operation of sprinklers is essential to the protection of patients in a nursing home against the danger of fire.

Mr. MARTIN. Yes, sir.

Senator PERCY. Mr. Pepper, if you could take over as chairman now, I would appreciate it very much, indeed.

Are you able to stay, sir?

Mr. PEPPER. I am very grateful to you and for your kindness in staying to do your duty.

Senator PERCY. I shall always regret not seeing the Magna Carta, but please go right ahead.

Mr. PEPPER. This is a very essential thing to the public interest, and you are a great public servant to stay here and carry on.

Senator PERCY. I have no further questions.

I wish to thank the witnesses very much, indeed, and want to join in expressing to the Comptroller General my appreciation for an outstanding job.

Mr. PEPPER [presiding]. Thank you very much, Mr. Martin.

Our joint committee wants to express a great gratitude to the GAO and all the experts with you in your survey for the very fine public services you have rendered.

Now, we are going to have a panel consisting of representatives from the Department of Health, Education, and Welfare and the Department of Housing and Urban Development.

This panel will consist of Dr. Faye Abdellah, Director, Office of Long-Term Care, Department of Health, Education, and Welfare, who will be accompanied by Mr. Marvin Hitt, Director, Office of Long-Term Care Standards Enforcements; Mr. Michael Morelli, Office of Nursing Home Affairs; Mr. Jonas Morehart, Office of Facilities, Engineering, and Property Management; and Mr. Gene Haislip, Deputy Assistant Secretary of Legislation.

We shall also include on the panel Mr. George Hipps, Acting Director, Office of Underwriting Standards, Department of Housing and Urban Development.

Now, then, I guess we will just call upon you in the order on which you appear on our program here.

Dr. Abdellah, you are now the Director of Office of Long-Term Care.

STATEMENT OF DR. FAYE ABDELLAH, DIRECTOR, OFFICE OF LONG-TERM CARE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY MARVIN HITT, DIRECTOR, OFFICE OF LONG-TERM CARE STANDARDS ENFORCEMENT; MICHAEL MORELLI, OFFICE OF NURSING HOME AFFAIRS; JONAS MOREHART, OFFICE OF FACILITIES, ENGINEERING, AND PROPERTY MANAGEMENT; AND GENE HAISLIP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION

Dr. ABDELLAH. Thank you very much, Mr. Chairman.

First, I want to thank you for your support in the change of out name to the Office of Long-Term Care. It seems quite fitting that tha becomes official today and, of course, broadens our interest and support in terms of alternatives to institutional care, and we do thank you very much.

For HEW, I will be the key witness, and to my right is Mr. Haislip, and Mr. Hitt will speak specifically to the Chicago situation.

I would like to read my prepared statement and then provide an opportunity for questions.

Mr. Chairman and members of the subcommittee:

I appreciate the opportunity to appear before you today to discuss fire safety and related problems in nursing homes.

I would first like to take a few minutes to explain how the Department of Health, Education and Welfare enforces the statutory fire safety requirements and to report on the current status of our enforcement efforts. As you know, under titles XVIII and XIX of the Social Security Act, the Department is now required to enforce for skilled nursing facilities the applicable requirements of the 1973 edition of the Life Safety Code (except for existing facilities which have already met the 1967 edition requirements)—a consensus standard published by the National Fire Protection Association (NFPA). The 1973 edition of the code was substituted for the 1967 edition by Public Law 94–182, the provisions of which became effective on June 1.

Although the law only requires that the Life Safety Code be applied to skilled nursing facilities (SNFs) participating in the medicare or medicaid programs (with waivers permitted under certain circumstances), the Department has required, by regulation, that hospitals and intermediate care facilities also comply with the code provisions. In enacting the legislation requiring the application of the Life Safety Code, Congress recognized the fact that the code contains provisions which are nationally accepted and which provide an acceptable degree of safety for patients and staff in institutional buildings.

This is a very important point we would like to make, that the standards today provide only an acceptable degree of safety, not the maximum degree of safety.

The Department's principal enforcement mechanism is direct survey of nursing homes by State surveyors. Our regional offices of Long-Term Care Standards Enforcement, which were established 2 years ago, monitor State survey activities for long-term care facilities

and provide training and consultation to State survey agencies. The directors of our regional offices of Long-Term Care Standards Enforcement, under delegated authority of the regional directors, review surveys and determine whether skilled nursing facilities comply with Life Safety Code requirements. They also pass judgment on requests for waiver of specific requirements for these facilities.

Waiver determinations for SNFs, which are explicitly authorized by law, are made on a case-by-case basis. Waivers are approved only if the waiver will not adversely affect patient health and safety and if by requiring compliance an unreasonable hardship on the facility would result. These waiver criteria can be applied to all code requirements, including the sprinkler requirement. However, the Department does not permit waiver of the sprinkler requirement in one-story unprotected wood frame facilities of multistory protected wood frame facilities, because the type of construction in these facilities offers the least resistance to fire.

In addition, specific criteria have been established for the waiver of the sprinkler requirement on one-story protected wood frame facilities. These criteria must be satisfied before a waiver of the sprinkler requirement can be considered. Although these specific criteria need not be met to approve waivers for the sprinkler requirement in other types of construction, the Department has instructed State surveyors to consider these criteria in establishing the basis for waiving the sprinkler requirement in other types of construction. The Department believes that it would be unrealistic to specify waiver criteria in all types of buildings because each building is unique and a judgment must be made on a case-by-case basis by professional surveyors. However, HEW is continuing to review this matter.

Intermediate care facilities are also subject to Life Safety Code requirements. In this case, the State survey agency determines whether these facilities comply with Life Safety Code requirements and also approved waiver requests. The Department's Directors of Long-Term Care Standards Enforcement (OLTCSE), in this case, monitor State actions to insure that Federal criteria and guidelines are being followed.

In an effort to upgrade the quality of fire safety surveys the Department has conducted a number of training sessions on fire safety. The most recent were conducted in the fall of 1974 for all of the 10 regions. Another training program is being scheduled for this summer to include in each region to orient surveyors to the 1973 Life Safety Code. Our Regional Offices, aided by the Department's Regional Office of Facilities Engineering (ROFEC), providing training and consultation to State surveyors on an ongoing basis. Regional validation surveys of a randomly selected sample of nursing homes serve not only to monitor State enforcement practices, but also identify areas where additional training may be required.

The Department's continuing efforts to improve the quality of surveys and its strong stance on enforcing Life Safety Code requirements have forced many nursing facilities to make the necessary improvements or to be dropped from participation in the programs.

In the State of Pennsylvania alone, since our last meeting, 200 field mission facilities with serious deficiencies are no longer participating in Federal programs.

I would now like to turn to the subject of the automatic sprinkler requirements which is the key issue this morning. The 1967 edition of the Life Safety Code does not require automatic sprinklers in buildings of fire-resistive construction, regardless of height, nor in one-story buildings of protected noncombustible construction. The 1973 edition exempts buildings of fire-resistive construction, regardless of height, as does the 1967 code, and buildings up to three stories in height if they are of protected, noncombustible construction. There are other variations regarding construction types and sprinkler requirements in the 1973 code.

The Secretary accepts the recommendations of the association in terms of the materials and standards under the terms of the existing code—as of June 1, the 1973 edition is the current one in effect.

The recent tragic fires in Illinois have raised serious questions as to the degree of safety provided in institutions of fire-resistive construction that are not required to have automatic sprinklers. These facilities were in compliance with the provisions of the Life Safety Code, yet 31 elderly residents perished. We in HEW are deeply concerned over these tragedies. We took immediate steps working in Chicago to investigate both fires. Mr. Hitt will speak to these a little later.

Fire safety experts within the Department and at the National Bureau of Standards have been studying the reports of these investigations and will soon make specific recommendations to us on actions which should be taken to help prevent similar tragedies in the future. In fact, a departmental committee met yesterday and is meeting again today for the purpose of recommending appropriate action.

Over the past several years, there has been an increasing body of opinion which argues for requiring automatic sprinkler protection in all nursing homes without regard to type of construction. A few States, such as California and Ohio, and most recently the city of Chicago, require that all nursing homes have automatic sprinkler protection.

I would like to suggest that, before any decisions are made with respect to requiring automatic sprinklers, we look at other possible solutions and weigh all proposals in terms of their cost effectiveness.

I might add here also that, in terms of the needs of individual facilities, there are the basic requirements of health and nutrition and occupational therapy—everything we would want elderly individuals to receive in these long-term care facilities. Their overall needs must be weighed against the desirability for sprinklers.

How much additional safety will automatic sprinklers provide? Are there other requirements or combination of requirements which, if required, will provide additional safety yet cost much less? We don't have answers to these questions, but we are trying to find out. We are looking to the National Bureau of Standards regulations to give us guidance in this direction.

Under Secretary Lynch has recently established a departmental work group to examine costs of requiring compliance with the Life Safety Code and to recommend changes which would bring about a proper balance between costs and the degree of safety provided.

In addition, the Department has a contract with the National Bureau of Standards to study the effectiveness of many of the fine safety requirements pertaining to institutional occupancies and to determine whether additional or different requirements should be

mandated. One of the things they are looking at is the placing of automatic sprinklers at selected locations rather than throughout a facility; there is no question that there is evidence to show that lives can be saved by automatic sprinklers. They may determine, for example, that placing sprinkler heads in a corridor, outside each patient room door, would save as many lives but cost much less than sprinklers throughout.

In response to our request for recommendations on Life Safety Code changes suggested as a result of the recent fires in Illinois, the National Bureau of Standards provided us with an analysis indicating the degree to which patient safety is increased for each category of change.

If the chairmen wish, we will be glad to make the report available or to have one of the fire safety engineers here today explain the report. You may also wish to discuss the report with NBS officials. I believe that the report provides a good example of the type of analysis that must be done before decisions are made with respect to extending the current provisions of the Life Safety Code to require automatic sprinklers throughout every facility.

[The report was supplied and is reproduced in the appendix, pp. 183–197.]

As you are aware, the cost of installing automatic sprinklers is considerable. Estimates range from 50 cents per square foot to $3 per square foot, depending on who provides the estimate. The General Accounting Office, on the basis of four actual installations in 1975 in Ohio and Minnesota, has indicated a cost between $1.21 to $1.55 per square foot. Using the higher cost, the GAO has indicated that the cost per bed is $625 and has amortized this cost over a 20-year period at 9¼ percent interest. On this basis the cost per bed is $5.57 or about 19 cents per bed per day.

Assuming that these figures are representative of actual costs throughout the country, which has not been established, the actual cost of installing sprinklers in all nursing homes (SNF's and ICF's) that are currently participating in the medicare or medicaid programs but which are not sprinklered would be $412,500,000. This figure is based on an estimate that 50 percent of the approximately 16,500 SNF's and ICF's currently participating in medicare or medicaid, with an average capacity of 80 beds, would have to install sprinklers. Our best estimate is that, at current prices, the national average cost for installing sprinkler systems in existing nursing homes is approximately $2.30 per square foot. At 1978 prices, the average cost approaches $3 per square foot. At $2.30 per square foot, the cost per bed would be approximately $927, resulting in a total cost of $611,820.000.

Again, this is a very large investment, one that needs to be weighed in terms of the total needs of the individuals in these facilities and arriving at a balance of both safety and health requirements.

Automatic sprinklers do help prevent multiple-death fires (defined by the NFPA as three or more deaths). The NFPA has never reported multiple death fires in buildings which were completely sprinklered. The May 1973 report of the National Commission on Fire Prevention and Control entitled "America Burning" estimated that there are between 3,500 to 4,000 fires annually in nursing homes and homes for the aging, which indicates, I might say parenthetically, that the reason there are not many more fires is because of the dedication of

the personnel in these homes and the kind of training that is now going on.

In the 20-year period from 1951 to 1970, 496 residents of facilities for the aged perished in multiple death fires.

And, while we are all in agreement that automatic sprinklers can help prevent multiple death fires, I believe that we also agree that automatic sprinklers cannot save an individual who is intimate with the source of ignition, especially if the patient is bedridden or otherwise immobile.

In conclusion, I wish to thank you for the opportunity to present our views on this most important issue. The Department will be pleased to assist the committees in whatever way we can in future deliberations. My colleagues and I will be pleased to answer any questions you may have.

Thank you.

Mr. Chairman, Mr. Hitt is on my left to speak specifically to the Chicago fires and is most knowledgeable on our staff about that.

Mr. Morehart in the second section behind me can speak very specifically about the National Bureau of Standards' studies, also about any questions that you might have regarding the carpet test and other related specific factors about the 1973 code.

Mr. PEPPER. Doctor, we will wait until we hear from Mr. Hipps before we ask some questions.

Now, we will hear from George Hipps from HUD.

STATEMENT OF GEORGE HIPPS, ACTING DIRECTOR, OFFICE OF UNDERWRITING STANDARDS, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Mr. HIPPS. Thank you, Mr. Chairman. I do have a brief statement directed to the loan insurance program.

Thank you for the opportunity to testify on the nursing home and fire safety equipment loan insurance program under section 232(i) of the National Housing Act.

As you know, Public Law 93–204, signed on December 28, 1973, added to section 232 of the National Housing Act a provision for FHA insurance for supplemental project loans to finance purchase and installation of fire safety equipment in nursing homes and intermediate care facilities, including those not financed with FHA insured mortgages.

The legislation specifically requires that equipment installation bring the facility into compliance with HEW requirements for providers of services under the medicare and medicaid programs. The committee reports indicated that the program should be implemented with the assistance of HEW. Carrying out this intent, meetings were held in early January 1974 with the Department of HEW to prepare for implementation of the program.

Drafting of regulations and a program handbook began immediately. Development proceeded to the point that a memorandum of agreement was prepared by HUD for signature by both Departments. Former HUD Secretary James T. Lynn signed the memorandum of agreement on March 25, 1974, and it was forwarded to HEW for

execution. Further meetings were subsequently held with HEW to resolve objections to the agreement as submitted and a revised agreement was finally executed by both parties in October of that year.

While negotiating the final memorandum of agreement, HUD drafted proposed regulations which were published for comment by HUD on June 6, 1974. Final regulations were subsequently published for effect on August 12, 1974.

During this same period, we proceeded with the preparation of a program handbook, which included HEW's participation in the program. In September 1974, we began planning for orientation meetings for personnel in both Departments. Three such meetings were held in late October to brief HUD and HEW field office personnel, and the program was operational on November 1, 1974.

During this period of time, from January to November 1974, HEW had been enforcing fire safety standards and requirements before the program became operational. As a result, we received many requests to insure loans retroactively. As you may know, FHA insurance under section 232 is on a prospective basis, thus precluding insurance of mortgages where work has commenced prior to application for insurance.

Soon after the program became operational, we informed all FHA mortgagees of the program and encouraged their participation. To date, no projects have been insured nor commitments issued.

In developing the operating procedures for the program, it was felt that we should keep as much of the processing as possible outside of HUD because of the processing time lags which have developed in some HUD/FHA programs. We believed HEW participation in the program was necessary to assure compliance with fire safety requirements applicable to the medicare and medicaid programs. For this reason, we elected to identify the 10 HEW regional offices as the initial contact point for all applicants.

The following procedural steps are followed in utilizing the program:

One: The applicant takes plans for correction of fire safety deficiencies to HEW.

Two: HEW reviews the plans and advises the applicant in writing—with copy to HUD—that the plans were acceptable and that he may submit an application to the local HUD office.

Three: The applicant submits an application to the local HUD office through a mortgage lender willing to make the loan on an insured basis.

Four: HUD/FHA processes the application mainly on the financial capacity of the proposed borrower. If HUD/FHA approval is obtained, a commitment is issued.

Five: After issuance of the commitment, installing of the equipment may begin.

Six: HEW inspects during the installation of the equipment and advises HUD when the installation has been satisfactorily completed.

Seven: HUD endorses the loan for insurance.

That completes my prepared remarks. I will be happy to respond to any questions you may have.

Mr. PEPPER. What concerns me is that these fires occurred in January and February of this year, and here it is June 3 and you representatives of two of the major departments of Government and

the ones that have to act on this matter are still studying the question and still getting reports which you have not yet evaluated and upon which you have not made a decision.

Now, that is 5 months since the fire occurred, and now you are considering, according to your statement, which is the most desirable method to use and can prevent such a tragedy as these which will get effective cost benefits.

Now, we have already sustained an enormous and immeasurable cost in the loss of 31 lives.

Does Government have to move this slowly when life or death is involved? Citizens of this country are in a way entrusting their lives to public-State authorities when they go into these nursing homes since these nursing homes are supposed to be approved by State and Federal authorities. These people who are patients there, it seems to me, are entitled to rely upon competent observation and scrutiny of these nursing homes. By the fact the nursing homes are permitted to be open and they receive Federal funds, it would seem to me that the Federal Government should confirm their competence and that the Federal Government should see to it that the elderly are safe within those homes.

Why on the 3d of June has our great Government not come up with a solution to this problem with recommendations as to what to do?

Does Government have to move that slowly?

Were you waiting for the GAO report? The report has just been officially filed and released. I do not know whether you have seen it.

Have you seen the GAO report prior to this, Doctor?

Dr. ABDELLAH. Yes, Mr. Chairman.

Mr. PEPPER. When did you see it?

Dr. ABDELLAH. I did see it wrapped up about a week ago.

Mr. PEPPER. Mr. Hipps, when was HUD aware of this?

Mr. HIPPS. Within the past week.

Mr. PEPPER. Did you all meet together on the GAO report before you made a decision on this matter on what to do or recommend to the Congress?

Mr. HIPPS. I think you have to understand HUD's position with respect to this program.

Mr. Chairman, we are the insurer of loans. We do not set the standards that are to be followed, nor do we certify the nursing homes themselves.

That, Mr. Chairman, falls within the responsibility of HEW.

Mr. PEPPER. Yours is only to make a loan certified by HEW?

Mr. HIPPS. That is the sequence.

Mr. PEPPER. Mr. Hipps, if I understand from you, there was only one application for a loan to be made, and was that certified by HEW?

Mr. HIPPS. There was one that we reviewed that HEW found acceptable which we found unacceptable because the nursing home did not have the financial capacity to pay the additional loan.

Mr. PEPPER. Did you offer them the loan payable over a long period of time?

Mr. HIPPS. I do not have the specific circumstances of the terms of that proposal, but normally, yes, it would be a long-term loan.

Mr. PEPPER. You recall how long or how long you may extend the loan?

Mr. HIPPS. It is up to 20 years.

Mr. PEPPER. You say that in this one application the nursing home was not able to pay back the loan over a period of 20 years.

Mr. HIPPS. That is my understanding.

Mr. PEPPER. And HUD certified it, but you did not find a borrower qualified because they did not have the financial capacity to repay the loan.

Mr. HIPPS. No.

Mr. PEPPER. How much of a subsidy would have been necessary in that case to justify your making a loan?

In other words, what subsidy would HUD have required in order to be able to put in a sprinkler system?

Mr. HIPPS. I cannot answer the question, Mr. Chairman. I have not particularly examined that particular application itself. That information could be obtained, I am sure, and provided for the record.

[The Department submitted the following information for the record:]

The application in question was submitted by the Nursing Home of Boaz to our Birmingham Office. The applicant was neither the owner nor the primary lessee of the facility but is categorized as a subtenant. The credit report obtained on the applicant indicated that income was not sufficient to cover operating expenses. An audited financial statement for the period ending November 1973 showed a profit to the Nursing Home of $6,335 and a similar statement for the period ending November 1974 showed a profit of $799. Our calculations, including the debt service on the proposed fire safety equipment loan, projected a $3,000 loss utilizing a 93 percent occupancy factor. To make this loan acceptable a 100 percent subsidy would appear to have been necessary.

Mr. PEPPER. Do you not think it would be desirable to set up some machinery that an applicant may be examined concerning his ability to repay all of it back within the 20-year period allowed for the loan, and if not, a subsidy could be provided to pay for the part they could not otherwise pay?

Mr. HIPPS. I think that is one thing that is under study, from what as I have read the possibility of grants as opposed to loans, but I do not think I can comment on that at this moment.

Mr. PEPPER. Would it be more appropriate for HUD to extend that subsidy if the law should allow one or would it be more appropriate for HEW to extend that?

Mr. HIPPS. I do not think I can really correctly answer that question at the moment without first having an opportunity to examine what kind of a proposal it would be and then determine who would be most appropriate to administer.

I believe HEW has administered a grant or a combination of loan and grant program in the past.

Mr. PEPPER. Does HEW now have any authority or fund to give a subsidy to a nursing home that needs to meet safety requirements that is financially unable to do so without aid?

Dr. ABDELLAH. No; we do not.

Mr. PEPPER. Would it take legislation?

Dr. ABDELLAH. Yes, sir, it would.

One of our problems in the HUD–HEW program, as indicated in the GAO report is that, as Mr. Hipps has indicated, the HUD

program is a prospective program, so that when the applicants did come in seeking a loan guarantee, they had already made arrangements and had already started to install fire safety equipment. The prospective requirement is a real handicap to the applicants.

Mr. PEPPER. Do you think it would be desirable for Congress to authorize HEW to make subsidies and make grants to nursing homes to enable them where that was necessary to meet the safety requirements?

Mr. HAISLIP. That would be a significant change from the manner in which we have proposed standards thus far.

Mr. PEPPER. Give your name for the record.

Mr. HAISLIP. Gene Haislip, Deputy Assistant Secretary for Legislation.

You have to bear in mind that the Federal Government provides extensive multibillion-dollar expenditures for health care in this area to both medicare and medicaid and the standards have been imposed by requiring that facilities meet certain standards in order to be reimbursed under these systems.

I do not know whether you prefer to characterize that as a subsidy, but that is the extent of Federal involvement and that is the manner in which standards have been imposed and not through some sort of direct grant program.

Most of these nursing facilities are private facilities and their capacity to react to regulations or requirements depends upon individual management and funding in many cases.

These are matters over which only those individual owners have control and would present a real question as to whether we simply automatically blanketly subsidize their facilities in any respect.

Mr. PEPPER. Well, it would seem from the evidence that you all have given here that you have no record of a multiple death fire in a nursing home which was protected by a sprinkler system. In addition, there were many fire deaths that occurred in the country in the last 20 years in nursing homes which did not have sprinkler systems. This would seem to indicate that the sprinkler system, even though other requirements would be made, is an essential contribution to the safety of those patients.

Now, let me ask you this, Dr. Abdellah. Is the rule or rather the provision that a fire-resistant building does not have to have a sprinkler system, is that a rule and regulation of HEW, or is that a statutory requirement?

Dr. ABDELLAH. It is part of the requirement of the code.

Mr. PEPPER. Is that passed by the Congress or promulgated by HEW or by some other department of Government?

Mr. MOREHART. My name is Jonas Morehart, Office of Facilities, Engineering, and Property Management for HEW.

Your question has to do with who promulgates the Life Safety Code? It is the National Fire Protection Association, a private nonprofit association consisting of about 35,000 members of the fire service, health care facilities, and so forth.

Mr. PEPPER. You mean there is a rule or regulation promulgated by a private association?

Mr. MOREHART. This is a national consensus standard.

Mr. PEPPER. Well, is it embodied in any rule or regulation of HEW?

Mr. MOREHART. No, sir. It is embodied by reference in the Social Security Act.

Mr. PEPPER. You mean the Social Security Act also authorizes the fire association to lay down fire protection criteria?

Mr. MOREHART. It refers to the standards as a national consensus standard.

Mr. PEPPER. What I am getting at is this: I presently believe that we should not provide any Federal money from medicare or medicaid to a new nursing home if it does not have a sprinkler system in effective operation.

Do we have to have legislation to do that, or can HEW simply eliminate the criteria of fire-resistant construction, which itself unfortunately eliminates the necessity for a sprinkler system?

Can you eliminate the practice of improper "fire-resistive" definitions which you have observed in the past?

In other words, will it take legislation to accomplish what we are looking for, or can it be done by regulation by the appropriate department of Government?

Dr. ABDELLAH. Mr. Chairman, the Life Safety Code which is recommended by the National Fire Protection Association, is the Code which the Secretary of Health, Education, and Welfare follows so that this is a mandate by Congress. Therefore, there would have to be legislation in order to carry out your wishes.

Mr. PEPPER. Now, wait a minute. What is the answer to my question?

Can the change be effectuated by rule or regulation, or does it have to be by statute of the Congress?

Dr. ABDELLAH. It would have to be by statute of the Congress because at present, the statute reads that the Secretary apply the Life Safety Code of the National Fire Protection Association.

Mr. PEPPER. There was one surprise that I got, Dr. Abdellah, from your testimony, the actual surveys of these nursing homes is not made by Federal officials but by State officials, and apparently they report to the Federal Government. Is that true?

Dr. ABDELLAH. Yes, Mr. Chairman, that is true.

The Department does not have the manpower to do the actual annual surveys for all facilities.

Mr. PEPPER. But it is Federal money being put into these nursing homes, is it not?

Dr. ABDELLAH. Yes, sir.

Mr. PEPPER. Well, I think you should be provided with the personnel to protect the proper use of Federal moneys.

How many billions of dollars go into Federal payments through medicaid and medicare to the nursing homes?

Dr. ABDELLAH. $3 billion.

Mr. PEPPER. In other words, we are spending $3 billion a year.

How many people are in the nursing homes under the Federal program?

Dr. ABDELLAH. There are 1.1 million persons.

Mr. PEPPER. 1.1 million people in these nursing homes and we are paying $3 billion a year to keep the people in these nursing homes,

yet you say the Federal Government does not have the personnel to see to it that our money is properly spent, and the people in there properly and safely protected.

Dr. ABDELLAH. May I point out something?

Mr. PEPPER. I am not saying it is your fault. Somebody is at fault for not providing inspection as to where the Federal money goes.

Dr. ABDELLAH. I do not mean to imply the Federal Government does not carry out any inspections.

Through our 10 regional offices, these facilities on a sample basis do have routine validation surveys, but we do not carry out the annual survey.

This is a State responsibility for which the Federal Government reimburses the States.

Mr. PEPPER. I am sorry, Dr. Abdellah, and you other witnesses, but I have to go for another engagement, but others will carry on. I thank all of you very much.

Mr. HAISLIP. Just to respond to which Federal funds are funneled to the States when the States make certain representations, by statute the States have the responsibility for administering the medicaid program, so they have this particular responsibility with regard to medicaid funds.

It is a different situation with regard to medicare. There again, this is a matter that is mandated by law and it would be necessary that we have a basic change in the character of this statute.

Mr. WEINER [presiding]. Mr. Abdellah, or any of the other members of the HEW panel, you say you are providing training and consultation to State surveyors on an ongoing basis.

HEW has been phasing out the surveyor training program. We understand you might phase out Tulane's excellent program and we have seen what they have accomplished.

I agree with your assessment of the surveyor training, so is not this phaseout inconsistent with your stated goal?

Dr. ABDELLAH. I realize that there have been misleading reports about Tulane.

Mr. WEINER. Are they going to continue?

Dr. ABDELLAH. At the moment, that is our only facility for training of State surveyors.

I see no choice for us to have that facility continued.

My colleagues in the Social Security Administration, the Rehabilitation Service, have recommended that that effort be continued.

There are plans to establish a Federal institute locally which is in the planning process which has some strength in that it would certainly pull upon Federal personnel and the faculty and also eventually reach out to the whole training effort.

We are committed to the training of State surveyors and we must have the training component.

I personally have recommended that this training effort at Tulane be continued. We have nothing to substitute for it, as yet.

I see no other alternative to that, Mr. Weiner. I do not wish to say that the program cannot be strengthened.

We recognize that there are problems in that situation, but at the moment that is the only one we have.

Mr. WEINER. I just want to make clear in my own mind because we have been talking about it and they are very, very upset.

That program will not be discontinued, is that right?

Dr. ABDELLAH. What I am saying is, I have recommended, as my colleagues in social security and SRS, that it be continued.

I personally have no control whether it is continued or not.

Mr. WEINER. You do not know what is going to happen?

Dr. ABDELLAH. As of this moment, it is still continuing. I have not heard that it is not.

Mr. WEINER. All right, in 1975, GAO recommended that you establish waiver standards for all nursing homes regardless of construction type to insure that sprinkler waivers did not adversely affect patient safety.

Evidently, the department did not accept that, and I read it is still your position.

Can you explain why and how you can insure patients' safety without minimum standards?

Dr. ABDELLAH. I call on Mr. Morehart.

Mr. MOREHART. The question of waiver standards which has come up here has to do with a very specific criterion that was developed for waivers for a one-story, protected wood-frame construction.

This was a very pressing need and it was developed. If criteria or standards were to be developed similarly for other types of buildings it would put a very severe restraint on the individual surveyor or the individual office making the waiver, and some types of facilities would not be able to qualify for the waiver because of these guidelines, whereas from a commonsense standpoint, they should have a waiver.

Mr. WEINER. But you are intending to promulgate any specific regulations that state what should be. You are on a case-by-case basis making a decision, so perhaps things like Chicago can happen again.

Mr. MOREHART. If every facility could be designed and built identically and operated identically, then you could begin to draw up uniform guidelines for this.

Mr. WEINER. In your opinion, do you not think the possibility of automatic sprinklers is working and do save human lives?

I am still not clear about your position on this in my own mind.

Mr. HAISLIP. I am sure OMB would have an opinion.

I think the problem here is one of taking a particular piece of resource—here, we talk about $600 million—and deciding how a maximum benefit can be achieved in terms of helping a class of people.

Now, I think Dr. Abdellah would be delighted, if you wish to listen, to give you long lists of deficiencies that need to be corrected in nursing homes.

These are deficiencies which also affect people's lives.

Mr. WEINER. It would be very helpful, but perhaps you can provide it later for the record. Would you be willing to do that?

Dr. ABDELLAH. I would be glad to do so.

[The information was later submitted and is reproduced in the appendix, pp. 198–215.]

Mr. HAISLIP. The point is: Which of these deficiencies are you going to cure and how much are you going to spend for them? This particular matter—fire safety—while extremely important, is, alas, only one of many deficiencies.

There are deficiencies in nutrition and quality of care and surveillance and many other areas which also result in people dying.

Mr. WEINER. I agree with you completely on the total of the Federal allocation dollars, but I would like to relate one personal experience having gone around to various nursing homes, having visited with residents. If you ask a patient what concerns him most about his care in a nursing home, he will generally say two things—it is fine, but not like home, and No. 2, he will say fear of a fire because they have seen and heard the stories about the Chicago fires.

They are just deadly afraid of fire, and it just seems to me that on a psychological level, if you are going to provide some kind of happiness in their twilight years, let them be assured of safety.

Mr. HAISLIP. It is very important. We agree.

Dr. ABDELLAH. One should consider balancing priorities with the limited health dollar—where funds and resources should go. We recognize that the sprinklers do save lives, and ask that consideration be given to the recommendations of the National Bureau of Standards, the report that will be coming out if we find that their recommendation is sustained it may be that sprinklers are only needed in corridors and hazardous areas.

Mr. WEINER. When can we have that report?

Mr. MOREHART. We anticipate probably at least another year, although it is part of a 5-year contract which is about 1 year down the road.

Mr. WEINER. We have to wait 1 year? Really, Mr. Pepper's point about the need to avoid delay and act promptly is very valid here.

Mr. MOREHART. If I may, I would like to set the record straight concerning what was said earlier this morning, and that is, that the human element is failing. I cannot agree that this is the case because we are having at least 10 fires in nursing homes every day of the year.

If the human element was always failing, then you can see the number of disasters that we would be faced with.

The fires we are having are accidents, and just like automobile accidents, we have millions and millions of miles driven every year when no accidents ever happen.

This is a case of multiple loss of life, and this is all we are talking about; we are not talking about the several hundred single fatalities from a fire. We are talking about 25 lives per year and the amount of money, whatever it may be, if put on other health care programs, could result in considerably more savings of life.

Mr. WEINER. Well, I think the Senate committee, if I read the summary of their report accurately, has statistics that show they are three times more heavily involved in deaths from fire as the general population as a whole.

It should be a priority. In addition, it is the single most important thing to an elderly person in a nursing home.

Mr. HAISLIP. It is a priority.

Mr. WEINER. You awarded HEW's contract to the American Health Care Association for their safety code.

What were their requirements relating to sprinklers?

Mr. MOREHART. This was a contract to the American Health Care Association? Did I understand you correctly?

Mr. WEINER. Yes.

Mr. MOREHART. As I recall, this was a series of tests, six tests; the entire building burned down.

One of the things the tests did show was that the sprinkler could effectively control the fire and confine it to the room of origin.

There is no question in my mind as a professional fire protection engineer about the effectiveness of the sprinkler system; its effectiveness is proved by 100 years of statistics. But the question that really bothered me as a professional is, we are looking at these sensational media-reported cases of multiple fire deaths, and we are not giving due consideration to solving the problem of the individual.

Mr. WEINER. For HEW, why did it take over 6 months to process the four loan applications cited in the GAO report?

Do you not think this long processing time creates a problem for nursing homes trying to make corrections within the allotted time for correction?

Mr. HITT. I am Marvin Hitt, Director, Office of Long-Term Care Standards Enforcement, and I will try to respond to your question.

I think there are delays in the processing. When we receive letters of interest in our office, we catalog them, and send out packaged materials to the inquirer. The packaged materials consist of a handbook and some of the material referred to and other correspondence.

Sometimes the providers respond immediately with other materials, and the materials they send to us might be obsolete from the standpoint they need updating.

We feel we had to make an outside inspection so we could certify to HUD that if this project was completed the facility would be in compliance with fire regulations. All of these things create some delay.

When we received plans for engineering and architectural appraisal, many times our regional engineers decided they needed additional information and they would have to go back to the provider and again we would have a time delay.

Sometimes, they just would not respond. This is beyond our control.

Mr. WEINER. Well, we have some questions on HUD on these situations also.

Again, for HUD, since you rely on validity of State inspection reports for medicaid and medicare certification, could you not rely on them for the HUD insurance program?

Why the timelag on that?

Mr. HITT. Well, that is a possibility, yes.

Mr. WEINER. Could that be done?

Mr. HAISLIP. We would have to supply that for the record.

[The material was later submitted and is reproduced in the appendix, pp. 216–228.]

Mr. WEINER. Is there any reason why it would be part of a statute since you are determining the process?

Dr. ABDELLAH. As the program was developed, we had recommended HEW involvement in the architectural review and survey because, although some States have qualified people to do this, there are many States which would not have qualified people to carry out their architectural survey. It was the intent of HEW to be helpful by providing the expertise to those States where it was not available.

Mr. WEINER. Well, OK.

Mr. HITT. I think too, if I may add, we did not rely totally on the States for this survey certification effort.

That is part of it, Mr. Weiner. They send the product of those surveys to us and we monitor the process, so it is not a total reliance on the State.

Mr. WEINER. That is what it seems to me, too, in view of the fact of HEW's great involvement here, obviously.

Certainly, with consultation, this would give at least a key to the process.

I believe that this is also recommended by the General Accounting Office.

Would you give us some examples of the situation which might exist at the qualifying nursing home in meeting a reasonable hardship requirement for a waiver?

Dr. ABDELLAH. Do you want to respond to that, Jonas?

Mr. MOREHART. Would you rephrase the question, please?

Mr. WEINER. What qualifies for a waiver in terms of unreasonable hardship?

Mr. MORELLI. If I might clarify the question as I understand it, under what grounds would a waiver be issued?

Dr. ABDELLAH. This is Mr. Morelli of my staff.

Mr. MORELLI. Our basic criteria are that a waiver may be issued if it will not adversely affect the health and safety of patients and would not result in undue hardship on the facility. I think your specific question is what would constitute an "unreasonable hardship" on the facility.

We have some guidelines we have developed, and these are in survey manuals.

One thing we look at is the estimated cost of correcting a deficiency: What would it cost to install a sprinkler system, if that is a deficiency.

Additional considerations would be the extent of destruction to the existing building, disruption of services to the patients, the availability of financing in that area, and the remaining useful life of the building. In other words, is it worth making that expenditure if the building is an old one?

Mr. WEINER. If I might turn to another matter here, Mr. Hipps, I would like to ask on what grounds does the Department support its position that it should not grant loans when the project had been begun, even though the loan is in effect?

Mr. HIPPS. That is the interpretation made by the General Counsel of the language of section 232 of the National Housing Act.

Mr. WEINER. But it is an interpretation, not in the statute.

Mr. HIPPS. That is their legal interpretation of the language of the statute.

Mr. WEINER. Would you be kind enough to supply us with a memorandum which they issued, making that interpretation?

Mr. HIPPS. Yes.

Mr. WEINER. Thank you.

[The memorandum follows:]

HUD-96 (4-72) PREVIOUS EDITION MAY BE USED

Memorandum

U.S. DEPARTMENT OF
HOUSING AND URBAN DEVELOPMENT

TO : George O. Hipps, Acting Director
Office of Underwriting
Standards, FT

DATE: JUN 7 1976

IN REPLY REFER TO:
GHM:DC

FROM : William E. Grossman, Multifamily Mortgage Branch, GHM

SUBJECT: Public Law 93-204 - Section 232(i)

This is to confirm previous advice I gave you that a loan to be insured under Section 232(i) is for the purchase and installation of fire safety equipment for a nursing home or intermediate care facility on a prospective basis rather than for equipment already installed in the facility.

I am attaching, for your information, a copy of a letter dated July 11, 1974, from the General Counsel, Robert R. Elliott, to Senator Philip A. Hart. In his letter, Mr. Elliott sets forth the Department's legal opinion that Public Law 93-204 ". . . does not authorize the insurance of loans to reimburse owners of nursing homes for previously purchased and installed fire safety equipment. . . ."

Assistant General Counsel

Attachment

Director
Multifamily Underwriting
Division

JUN 9 - 1976

RECEIVED

Referred to

Director, Office of
Underwriting Standards

JUN 9 1976

JUL 11 1974

2386(1) Fire Safety hearings

Honorable Philip A. Hart
United States Senate
Washington, D.C. 20510

Dear Senator Hart:

This is in response to your letter of June 18, 1974, on behalf of Mr. Jerry C. Kole of Town and Country Nursing Home, Inc., who has requested that the proposed regulations for HUD-insured loans for "Fire Safety Equipment in Nursing Homes," be amended to provide for insurance of loans on fire safety equipment which has already been purchased and installed.

These proposed regulations implement Public Law 93-204, which authorizes the Secretary to insure loans "... to provide for the purchase and installation of fire safety equipment ..." In our view, the statute does not authorize the insurance of loans to reimburse owners of nursing homes for previously purchased and installed fire safety equipment and the proposed regulations properly provide for loan insurance only for prospective installation and purchases.

In response to your question, amending the statute to provide for loans covering fire safety equipment purchased and installed prior to the effective date of the statute, or the regulations implementing the statute, would be legally possible. However, we do not believe that it would be generally desirable to depart from the pattern established for all other mortgage and loan insurance programs under the National Housing Act in which commitments to insure are only issued for work to be performed prospectively. This procedure enables HUD to determine not only the acceptability of the construction to be performed but also the financial feasibility of insurance of the indebtedness in relation to the prospective value of the security.

We recognize that Mr. Kole was faced with the dilemma of meeting fire safety requirements, without a then-existing federal program of loan insurance, and may have had to finance the purchase and installation under less favorable terms than may be obtainable when the final rules are made effective. However, making the program available for refinancing of indebtedness or expenditures already incurred, we believe would go well beyond the objective of providing federally insured financing for the prospective purchase and installation of fire safety equipment for nursing homes which might not otherwise be able to finance the purchase and installation of required equipment.

Sincerely,

/s/ Robert R. Elliott

Robert R. Elliott

Mr. WEINER. Why do you believe that no loans have been insured under the program?

Mr. HIPPS. I think there are probably several reasons.

Recalling back to the time the program was being considered and developed, it was clear from some of the information and comments received from the people in the nursing home industry that the type of program provided was not what they thought they were going to get.

Really, many of them, Mr. Weiner, believed that they were getting a grant program. They did not really understand that this was a mortgage insurance program and that it required the participation of private lending institutions.

This is the type of program that has not been particularly attractive to mortgage lenders, although we encourage their participation.

This type of loan is not one that is typically made by a mortgage banker.

Mr. Weiner, you must remember that mortgage bankers originate the bulk of the loans insured by the Federal Housing Administration.

Those, I think, are the primary considerations.

Mr. WEINER. In your opinion, could this loan program, the insurance program work?

Mr. HIPPS. Can this insurance program work?

Mr. WEINER. Yes, Obviously, it is not working now—no loans.

Mr. HIPPS. I do not think that the program is going to work any better than it has now.

I think probably the reason it has not worked is more related to the fact that it is easier to do business with a conventional lender than it is with the Federal Government because of the typical red tape.

Mr. WEINER. It is difficult in the private loan market also.

Mr. HIPPS. The interest rate is 9.25 percent right now.

By regulation, that interest rate was established at one-quarter of 1 percent above whatever the current interest rate is for a multifamily mortgage in the FHA insurance program and is currently 9.25 percent.

I understand that kind of money is obtainable to those who have the financial wherewithal to obtain it in the marketplace.

Then you have to find a lender willing to make the loan and although at the time a program was implemented and announced, there was some initial interest on the part of a very small number of mortgage bankers about the program that interest never continued.

Mr. WEINER. Let me ask you the same question Congressman Pepper asked GAO earlier.

In view of the problems, perhaps direct loans would be a more efficient way to do it.

What would be your reaction to that?

Mr. HIPPS. I cannot respond to that. I think before you can answer that kind of question, you really need to do a complete analysis of the benefits and drawbacks of direct loans and things of that nature.

Mr. WEINER. Would it be possible for your department to provide a staff study on your opinion on this?

Mr. HIPPS. I presume it can be done. It would take a good deal of time.

Mr. WEINER. One other question. There is another loan program, too, according to the GAO in their report.

Why have regulations to implement the Housing and Community Development Act of 1974 not been published?

According to our information, this act gives you the authority to insure loans for projects which have begun.

Mr. HIPPS. That program is under title I of the National Housing Act.

It is my understanding that some of the considerations that went into the delay and implementation of the program really relate to the characteristics.

There again, you are typically dealing with the title I programs of HUD with home improvement lenders.

Those type of lenders are typically not making the kinds of loans involved here and the dollar amounts envisioned.

It was also felt that since the experience with the program under section 232 had been as it has been, that if the program under section 232 was not working well, there was no reason to think that the one under title I would work either.

You also have to remember under title I the lender who makes the loan is taking a coinsured risk, unlike the one under title II where the lender is protected up to 100 percent of his investment.

It makes it even more unlikely that many lenders would be too anxious to engage themselves in that kind of a coinsurance risk, given the dollar amounts of the loans that you can anticipate.

Mr. WEINER. Is it your intention to issue regulations?

Mr. HIPPS. I believe it is, yes, sir.

Mr. WEINER. You have any idea when?

Mr. HIPPS. No, sir, that is not in my area of responsibility.

Mr. WEINER. I appreciate that.

Well, that concludes my questions.

I just want to thank you, Dr. Abdellah and your associates, on behalf of Chairman Pepper for a very thorough, as always, presentation.

You come with an army of preparation and it is very difficult for us to match, but we really appreciate all the work you have put into it.

Also, Chairman Pepper is very grateful for your change of the title of the Office of Nursing Home Affairs to the Office of Long-Term Care to reflect greater Federal concern with developing alternatives to institutionalization.

We are very grateful that on extremely short notice, Mr. Hipps, that you have provided your testimony today. We know it was unusual. We are grateful to you and your shop for putting it together in a week. I now yield to my very distinguished and brilliant colleague, Val Halamandaris.

Mr. HALAMANDARIS. Four or five years from now, somebody will likely look back and see why nursing homes are not sprinklered and wonder why. Today's record will be available to show our resolution that they should be, along with your opposition to the requirement, based on fear of the potential cost of installation.

I have a couple of questions I would like to address to Dr. Abdellah.

In your research paper last year you suggested that two-thirds of the nursing homes of this country have four or more deficiencies.

I wonder if there has been any improvement in that, do you feel encouragement in what you have seen this past year?

Dr. ABDELLAH. Yes; I am very much encouraged. In fact, in view of our discussions, we have seen major improvements in the area leading to requirements for the Life Safety Code.

I would like to see much more emphasis on activities in relation to improvement of the quality of care, the level of care, provided. In relation to this, our undersecretary, Mrs. Lynch, announced last February phase II of the long-term care strategy campaign which is focused on services needed and provided to patients and residents. Because of the encouragement and changes in meeting the Life Safety Code requirements, we feel there should be greater emphasis on quality of care.

We do not hear about those patients who die from poor quality of care. This aspect must be addressed.

Mr. HALAMANDARIS. We all endorse that effort. However, I think we would be remiss in our duty if we did not suggest that we proceed on the other front as well. We must continue the effort to achieve fire safety in nursing homes. We do not want to lose the gains made in that direction.

Last year GAO mentioned, and, Dr. Abdellah, in your testimony reiterated the same point, that many States are relying essentially on untrained individuals to make fire safety surveys.

I am talking about using sanitarians, nurses, and policemen who make judgments as to fire safety.

Can you tell us for the record what has been done to require the States to use qualified inspectors?

Dr. ABDELLAH. Yes; I would be very happy to submit our report that was prepared by the Bureau of Quality Assurance in our Department that details the qualifications of the State surveyors.

[The report was submitted and is reproduced in the appendix, pp. 223–295.]

Dr. ABDELLAH. I am very much encouraged by their report. For example, more than half of the State surveyors today have a minimum of a B.A. degree and have specific training in survey techniques.

Much of this is picked up through the efforts out at Tulane, and some of the earlier programs.

Also, one might categorize about two-thirds of these individuals, as professionals. For example, there are 41 physicians who are doing State surveys, over 400 professional nurses, social workers, and hospital administrators.

Of about 2, 200 State surveyors, only 127 of those do not identify with a specific health discipline. There is a major change from 2 years ago and I am encouraged that most of the surveyors are committed health professionals.

Mr. HALAMANDARIS. The point is a little more specific than that.

I recall in the survey last year, we learned that 22 out of 24 inspectors in 1 State were retired Army officers.

I have nothing against retired Army officers. They may even have had a strong background in health.

My point is, they do not have an engineering background or other training which would qualify them to appropriately apply fire safety standards.

Do you see that as a problem?

Dr. ABDELLAH. Yes; of course, and many States do have very qualified individuals doing this; in each of our regional offices there is a qualified fire safety engineer. In some cases, there are three, some from a Federal level. We do have a very good picture in terms of qualified safety engineers.

In some States, some are fire marshals with limited training, but in most States, we find many of them are participating in the life safety code training courses at the local, State, and individual level.

I think the picture is changing, and I want to mention one important point that was brought out this morning. I see, as I am sure you do also, the change in involvement of industry, in this effort, the American Health Care Association has issued fire safety training manuals. They have also issued, at their own expense, a set of training manuals in patient assessment for some facilities.

I have persuaded them to shift some of their public relations money into the training effort of fire and safety for nursing home personnel. I think that there is greater understanding and an improved working relationship between industry and the States and Federal Government.

Mr. HALAMANDARIS. Good. In terms of the medicaid program it seems to me the Department of Health, Education, and Welfare is in a difficult position. Anyone trying to administer that program gets whipsawed between the Congress and States.

Have any of you reached any personal decisions about changing the nature of the medicaid program?

Have any of you reached the point where you believe direct Federal enforcement is either necessary or prudent or desirable?

Dr. ABDELLAH. That is a hard one. I think we certainly would not in any way relinquish our responsibility for monitoring our capability.

Mr. HALAMANDARIS. I just want an informal response. It is my thought that perhaps direct Federal enforcement would help.

I wonder if that concept would be supportable. Do you find it desirable?

Mr. HIPPS. Well, you have raised such a fundamental question.

In some ways the medicaid program suffers from dualness dilemma.

It is basically a State program, but yet it has a lot of Federal involvement.

It is never clear who has the final say on these particular measures, and the Federal Government does attempt to fulfill its responsibility, but again recognizes that administratively it does not have that responsibility.

The administration has proposed turning it over to the States with broader latitude to clarify. I think the question is just where you come down philosophically on the question of State and Federal relationships, and to what degree do you believe there is confidence in those two different approaches, and who do you think is closer to the problems.

There has been a lack of money in the States to do much about that. The proposal which would clarify that, and provide them with money, could change that picture.

There have been dramatic increases in State capability across the board in the last decade, relative to the past.

It is not an answer.

Mr. HALAMANDARIS. It is an intriguing problem, and I think it is one the Congress is currently grappling with.

We have the administration's proposal, and some others, but we can discuss that point at some different time. However, I am stating my own preference. I am starting to believe that the States are doing a fine job, but others are performing poorly.

I do not wish to remove the authority to regulate nursing homes from the States, but when you reach a point where we can determine that a particular State is simply not living up to expectations, and not doing the job, then I believe the Federal Government should step in and help the State to meet its responsibility.

Dr. ABDELLAH. That is a problem, and we do have a current obligation in that regard.

We are responsible for the coordination of policy related to the medicaid program, and it is a difficult problem.

You may remember about a year ago we planned to publish a regulation that would strengthen the Secretary's authority in terms of waiver for the Life Safety Code in relation to the medicaid program.

With the exception of the State of Washington, all States agreed not to give the Secretary increased authority in relation to medicaid. There seems to be reluctance on the part of the States to relinquish some of this authority to the Federal Government.

Mr. HALAMANDARIS. I would agree, however, I have a strong sense of déjà vu, sitting here today, and talking to all of you HEW officials about nursing home fires.

I have a long memory of past fires, and talking about them with various HEW Secretaries and personnel.

I must digress to applaud Dr. Abdellah with her efforts, and all of the dedicated people who work with her. However, it seems to me that promises to us made by previous HEW officials were somehow lost within the bureaucracy of HEW.

Senator Moss referred to one of these promises in his opening statement.

I am going to address my comments really to Mr. Morehart because I understand he is the officer in charge of technical standards.

Just to set the stage for you briefly, during our hearings on the Marietta, Ohio Nursing Home fire, we learned of the major role which carpet played in the fire. We learned through testimony at those hearings that the only fire test for carpet was the so-called pill test; a test for ease of ignition, a comparatively ineffective test in terms of flammability. In fact, it allows some 90 percent of the carpet made in this country to continue to be sold in the marketplace.

Second, the Steiner tunnel test was characterized as a more effective test but HEW stopped short of adopting it, saying that the chamber test was the ticket. It was HEW's recommendation we test and study, and wait awhile, and maybe this so-called chamber test was going to be the thing.

Five years have gone by with all this bickering and we still have no standard; now I hear HEW is proposing to use the pill test, and the so-called radiant panel test. The latter is a completely new test; is that correct?

Mr. MOREHART. You have a very good source of information.

The current standards that are in effect now, are those referenced in the Life Safety Code.

This is based on the tunnel test, and we have for many years required appropriate compliance with that.

We are looking at a new standard, or new criteria, which is based on the radiant panel.

This is out for comment now.

One point that you made was that the pill test is inadequate, and I cannot agree; it is a very stringent test.

The pill test probably is responsible for saving many lives in this country, which we have no way of counting of course.

The new standard is based on the radiant panel, which should solve many of the problems.

Mr. HALAMANDARIS. I cannot disagree with you, Mr. Morehart.

If my mother was in a nursing home, with a carpet on the floor, and the only standard that the carpet passed was the pill test as you propose for patient rooms, I would be worried.

I would prefer the more stringent standard, the so-called Steiner Tunnel test which the Public Health Service now requires and has recognized for a number of years. I am wondering why all of a sudden there is a change to a pill test, and then to the radiant panel. I would like to know if the radiant panel test is supported by any recognized authorities such as Underwriters Laboratories?

Mr. MOREHART. The radiant panel test simulates what happens in a corridor situation during a fire from a flashed-over room feeding hot gas into the corridor.

The hot gas travels along the ceiling of the corridor, and heat radiates onto the carpeting in the corridor, which I can only characterize as similar to raising the flash point of fuel oil to a given level.

In an open room you would not have this potential for the concentrated radiation; therefore, the radiant panel test is not applicable to an open area.

As to your concern about the inadequacy of the pill test, the National Bureau of Standards has made a series of tests, where they have actually burned a large piece of furniture, or a large amount of wood in the corner of a room, and measured the difference in the flame spread travel between a mediocre carpet, such as the minimum of the pill test, and the best that we could get, and I believe the difference in flame spread is in the neighborhood of 20 inches.

We are really not buying any additional safety in this 20 inches by making a more stringent requirement on the carpet.

Mr. HALAMANDARIS. Let us talk about the carpeting and other products which were totally consumed by the fire even though they had a low rating.

Are you troubled by the fact that these products, particularly with burning plastics, release toxic gases?

Mr. MOREHART. First of all, concerning the carpeting in the Cermak fire as I recall, there was only a very small amount of scorching in front of the door of the room of fire origin.

There was absolutely no spreading of the fire down the corridor, and I think Mr. Best could probably bear this out.

As far as toxicity is concerned, it is something that was touched on two or three times this morning. A recent study in the State of Maryland has shown that people do not die from these exotic chemicals, they die as a result of carbon dioxide.

Over 80 percent of the fire deaths in the State of Maryland the last couple of years have borne this out, so it does not matter what we have, if it is comfortable, it is going to burn, and anything that will burn will give off carbon dioxide as a matter of course.

Mr. HALAMANDARIS. Do you favor the promulgation of smoke generation standards?

Mr. MOREHART. In our new standard, we have the criteria for smoke development. It is not based on the tunnel. It is based on the new NFPA standard on smoke generation of solid materials. It has just been officially adopted by the NFPA.

Mr. HALAMANDARIS. Will you tell me once again, what is the status of this regulation that you are considering? Is that about to be promulgated?

Mr. MOREHART. The standard is currently out for comment within the Department.

Mr. HALAMANDARIS. I would be very interested in receiving a copy of it if you could send us one.

I know the Senator would like to read it, and react to it formally.

Could you do that?

Mr. MOREHART. Yes, sir.

[The information received is reproduced in the appendix, pp. 296–325.]

Mr. HALAMANDARIS. Thank you very much.

That concludes the questions I have.

Mr. WEINER. I have no further questions. Thank you.

Dr. ABDELLAH. Thank you.

Mr. WEINER. Our next panel is made up of Mr. Ross Richardson, the Assistant Illinois State fire marshal, and we have only one further witness after Mr. Richardson, Mr. Richard L. Best, fire analysis specialist, National Fire Protection Association, he will have a very useful presentation, so I hope our visitors will be able to stay.

Mr. HOLTON. Excuse me, Mr. Weiner. As you know, Francis Murphy of the Chicago Fire Department was scheduled to be here today. He was to report to us on the Wincrest fire, and the findings of Mayor Daley's commission, which investigated the causes of that fire.

Due to illness in his family, he is not able to be a witness here today.[1] Since we do have a copy of the commission's official report, which was issued shortly after the Wincrest fire, we will submit that for the record in lieu of Mr. Murphy's not being here today.

Mr. WEINER. If there is no objection the report will be accepted for the record.

So ordered.

[Cover and pp. 3–13 are reproduced in the appendix, pp. 326–337. A copy of the complete report is retained in committee files.]

STATEMENT OF ROSS RICHARDSON, ASSISTANT ILLINOIS STATE FIRE MARSHAL

Mr. RICHARDSON. My name is Ross Richardson, assistant State fire marshal for the State of Illinois.

We are the State life safety survey for the Cermak House.

[1] Chief Murphy later testified in Chicago, Ill., on Aug. 12, 1976, before the Subcommittee on Retirement Income and Employment of the House Select Committee on Aging.

We also had responsibility for the investigation of the fire that occurred on February 24, 1976, in the early morning hours.

I have a fairly brief written statement, which I will read, and then turn it over to questions.

The intent of fire prevention officials is to eliminate or reduce hazards that cause fires, and to limit the spread of fire and its deadly products if one starts.

The fire official limits fires in buildings by detection, compartmentalization, and extinguishment.

The quicker the detection, the quicker the fire can be brought under control by firefighters.

Compartmentalization serves to contain and isolate a fire within an area or specific room of a building. Extinguishment, of course, provides an automatic system to put out a fire before it can become a threat to the entire building.

All fire safety codes are based on these three principles, including NFPA–101, the code HEW has in effect for all health-care facilities receiving medicare and medicaid moneys, and the minimum standards for long-term care facilities enforced by the State of Illinois.

Under these two codes, automatic sprinkler protection is required in all nursing homes except those deemed to meet fire resistive construction requirements or protected noncombustible construction requirements if a one-story building.

The homes in which the recent tragedies occurred, Wincrest Nursing Home of Chicago, and Cermak House of Cicero, were fire-resistive construction and did not require sprinkler systems under these codes.

Fire deaths and injuries are caused, in the overwhelming majority of cases, by inhalation of smoke and toxic gases.

No one was burned to death at Cermak House or Wincrest. All victims were claimed by smoke inhalation.

The fires were limited almost totally to the room of origin. The construction of the buildings prevented the fire from burning beyond this room. Yet none of those who died were occupants of these rooms. Victims were occupying other rooms, felled as deadly smoke spread throughout the floor.

This occurred because the final link in fire compartmentalization was broken. Although all patient rooms were provided with doors to withstand the spread of smoke and heat, doors were left open, and people within these rooms died. The doors to the rooms of fire origin were left open, failing to contain the fires within those rooms.

What is the single most important fire safety improvement that can be made in nursing homes?

The Illinois Division of Fire Prevention believes that automatic door closers, equipped with smoke detection devices to trigger the closing device at the first whiff of smoke, would significantly reduce these tragedies.

Such a device would automatically contain fire to one room, protecting residents in adjacent rooms while rescue and extinguishment operations swung into action.

If these devices had been installed in Wincrest and Cermak House, certainly the number of deaths would have been reduced.

Sprinkler systems are an effective method of fire control, and the wider their application, the more we will reduce fire losses.

But we believe they are not the ultimate panacea. Most sprinkler heads are set to flow when the temperature at the head reaches 160° F. This leaves the possibility of a smoky, smouldering fire burning without triggering the head.

At Wincrest, the fire started in a closet, which might have shielded the fire from the sprinkler, had one been present. A similar situation existed at Cermak House. Nursing home patients because of age and health are extremely susceptible to smoke, and even though sprinkler systems will control and extinguish a fire when operating properly, they may not adequately control smoke to prevent death and injury. The Division of Fire Prevention is in favor of sprinklers, but we believe that all available fire safety systems must be carefully evaluated before health-care dollars are invested in them.

Another major concern is the heavy loading of patient rooms with combustible furnishings. Modern synthetic materials have increased fire hazards by the speed and toxicity with which they burn. Much work remains to be done in proper testing and evaluation of these materials. These industries must redirect their efforts to provide safer, less combustible materials in furniture construction, not only for nursing homes, but for all building occupancies across the country. We hope the Congress will take action to encourage these industries in this effort.

In conclusion, the Illinois Division of Fire Prevention wishes to stress that although nursing homes are much safer now than in the past, much needs to be done to insure greater levels of safety. We feel door-closing devices on all doors is the most important single step that can be taken, but that the issue is complex and no single action will resolve the problem. As the public becomes more conscious and concerned about fire safety, and becomes willing to expend the effort and money to insure its reality, the tragic fire loss in this country will be reduced, and in time, perhaps eliminated.

Mr. HOLTON. I thank you very much for that fine statement.

Only one or two brief questions. First, do we understand your position to be that you prefer to see smoke detectors and door closers put in place rather than sprinklers?

Mr. RICHARDSON. Yes, and now I am referring to fire resistance and combustible homes that are not now required to have sprinkler systems.

Mr. HOLTON. As opposed to a frame construction.

Mr. RICHARDSON. All other forms of construction, where sprinklers are required, and have been installed.

Mr. HOLTON. Fine.

Thank you.

One final question. As a consequence of these two fires, do you expect the State of Illinois to promulgate any standards with respect to training personnel in nursing homes, or with respect to types of contents in rooms such as vinyl chlorides, etc.?

Mr. RICHARDSON. It is sort of a three- or four-part question. As far as the contents of the rooms, I really believe that is a problem that is centered on the national industries involved, and is not something a State on its own can do anything about.

There is a great deal of work that has to be done, but so far there has really been no impetus to do the job, and that I would hope would come from the national level here.

Mr. HOLTON. I think your point is very salient, especially with respect to the testimony we heard earlier from HEW officials, who wish to delegate their responsibility to the States. As I understand, you are telling us that States are not equipped to do the kind of testing and set the standards necessary that we are talking about today.

Mr. RICHARDSON. Right. As far as fire safety or training goes, I feel this is very important.

In the Cermak fire, the staff failed to take one correct action, which was to close the patients' doors, and many people died as a result, and they had an opportunity to close those doors early in the fire.

We are conducting programs of fire safety training across Illinois. It is somewhat limited, there are limited funds.

I understand HEW does have small amounts of money available for this, and I would like to say certainly, HEW will be able to distribute more money to the State to provide these programs.

Mr. HOLTON. As a licensed nursing home administrator myself, I remember the great emphasis placed by State officials and Federal inspectors regarding the posting of patient evacuation plans.

There were certain other training requirements, those were primarily centered around the use of firefighting devices that were handy in the homes such as fire extinguishers.

I recall very little emphasis being placed by State and city officials or Federal agents on the aspect of door closures.

Mr. RICHARDSON. Our training program is aimed very much at immediately notifying the fire department, letting the fire department handle the fire.

Ignoring the fire extinguishers, whatever else is in there, as much as possible, we go after the other first.

We have a four-part program, where we call it RACE, rescue the patient immediately in danger; sound the alarm, close the doors, and then worry about extinguishment, and at that point the fire department is practically there anyway, so they could do the job.

Mr. HOLTON. Do you feel that nursing home employees should be required to be trained and tested in fire procedures as a precondition of employment?

Mr. RICHARDSON. I do not think you could make any precondition, but I think you could certainly institute a training program within the first 2 weeks or first month to nursing home employees on the job.

You are talking about somebody who is making a minimum wage, and possibly lower, and one of the big problems is the turnover involved; one of the things we found that Cermak House was—almost all of the employees had been there no longer than 6 months, some as short as 1, 2, 3 months.

Mr. HOLTON. What you are saying is that there should be some kind of fire training within the first 2 or 3 weeks after a person is employed in the nursing home.

Mr. RICHARDSON. Yes, some sort of mandatory training program.

Mr. HOLTON. Did you make that recommendation to the appropriate State officials?

Mr. RICHARDSON. We are working on that.

Mr. HOLTON. I have no further questions at this time. Thank you.

Mr. WEINER. I have a couple of questions.

You said that smoke detection devices should be encouraged, those that trigger something at the first whiff of smoke.

Do you want to define that?

Mr. RICHARDSON. Smoke detection devices are not enough. You have to have innovative devices which will trigger when there is even no visible smoke at all. The device I am speaking of is one that has come out, that is a door closer, incorporated with the smoke detector in it, which can be set at any opening.

Now, nursing homes have a tremendous objection to this particular device. They say people had to keep their doors closed, they cannot push the dooor open, they get caught in the doors, but the state of the art has gotten to the point where the pounds of pressure to open the door are low, where the door can be set at any opening, small or wide.

Mr. WEINER. You said at Wincrest the fire started in a closet.

Would a smoke detector be placed in a closet?

Mr. RICHARDSON. No, the smoke detector would be placed in a room, or at the doorway.

Mr. WEINER. So regardless, the sprinker would put it out just as fast or faster.

Mr. RICHARDSON. Not necessarily.

Mr. WEINER. Will you explain why?

Mr. RICHARDSON. I did it in my statement, that certain fires are not going to trigger enough heat to quickly set a sprinkler system off, and because of the placement of heads, you may get a fire going in an area where the sprinkler cannot effectively combat it.

Now, it is going to control the fire, there is no doubt about that, but the question is how much smoke is going to generate while it is controlling the fire.

That is the big danger.

Mr. HOLTON. I might just say it looks like we have two issues, one emphasis for smoke control devices, and the other emphasis for sprinklers, as the means of keeping temperatures low, and to retard flash over from taking place.

After having seen a large number of related documents over the last several months, it appears that we would be making a desperate mistake to try to rely totally on a single system. What we do in fact need is a fail-safe system that will allow several kinds and levels of defense.

Mr. RICHARDSON. Now, my point is, taking the Cermak House, that is where I was most intimately involved with, if there had been a door closer on that door, or if the door had been shut by a staff member, the fire never would have burned beyond the room, it would not have threatened anyone else on the floor, and I am very certain that no deaths would have resulted.

On the other hand, Ohio has adopted the complete sprinkler bill, and what they are getting now is a lot of nursing homes being built to be protected, and then you have the problem of concealed spaces, combustibles in concealed spaces, and when you are an inspector looking at a home already constructed, it is difficult to determine whether there are fire hazards in those spaces.

Mr. WEINER. Can you compare the fires in nursing homes with sprinklers to ones without sprinklers, and will you speculate on the potential damage on fires where sprinklers are utilized?

Mr. RICHARDSON. I believe a fire can be caused by improper use of materials, and I know of this one fire that was caused by a mattress so that there would have been a clear shot in the mattress to the head, the head would be triggered, and it would have put that fire out.

The sprinklers are very effective. I do not mean to say that they are not, but the impetus in the health industry is saying we want sprinklers, we want sprinklers, but they want everybody to, you know, back off with the other requirements of the Life Safety Code, and I think you will get some protection, but there still will be enough smoke to kill people.

Mr. HALAMANDARIS. What you are saying is that sprinklers are not a panacea, that you cannot abandon the rest of the requirements of the Life Safety Code.

Mr. RICHARDSON. That is my personal opinion.

Mr. WEINER. From your investigation and also, from your opinions, both before and after the fires in Chicago, did you find the Wincrest and Cermak homes in compliance with Federal Safety Code requirements?

Mr. RICHARDSON. The Cermak was.

In my opinion, it was an outstanding building.

Mr. HALAMANDARIS. Thank you.

The other was not?

Mr. RICHARDSON. The Wincrest was not.

Mr. WEINER. Thank you very much.

Mr. RICHARDSON. Thank you.

Mr. WEINER. Our final witness is a real expert in the field.

Will Mr. Richard L. Best please come forward?

Mr. Richard Best is with the National Fire Protection Association.

We do thank you for coming, Mr. Best, and would you please introduce your associates.

STATEMENT OF RICHARD L. BEST, FIRE ANALYSIS SPECIALIST, NATIONAL FIRE PROTECTION ASSOCIATION, ACCOMPANIED BY MARTIN GRIMES, ASSISTANT VICE PRESIDENT, NFPA; AND JOHN SHARRY, LIFE SAFETY CODE SPECIALIST, NFPA

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

On my right is Mr. Martin Grimes, assistant vice president, and on my left is Mr. John Sharry, who is our life safety code specialist at the NFPA.

Mr. SHARRY. Thank you very much.

Mr. Chairman, frequent references were made this morning to the Life Safety Code of the National Fire Protection Association.

I would like very, very briefly to indicate that these codes are developed on a consensus standard system, with a committee, which has a public review and comment period, and then which creates a total adoption.

The association has numerous activities. We produce some 225 codes related to fire protection, and we in addition have published many supplementary materials and are involved in research, and the

Life Safety Code, particularly, has been the result of many years of work that we have developed.

It is in fact a total system, and one that has been greatly needed.

Any one element is supplementary or complementary to the other element.

To take one item in isolation as the last witness clearly illustrated would be wrong, and it is very important to remember this, when one talks about the value of sprinklers, and the need for other devices, to consider everything as an interaction, right from the training aspect, right through to the mechanical automatic aspects of it.

Another function apart from standards of the NFPA is in their investigation in depth of fire significance.

These investigations are carried out as best by Mr. Best, will give information on fires, and they are carried out in depth, not just for the purpose of finding out what happened in that particular fire, but too in feeding the research to various people involved in research, and to assess the performance of the standards.

Bear in mind that these standards, the Life Safety Code in particular, has been applied to State and local ordinances for a longer period than used by Federal agencies.

In that time, there has been an evolvement of the standard, and it is a continuing dynamic process.

The standards used have been reviewed every 5 years, and the Life Safety Code is generally reviewed in 3 years.

The only other aspect is the NFPA codes are developed by the NFPA, they are proposed, and this has been available for adoption by Federal, State, or local officials, and then by industry.

Thank you.

Mr. HOLTON. We appreciate your comments.

Mr. BEST. Thank you.

Mr. Chairman, the National Fire Protection Association was organized in 1896 and has continuously addressed the problems of fire safety since its inception.

With a staff of 220, it serves not only a membership of 33,000 persons drawn from the many disciplines involved in fire protection, but also the public at large.

The activities of NFPA range over the entire spectrum of fire prevention and control. The two particular activities relevant to this testimony, however, are NFPA's standardsmaking process and the investigation and analysis of fire behavior and effect.

The 225 codes and standards related to fire are produced by utilizing a balanced representative committee procedure, with a public review and comment process. Standards are developed on the basis of engineering design, technical expertise, human susceptibility and reaction, and fire experience. The standards are dynamic in that they are continuously revised as need is determined and technology advances.

One of the standards is known as the Life Safety Code, which promulgates minimum standards for protection of life from fire and other emergencies. This standard is widely used by Federal, State, and local government by adoption by reference or by inclusion in regulations or ordinances.

The other relevant activity is the in-depth investigation of significant fires with a view to further analysis for both research purposes and also to determine the effectiveness of NFPA standards.

Many such investigations are carried on in association with the National Bureau of Standards and, more recently, the National Fire Prevention and Control Administration.

The NFPA Analysis Department, in cooperation with the National Bureau of Standards, conducted an investigation of two recent fires, the Wincrest Nursing Home in Chicago and the Cermak House in Cicero, Ill. Significant factors of both fires will be contained in detailed reports which will be published in the NFPA Fire Journal in the near future. The following is a summary of the significant factors of both fires.

The Wincrest Nursing Home is located in Chicago's north side. The four-story building is of fire-resistive construction with a protected noncombustible roof. The building has enclosed stairways. Heat detectors are provided in the chapel, stairways, and some closets, and one smoke detector in the corridor near the entrance to the chapel. Approximately 42 of the occupants of the building were in the chapel on the top floor on January 30, 1976, when a fire in 1 of the patient's rooms on that floor filled the corridor and chapel with heat and smoke. Reportedly, a staff member of the nursing home has been charged with setting the fire.

The fire started in the area of a wooden clothes wardrobe and ultimately involved the contents of the entire room. Two wardrobes were side by side constructed of plywood with hinged folding doors. Mattresses were innerspring units consisting of 69 percent cotton felt and 31 percent sisal pad. These combustible contents contributed to fire growth and development. In addition, the wallpaper on sleeping room walls consisted of vinyl wall covering, which may have contributed to the smoke production.

Fire damage was limited to the room of origin and the top portion of a closet door across the corridor. The corridor opposite the room of origin sustained heavy heat damage adjacent to and in both directions from the room of origin.

Thirty-five elderly residents were hospitalized as a result of the fire. Thirteen patients died initially, but others have died since the fire, and the total now is 24 dead. No fatalities occurred in the room of fire origin, which was unoccupied at the time of the fire. All residents who died—with the possible exception of two—were located in the chapel.

The Cermak House is located in Cicero, Ill., immediately west of Chicago. The Cermak House fire occurred on February 4, 1976, less than 1 week following the Wincrest Nursing Home fire. This modern nine-story intermediate care nursing home is of fire-resistive construction with automatic closing smoke barrier doors in the corridors and corridor smoke detection. On each floor smoke barriers divided the U-shaped building into a center section and an east and west wing. The west wing housed six patient rooms with four patients per room. A fire in a fourth floor room filled the west wing of that floor with smoke and heat and caused the deaths of eight residents on that floor.

The fire started in the area of a combustible clothes wardrobe in room 421 at approximately 6:30 a.m. At this time, the patients were being awakened and were beginning their daily routine. The cause of the fire has been attributed to a faulty electrical cord to the lamp on the nightstand between the bed and the wardrobe. Combustible material in the room contributing to the fire included mattresses containing 50 percent polyurethane foam plastic and chairs padded with urethane foam plastic.

No fatalities occurred in the room of fire origin. The three occupants of this room were removed by the nursing home staff. The fatalities were from rooms in the wing of origin, except one from the center section who apparently received exposure to smoke during evacuation. Reportedly, this person was suffering from respiratory illness. The corridor smoke doors worked as designed and contained most of the heat and smoke in the wing of origin. Fire damage was limited to the room of origin. Smoke and heat damage extended throughout the wing, with smoke damage in those rooms with doors open. The carpeting in the room of origin was consumed, but the carpeting in the corridor did not burn.

Reports of the Cook County Coroner's Office have been reviewed for 30 of the 32 victims of both fires, and they show that the victims died of smoke inhalation or smoke inhalation complicated by respiratory problems.

Thirteen of the Wincrest victims died on the day of the fire, and all 13 deaths were attributed to smoke inhalation by the coroner's physician. Most of the 11 other casualties died during the next 2 weeks from smoke inhalation complicated by respiratory problems—including pneumonia—or heart condition. The average age of these victims was 80 years old.

The coroner's report of the four Cermak victims who died on the day of the fire showed the deaths as smoke inhalation. The other four residents died later. In three cases, the cause of death was listed as smoke inhalation. In the fourth case, the victim died of smoke inhalation and extensive burns. The average age of the victims was 75 years old.

The multiple death fire problem:

The Wincrest and Cermak fires exhibit similar characteristics in their place of origin, contents involvement, rapid growth and development, smoke spread resulting in untenable conditions, and their tragic results.

Both the Wincrest Nursing Home and the Cermak House fires originated in a resident's sleeping room. The combustible contents of the sleeping rooms at both fires contributed to the severity of the fires and to the large quantities of toxic smoke produced.

Fire damage was essentially confined to the rooms of origin. The construction of the walls, floors, and ceilings was adequate to confine the fire to these rooms. The door openings between the rooms and corridors were the weak links, allowing the spread of smoke and toxic gas, resulting in the tragic multiple fatalities.

Some of the methods of reducing the risk of multiple death fires in fire-resistive nursing homes include: smoke detection, smoke control systems, reduction of combustible contents, door closers, sprinkler systems, and increased staff training. These are measures that can alleviate the multiple death fire problem in nursing homes.

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The NFPA Life Safety Code stresses the need for a written institutional firesafety plan, regularly conducted fire exit drills, and provisions for the isolation of fire by the closing of all doors adjacent to a fire. If the doors to the rooms where the fires started at Wincrest and Cermak had been closed and had remained closed until the occupants had been evacuated and the fire departments had responded, the unfortunate loss of life in the two fires might have been avoided.

Although door closers are a method of confining fire to the room of origin, they are not without their problems. Even with door closers installed, the sleeping rooms may be entered by staff or firefighters during emergencies to rescue occupants or to attack the fire, allowing the smoke and toxic gases to permeate the area.

Automatic sprinklers, which will both detect and control incipient fires as well as transmit the alarm signal to the fire department, must be considered. The record of automatic sprinkler performance is good. The NFPA records do not include any report of a multiple loss of life fire in a nursing home fully protected by automatic sprinklers. The NFPA Life Safety Code requires automatic fire extinguishing protection throughout all nursing homes with the exception of buildings of fire-resistive or one-story protected noncombustible construction. Although not required in these two types of construction, the code encourages the installation of sprinklers by offering design trade offs which recognize the increased safety to life provided. Life safety will be considerably enhanced by the installation of automatic sprinkler protection in any nursing home regardless of construction.

Amendments to the Social Security Act required that skilled nursing homes and intermediate care facilities that participate in medicaid benefits comply with the NFPA Life Safety Code 1967 edition. These two intermediate care facilities were required to meet the requirements of the 1967 Life Safety Code. An analysis of the conformance of the facilities with the code was made as part of the NFPA investigation. This analysis showed a few deficiencies with varying degrees of impact on the fire problem in these two cases.

In the Wincrest Nursing Home the lack of separation between the chapel and the corridor is considered a major contributing factor to the loss of life in the chapel.

The Life Safety Code requires self-closing fire doors to separate the chapel or assembly area from the rest of the nursing home. Other deficiencies noted included: a 37-foot deadend corridor between the chapel and the nearest stairway, which is in excess of the 30 feet permitted; and a section of exit access corridor 5 feet in width, which is less than the code-required 6-foot width.

In the Cermak House, the most serious discrepancy was a presignal arrangement of the alarm system that did not permit an automatic audible alarm throughout the building. The Life Safety Code specifically prohibits the use of presignal alarm system arrangements. Another discrepancy was a deadend corridor 34 feet long which is slightly in excess of the 30 feet permitted. The effect of the audible alarm arrangement is difficult to measure, but neither of these discrepancies is considered a major contributing factor to the loss of life.

The basic multiple-death fire safety problem in health care facilities as exemplified by these two fires is the failure to confine a fire's resultant heat and smoke to the room of origin.

Fast-developing fires as occurred in the two Chicago area nursing homes produced large quantities of smoke and other toxic gases that escaped from the rooms of origin and caused occupant deaths within the area directly exposed by the smoke and heat of the sleeping room fires—the third floor and chapel at Wincrest and the west wing of the fourth floor at the Cermak House.

The combustibility of the sleeping room contents intensified the problem, providing fuel for fast-developing and heavy toxic smoke producing fires. There was insufficient time for nursing home staff to safely evacuate the occupants from the area directly exposed by the smoke and heat of the sleeping room fires.

Time is of the essence. There is a need to slow the development of the fire or at least confine its effects, somehow; by reducing the amount of combustibles, by closing the door to the room of origin, by eliminating or controlling the smoke or by extinguishing the fire. These measures will buy the necessary time for staff to evacuate occupants to an area of safety.

In conclusion, the technology is available to prevent multiple-death fires from happening. Complete sprinkler protection in all nursing homes regardless of construction in conjunction with other protective features is one solution that would significantly reduce the risk of multiple-life loss.

Thank you for letting us provide the information.

Mr. WEINER. Thank you very much.

Unfortunately, we do not have a screen to see your slide. We had it until about a half hour ago. If you would be willing at some point the next time you are in Washington to provide the staff with a presentation, we would be very appreciative of that.

Mr. BEST. We would be happy to do that.

Mr. WEINER. Just let us know, and we would like to do that where the Senate and the House staffs could both be invited.

I have just a couple of questions. I would like to say you have done a real super A-one job on your investigation, and I think everyone is grateful to you for that.

According to your prepared statement, you seem to support the automatic sprinklers in all nursing homes.

Why then does the Life Safety Code exempt sprinklers?

Do you plan to change the code?

Mr. SHARRY. The Committee on Safety Life Code, the development of the Life Safety Code, felt in these two special superior types of construction, that they should be at a reasonable level of safety, and that could be achieved by offering two alternatives.

One is, of course, the complete compartmentalization, which is included with several other features, and an optional alternative to the automatic sprinklers.

The code is constantly under review, and the committee is currently taking a look at the possibility of requiring simply automatic sprinklers as a complete alternative, rather than complete compartmentalization.

However, since there are other factors involved, we are awaiting the results of a test underway in the National Bureau of Standards.

Mr. WEINER. How will sprinklers prevent death from smoke and toxic acids?

Mr. BEST. Sprinklers have an excellent record of extinguishing fires, controlling and extinguishing fires, although there can be smoke generated in the incipient stage of a fire, and additional smoke developed even though the fire is controlled by the sprinklers, the sprinklers will reduce the amount of smoke produced in a fire, as in Wincrest, there had been sprinkler protection in the room, even if it had not been completely extinguished, and the wardrobe, it would have prevented the burning of the rest of the contents in the room.

It would have reduced the overall amount of smoke.

Mr. WEINER. Does any other method of fire prevention that you are aware of have the same track record of avoiding multiple death situations, as the sprinkler does, either in combination or separately?

Mr. GRIMES. No; the sprinkler record, right from the origin of sprinklers of over a hundred years ago, is being one of preventing multiple life losses.

The only one where the sprinklers were installed, a multiple life loss, is where these sprinklers were rendered inoperative by some individual.

Could I refer to your question about smoke production, the sprinklers will in fact react when that critical temperature occurs, but that allows a sufficient time for a fire to begin to develop before it operates.

The sprinkler then operates over the fire, over the part affected, and it has the tendency, it may completely extinguish the fire, but if it is something like a mattress, or a chair or something, it might continue to smoke, it will not spread, but what it does do in effect of life safety, smoke will go through the building, and I suggest that where there had been a sprinkler, you would have had some smoke coming through to the chapel; however, it would have been cool smoke, because it had to pass through this spray of water, and, therefore, it would not have had the pressure, or the ability to travel so far, and probably not have the same effect.

It probably would irritate, but not have so much lethal gas.

Mr. HOLTON. That cool gas would not be capable of carrying as much particulate matter as well.

Mr. GRIMES. Yes.

Mr. HOLTON. I have several questions I would like to ask Mr. Best. In the course of your testimony, regarding the Wincrest situation, and reading from your text, you said the 37-foot corridor is in excess of 30 feet permitted by the code.

Is that the 1967 edition you are referring to, or is it the 1970?

Mr. BEST. The 1970 edition.

Mr. HOLTON. Mr. Best, you also commented, with regard for the need for separation of that area by some type of door.

Is that once again 1967?

Mr. BEST. The 1967 edition.

Mr. HOLTON. Do you feel that the absence of that door was a key factor in the loss of life?

Mr. BEST. We feel that the lack of doors was definitely a contributing factor.

Mr. HOLTON. In that sense, would you conclude that that facility was in violation of the life safety code?

Mr. BEST. By our interpretation of the code, yes; we feel it was in violation.

Mr. HOLTON. Thank you.

One or two brief questions. The corridor part of the code, which called for doors every so often, my recollection is that the length was about a hundred running feet.

Mr. BEST. 150 feet.

Mr. HOLTON. 150 maximum.

Mr. BEST. Yes.

Mr. HOLTON. Approximately how many patients' rooms could have access to a 150-foot long corridor?

Mr. BEST. A good reference is your Cermak floor plan.

You have each wing, it has a separate smoke compartment, and from the main body of the room is another compartment, and I will give you the exact count.

There were 23 patients in the wing, the west wing.

There were 26 patients in the east wing, and 25 patients in the main section of the building.

We are talking of six or more rooms.

Mr. HOLTON. The point is, based on your experience at the Wincrest fire, do you feel that the standard is adequate, or needs to be further tightened to reduce the number of running feet or open corridor?

Mr. BEST. Our life safety code in this type of occupancy, in this type of construction, is based on the plan, based on the reaction of staff, that the door to the room originally had been closed, and without the door of origin being closed, we have the smoke which is exiting the room of origin, and endangering others.

Mr. HOLTON. With respect to the Cermak fire, it has been alleged that the cause of that fire was an electrical short in a lamp cord.

Apparently the plug was such that when furniture was pushed to the wall, as in normal cleaning procedures, the cord was broken, allowing the short to take place.

Have you had similar experiences with other fires of this kind of origin where personnel pushed furniture against the wall, creating some kind of electrical short?

Mr. BEST. It has not been a major problem to my knowledge.

Mr. SHARRY. I had personal experience as a fire marshal, and I have seen this happen.

Mr. HOLTON. Do you feel the adoption of a plug of different design would protect against that?

Mr. SHARRY. That might be one way of stopping this type of thing. We are starting into an area of what people can do in a building after it is occupied.

It is very hard to control what is going on in the building after it is occupied.

Mr. HOLTON. Nevertheless, we are saying that building usage might tend to reduce the fire safety of the building overall, by changing it.

Mr. SHARRY. Yes.

Mr. HOLTON. One final question; in the Wincrest Home, on the fire floor, I noticed that there was an emergency lighting system

installed, the kind that is the wet cell type, tied into the electrical lines, and triggered to set off in the course of a powerline failure.

It is the kind that has the two-bulb light fixtures attached to it.

That fixture was located relatively near the ceiling, and they had plastic hoods which supported the lights.

It was rendered essentially useless because of the smoke in this location, close to the ceiling, where the smoke was the thickest.

Secondly, the hoods melted, turning the lights down, and making them useless.

Now, in this particular instance, since it was daylight hours, emergency lighting was not critical, and, in fact, I do not think the system was activated.

Would that particular unit based on your examination meet the NFPA standards?

Mr. BEST. Was that your question?

Mr. HOLTON. Yes.

What I am asking, is, does the particular unit and the Wincrest building meet the NFPA standards, and if it does, do you feel the performance was such that those standards should be reviewed?

Mr. BEST. I examined the emergency lighting in the chapel system specifically, and I did not note any plastic hood you referred to.

The units looked like they would be operable, as they were, the lens on the lamp were coated with a black residue, which may have diminished the amount of light, and, incidentally, one of the slides in the slide presentation shows this unit which would be of interest to you.

Mr. GRIMES. Regarding the position of the unit, there is a weakness with the emergency lighting, which is normally located at the ceiling.

The point of fire obscuration by smoke, and low-level lighting system would probably be more effective, and if you ever see a hospital night-lighting system, which is usually near the floor, you will realize it would show a path under the smoke, and there is no doubt that it was desirable for this to be considered, but as far as I know, the Life Safety Code Committee has not considered any change with relation to changing the position of the light.

Mr. SHARRY. It does not specify where it will be located as far as the lights, and on the other point, the Life Safety Code or any other standard, it does not spell out any product standard.

Mr. HOLTON. That I find is somewhat shocking.

I do not mean to be derogatory. I am just surprised.

Am I to understand that the code calls for emergency lighting systems, and then does not specify their characteristics or placement?

Mr. SHARRY. It would specify the performance as to how and when, but not specify the materials.

Mr. HOLTON. In the case of emergency lighting, who normally sets standards for their manufacture?

Mr. SHARRY. They are usually done by one of the nationally recognized testing laboratories.

Mr. HOLTON. Thank you. That answers my questions.

Mr. HALAMANDARIS. I have no questions.

Mr. WEINER. If there is no objection, we would like to submit for the record a summary and conclusions of the report on "Full Scale Fire Tests in a Nursing Home Patient Room," prepared for HEW.

Hearing no objection, so ordered.

[The material is printed in the appendix, pp. 338–339.]

Mr. WEINER. I want to thank you for coming here.

Mr. HALAMANDARIS. We have always enjoyed your good deal of information and help and assistance, and we would like to continue this very fine relationship in the future, and I thank all of you for taking time to sit through this hearing.

The hearing is adjourned.

[Whereupon, at 2:05 p.m., Thursday, June 3, 1976, the hearing was adjourned.]

APPENDIXES
APPENDIX I
ADDITIONAL LETTERS AND STATEMENTS SUBMITTED FOR THE RECORD

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S T A T E M E N T

of the

AMERICAN HEALTH CARE ASSOCIATION

JUNE 3, 1976

JOINT HEARING

Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate

* * * * * * *

Subcommittee on Health Maintenance
and Long-Term Care
Select Committee on Aging
U. S. House of Representatives

STATEMENT of the AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association appreciates this opportunity to contribute our comments to the record of this hearing. The AHCA is the nation's largest organization representing long-term health care facilities, with a membership composed of some 8,000 facilities, both proprietary and non-profit.

There is no area of concern which has attracted more of this organization's attention and activity than life safety from fire in nursing homes. Over the years, AHCA and its predecessor, the American Nursing Home Association, have been in the forefront of cooperative research and educational efforts on fire safety. This Association was also instrumental in supporting the adoption of the 1967 and, more recently, the 1973 NFPA Life Safety Code editions as the Federal standard for nursing homes participating in the Medicare and Medicaid programs.

An enormous improvement has been achieved in recent years in the quality and integrity of buildings in use as nursing homes in the United States.

By any statistical measurement, nursing homes are much safer places to live than any residential occupancy. Nevertheless, we cannot be satisfied with less than the safest possible environment which is practical to attain in our nursing homes consistent with maintaining a functional and pleasing atmosphere.

While it must be stated that we will never completely eliminate fires from breaking out in nursing homes, it is incumbent upon us to reduce the consequences of fires to lives and property in any way we can.

Need for Fact-Based Requirements

Despite the acknowledged improvements brought about since the adoption by the Federal government of the NFPA Life Safety Code, the time has come when various Code requirements must be subjected to rigid empirical analysis in order to determine their validity and cost-benefit. The Life Safety Code does not stem directly from factual analysis, but represents a consensus of a wide variety of "experts" and interest groups (including nursing home administrators - let it be fairly stated), all with their respective axes to grind. Not surprisingly, a decision to include any particular provision in the Code is as much the result of good old-fashioned lobbying as anything else. Demonstrably, the NFPA Life Safety Code, while extremely useful in many respects, is not a fact-based set of requirements.

Literal adherence to the LSC in existing buildings is rarely possible; hence the statutory provision for the granting of waivers. The waiver system has been fraught with unbelievable confusion and error, resulting alternately in non-enforcement of vital Code requirements, or the unnecessary expenditure of thousands of dollars and disruption of patient care in nursing homes due to erroneous application of requirements.

Research

In view of this dilemma, the American Health Care Association has turned its attention over the last three years to the conduct of research aimed at producing evidence on which conclusions might be drawn with respect to the most important fire protection considerations. The aim of this research, and its attendant educational efforts, is to give the nursing home administrator and staff the means by which to develop and put into effect an organized system of fire protection in which available technology can be combined with community fire services and staff response to achieve the best possible result. Additionally, it is our hope that Federal and State Code enforcement can be simplified and improved as results of various research efforts now underway become available.

As a part of this effort, AHCA conducted a series of full-scale fire tests in 1974 in an abandoned nursing home in Beverly Shores, Indiana under contract with DHEW. These tests showed fire and smoke development characteristics amazingly similar to the two recent fatal fires in Chicago and Cicero, Illinois. As part of this statement, we have attached reports prepared for AHCA by Gage-Babcock and Associates, Inc. on both the Wincrest and Cermak fires.

AHCA submitted the report "Fire Tests in a Nursing Home Patient Room" to HEW in August, 1975. Although both the conclusions and the report have been available to the Department for more than eight months, no action has been taken to implement the recommendations which were made as a result of the tests.

The ability of a fire to develop very rapidly with certain types of room furnishings was shown in these AHCA tests and clearly demonstrated in both the actual fires in Illinois. The actual fires were confined to one room, as were most of the fire tests, but lethal fire gases spread into other spaces on the same floor.

The tests also demonstrated the effectiveness of closed room doors and smoke barrier doors. In the actual fires, patients in rooms with the closed doors survived, as did patients beyond the smoke barrier doors in the Cermak House, Cicero.

The patient room test at the two Indiana test sites were conducted in buildings of protected wood frame construction. However, in the critical early stages, the fires in the two fire resistive nursing homes in Illinois showed nearly identical development.

The tests also demonstrated the effectiveness of automatic sprinklers when the building does not have all the many protective features which had been provided (but were ineffective) in the Wincrest Nursing Home and Cermak House. AHCA has long supported sprinkler protection in nursing homes as the most effective single means of preventing multiple death fires. Dr. Thomas G. Bell, Executive Vice-President of AHCA, made extensive reference to the value of sprinklers in testimony before the National Commission on Fire Prevention and Control in Los Angeles, California, in June, 1972. The Association continues to support sprinklers as an effective means of protection. However, AHCA objects to treating sprinklers as "add on" to a long list of expensive and superfluous fire protection features. Current Life Safety Code requirements are not working in the best interest of all concerned. It is time to reassess these requirements and develop meaningful standards. The knowledge and technology to do this is available now.

It is essential that greatly increased fire safety features do not impinge on the well-being of nursing home residents. The impact on existing nursing homes can be lessened by concentrating on automatic sprinklers, the one fire safety measure which years of experience have shown to be effective in controlling of fire while it is still small.

All the other fire safety measures now considered to be the primary line of defense by today's codes should take a back seat to sprinkler protection. Fire resistive construction, corridor partitions, floor to floor barriers, latching hardward, increased corridor and door width, smoke barriers, stairway enclosures, smoke and heat detectors, and all the other code requirements now forced on nursing homes together have been proven to be less effective than sprinklers alone.

However, as with every protective measure, full reliance should not be placed on any single device. The key is to create a fire-safe system for each nursing home in which all factors are coordinated to achieve a level of protection which is reasonable and proper for our patients and residents.

While HEW has been slow in implementing recommendations from these fire tests, several agencies within HEW continue to cooperate with nursing homes -- notably the Health Services Administration. HSA has worked with AHCA on several projects which are of material and direct safety benefit to nursing home residents. The agency sponsored the drafting of a fire safety manual for nursing homes which was published by AHCA. More than 10,000 copies have been distributed to date. In addition to the previously mentioned fire test, HSA is currently working with the Association to develop a manual on hazardous products due for distribution to health care facilities later this year. The manual will guide the purchasing of equipment and furnishings normally found in patient rooms. The recent fires in Illinois have underscored the need to more closely control contents of patient rooms.

RECOMMENDATIONS

I. *Enforcement of the Life Safety Code should emphasize essential fire protection features. AHCA believes that both new and existing buildings can achieve a satisfactory level of safety by adopting either of the protection packages described below:*

(A) Automatic sprinkler protection in buildings normally housing patients who are difficult to evacuate.

1) Installation should be based on "light-hazard" rules, and water supply should be capable of supplying 250 gallons a minute for not less than 20 minutes (5000 gallons). Wide-coverage sidewall sprinkler heads should be specifically allowed.

2) Small closets and toilets opening into sprinklered rooms in fire-resistive buildings should be allowed to be left unsprinklered.

3) Smoke detectors and heat detectors are redundant and are unnecessary in sprinklered areas.

(B) Control of Combustibles Plus Automatic Door Closers on patient sleeping rooms.

1) Certain types of mattresses are OK: those made of cotton without inner spring or box spring, laid on flat or coil springs, or cotton ticking inner spring mattress (a wood headboard appears to present somewhat of a hazard), or a polyurethane mattress with a heavy vinyl covering. Mattress box-spring combinations are not recommended.

2) Free-standing hardboard, plywood, or cardboard wardrobes are fast burning and dangerous in an unsprinklered room. No conclusions have been reached as to the relative hazard of closets or built-in wardrobes.

3) Overstuffed furniture (chairs and couches) is unacceptable.

4) Normal wooden furniture -- dressers, night stands, and lightly padded chairs -- is not likely to cause rapid fire development. Increasing use of plastics in furniture could be a problem.

5) Door closers on sleeping rooms should close automatically in case of fire in the room. Fusible link releases are suitable for this purpose, as has been shown by test, or the releases can be actuated by smoke detectors in the room, at the door, or from a central system which closes all the doors simultaneously. Closers which keep a door closed at all times should not be used because the door inevitably will be blocked open.

6) "Hazardous" areas, in which combustibles cannot be controlled, such as storerooms, janitor's closets, maintenance shops, etc. should be sprinklered. The fire-resistive enclosures permitted by the Life Safety Code in lieu of sprinklers are not as reliable.

II. *The Life Safety Code of the National Fire Protection ASsociation should be modified to delete requirements which cause high expenditures without significant life safety benefit or which are actually detrimental to good fire safety.*

(A) Allow construction in existing buildings up to 3 stories in height with approximately 20 minutes fire resistance (i.e. wood lath and plaster) with "protection package" (A) and one hour fire resistance with "protection package" (B)

(B) Delete the requirement for partitions between patient rooms and corridors to be carried up tight to the underside of the floor or roof above unless the patient room uses a lay-in acoustic panel ceiling.

(C) Return to the pre-1966 exiting basis: one person per 150 square feet gross floor area and 30 persons per 22 inch unit of stairway width (instead of 120 and 22, respectively).

(D) Eliminate the requirement for fire extinguishers in patient areas.

(E) Modify the requirement for counting the basement as a story if it has direct exterior exiting, thereby penalizing a much safer arrangement.

(F) A building should not be downgraded from "noncombustible" to "ordinary" on account of wood stud partitions sheathed with gypsum board.

III. *AHCA further endorses the recommendations listed on p. 531-532 of Supporting Paper No. 5 of the report of the Subcommittee on Long-Term Care entitled Nursing Home Care in the United States: Failure in Public Policy.* An exception would be recommendation #8, for which our recommendation I should be substituted. Also, item 16 - adoption of the 1973 edition of the Life Safety Code - has been enacted as part of P.L. 94-182, largely through the efforts of AHCA and the Maine Congressional delegation.

IV. *Federal Responsibility for Financing*

It has been 30 months since P.L. 93-204 was enacted by the Congress authorizing insured loans for the purchase and installation of fire safety features in nursing homes.

The program has been completely ineffective, largely because (1) there has been no particular need or motivation for lending institutions to issue loans (and suffer horrendous red tape) for this purpose when more favorable investments were available for the scarce money banks had available; (2) uncertainty about what items were actually required to achieve compliance hindered necessary cooperation among banks, providers, HEW, HUD and state health officials, and (3) a general wave of Medicaid cutbacks by the States has increased the risks attached to all nursing home loans.

Loan insurance through HUD is not the answer. Congress must seriously consider direct grants or loans in conjunction, for example, with any decision to implement new equipment requirements for nursing homes. A Federal decision of this type must be accompanied by a Federal commitment of full funding based on full advance knowledge of the costs.

Decisions such as these fall properly within the political realm (although they must be based on expert technical evidence and opinion). Why? Because a decision to spend more tax dollars (as well as to force the expenditures of more private dollars) is a decision to allocate resources for one objective - marginal improvements in fire safety for nursing home patients - rather than a host of other concerns of equal or greater value to patients in nursing homes. It is clear that even the protection packages we have suggested, which are designed to avoid redundant or ineffective features, could result in several hundred million dollars in new costs and offer only marginal additional protection*. The Congress and Executive Branch must weigh the benefits with the costs, and base its decision accordingly.

* Estimate based on AHCA 1975 membership survey and figures supplied by Gage-Babcock and Associates.

gage·babcock & associates, inc.
CHICAGO SAN FRANCISCO LOS ANGELES NEW YORK

Report No. 7255
March 1976

REPORT OF FIRE AT WINCREST NURSING HOME
Chicago, Illinois
Jan. 30, 1976

Prepared for

American Health Care Association
Washington, D.C.

Prepared by

Gage-Babcock & Associates, Inc.
135 Addison Avenue
Elmhurst, Illinois 60126

John A. Campbell P.E.

Report of Fire at
Wincrest Nursing Home
Chicago, Illinois
Jan. 30, 1976

Introduction

At the request of the American Health Care Association, I investigated the circumstances surrounding a fire which occurred at the Wincrest Nursing Home, 6326 N. Winthrop, Chicago, Illinois on Jan. 30, 1976. I visited the home on Jan. 31, 1976 and talked with administrator Mrs. Cassidy and with some staff members and with Chicago City Officials. Although the home is not a member of the American Health Care Association, they were very cooperative as were the city officials.

The fire originated in a wardrobe in a third floor patient room shortly before noon on Friday, January 30, 1976. At the time of the fire approximately 40 patients were attending mass in a chapel down the hall from the room of origin. The blaze was essentially confined to the room of origin; however, there was severe smoke and heat damage to the corridor and moderate smoke and occasional heat damage to other rooms with open doors, including the chapel which had no doors. Thirteen persons were either dead on arrival or died shortly after arrival at local hospitals. Thirty one persons were injured, 10 of whom have since died. The current fatality count is 23. The fire was allegedly of incendiary origin.

The building was of fire-resistive construction and there were no deficiencies with respect to the 1967 Life Safety Code which contributed to the fire and loss. The code deficiencies that were noted were not of any significance in this fire. The fire development and spread in this fire-resistive building would have been the same if the building were of protected wood-frame construction. If the building had been of wood-frame construction with plaster-on-wood-lath interior finish and had been equipped with automatic sprinklers, I believe no loss of life would have occurred.

The Wincrest Nursing Home Fire was almost identical to full-scale fire tests numbers 5 and 7 conducted by the American Health Care Association and described in the report "Fire Tests in a Nursing Home Patient Room." All three fires were started in a wardrobe by a match. The fires developed rapidly and spread flame and smoke into the corridor and smoke filled rooms with open doors. The major difference was that there were 40 patients exposed to the fire at Wincrest.

General Description

The Wincrest Nursing Home is an 88 bed Intermediate Care Facility which had 83 patients at the time of the fire. The home was non-sectarian but Mrs. Cassidy stated most of the patients were Catholic. This accounts for the large percentage of the residents who were in the chapel on a weekday.

The building was about a 50 ft. by 125 ft., 4 level building of fire-resistive construction. The first level is partially below grade and the 2nd through 4th levels are referred to as 1st through 3rd floors.

The third floor contained 8 patient rooms, with a total of 27 beds, the chapel, a small sitting room, a nurses station and some small service rooms. The approximate configuration is sketched in Fig. 1. Patient rooms were furnished with dressers, night-stands, beds and, if there was no closet, with wooden or metal wardrobes. The beds had innerspring mattresses with a thin plastic moisture resistant covering. Ticking was cotton; there were no box springs. There was no evidence of a significant amount of polymeric materials in the rooms.

Two enclosed stairways with direct exterior exits and an elevator served all 4 levels. The chapel was approximately 800 sq.ft. with a single entrance. No doors separated the chapel from the corridor. The 1967 Life Safety Code did not require doors except on patient rooms and hazardous areas. Neither the 1967 nor 1973 Life Safety Codes require two exits from a room under 1000 sq.ft. The chapel would not be defined as a place of assembly under the Life Safety Code.

All patient rooms and storage rooms had solid core wood doors except for a very small closet which had a hollow core door. Stairways were equipped with self-closing fire-rated doors.

Dead end corridor limits were less than the 30 ft. permitted for new buildings by the Life Safety Code.

There were no smoke-stop barriers on the floor and none were required since there was less than 30 patients on a floor. Even if smoke-stop doors were installed, the logical location for them would have placed both the chapel and the fire room on the same side of the smoke stop.

The Wincrest nursing home had manual fire alarm pull stations located adjacent to each stairwell entrance and heat and smoke detectors in some locations but not in patient rooms. The building fire alarm system had an auxiliary connection to a city fire alarm box located outside the front door.

The normal first alarm response is 4 engines, 2 truck companies, a manpower squad, 2 battalion chiefs and a division marshal. The nearest fire station is less than 1 mile although it is not known if that company was available at that time. The initial report from the scene was that the 4th floor was totally involved and 40 persons were trapped.

A second alarm was sounded at 12:04 p.m. The total response would have included 8 engines, 4 truck companies, 1 elevating platform, 2 squad companies, 3 or 4 battalion chiefs, a division marshal, 2 deputy fire marshals and the chief fire marshal plus a number of fire department ambulances. Total fire department manpower would have been about 75 men without ambulance personnel.

The room of origin is located about 35 ft. down the corridor from the chapel where an estimated 40 persons were attending mass. The nearest stairway to the chapel was about two thirds the distance down the corridor towards the fire room door. There were initial attempts to fight the fire by staff personnel; their efforts were unsuccessful and they were forced to withdraw. The fire room door was left open. Nursing home personnel evacuated patients down the west stairwell until firemen arrived and ordered them to get out.

The fire was essentially confined to the room of origin. There was heavy heat and smoke damage in the corridor and moderately heavy smoke damage in rooms with open doors. The chapel had light heat damage to plastic light diffusers located in line with the entrance and had moderate smoke damage to the ceiling and upper walls. There were no noticeable smoke deposits in the chapel on the lower walls. Maximum ceiling temperature in the chapel in line with the entrance are estimated at under 250^{o}F near the entrance and about 180^{o}F in from the entrance. These estimates are based on the damage to the plastic light diffusers. Emergency lights on the west wall of the chapel had been exposed to enough heat to cause the plastic supports for the sealed beam bulbs to sag. However, the lights were still operative.

There were very heavy smoke deposits on the ceiling and walls of the west stairway indicating the self-closing door had been open much of the time. This would have been necessary for rescue and fire fighting. Rooms that had closed doors had no noticeable interior smoke damage. Some small traces of smoke deposits were noticed along the top of the doors.

The interior gypsum board walls and gypsum board and tile ceiling finish contained the fire very well. The tile in the fire room was down presumably pulled down by the fire department. The suspended ceiling grid showed no visible heat damage and the wooden form boards above were neither scorched nor sooted. Neither fire nor significant smoke had penetrated the ceiling. Parts of the interior layer of gypsum board in the fire room had been pulled

down. The unexposed side of the gypsum board on the other side of the steel studs was clean and undamaged. Wood furring strips and plywood that had been under gypsum board were also undamaged. The corridor walls and ceiling had only surface damage.

Heat and/or flames from the fire room had heavily damaged a solid core closet door in an alcove directly across from the fire room doorway. A hollow core door on a closet off this alcove had been penetrated on the top only and the door on the patient room directly across the hall was separated from its hinge strip. It appeared to me the door had been damaged by fire and then possibly by impact during fire fighting. That door had been open during the fire.

Much of the interior room furnishings had been destroyed in the fire or thrown out during fire department overhaul. However, a damaged dresser that remained was charred on the outside only; clothes in the drawers were not damaged. This indicated the fire had been of relatively short duration. A newspaper photographer I talked to stated he was on the scene in about 10-15 minutes after a working fire was reported and there was almost no sign of smoke remaining at that time.

The majority of the victims were in the chapel at the time of the fire. I was told that 2 survisors were in a third floor room behind a closed door; however, I could not confirm that.

The fire was classified as of incendiary origin, allegedly started in the wardrobe with a match. A female attendant has been formally charged with starting the fire.

Staff Actions

The nursing home staff appeared to have reacted to this emergency as would be expected. They directed their efforts at extinguishing the fire and evacuating patients. This is in accord with much published information and probably reflects typical training and is consistent with instructions contained in section 17-412, Procedure in Case of Fire in the 1967 Life Safety Code. Section 17-412 does not even suggest closing the door but emphasizes continuing extinguishment efforts even if unsuccessful. The increasing fire intensity forced the staff out of the room and by then they either could not close the room door or they did not think of it.

I was unable to obtain a clear description of the evacuation operations. However, the staff members engaged in rescue operations until they were ordered out by the fire department. At least 3 staff members were injured.

Patient Removal

Chicago has programmed disaster plans to mobilize emergency services in incidents involving many victims. Hospitals, private ambulances, police, fire and supporting services are all involved. Such a plan was activated at this incident. An estimated 25 fire department and private ambulances and police vans were used to remove victims to hospitals. (The police vans are essentially a small patrol wagon that carries a folding stretcher - emergency medical service authorities have previously strongly critized their use as an ambulance.)

Newspaper photographs and television news coverage of the removal of victims showed a few deficiencies in handling the victims. It is not know if these deficiencies were common or the exception. At the time these incidents occurred the fire was out and there were three habitable floors in the building below the fire floor. Three specific incidents documented by news coverage were:

1. An elderly woman was being carried outside in below freezing weather on a stretcher in her nightclothes only. She had no blanket or other covering over her.

2. A fireman was carrying an elderly person out over his shoulders.

3. Firemen were using their self-contained breathing apparatus to "administer" air to victims outside the building. This serves no useful purpose at best and indicates either a shortage or inadequate deployment of resuscitation equipment.

The above handling of victims is likely to have had a traumatic effect on these victims. At that time there was no imminent danger on the fire floor and there would have been ample personnel available for removing victims to ambulances.

Possible Benefits of Added Protectives

No single additional protective measure except an automatic sprinkler system would have definitely prevented this high loss of life. Other protective measures would have still depended on specific staff and fire department reactions. The existing protective measures would have been more than adequate to safeguard the occupants if the fire room had been promptly closed and kept closed until the occupants were removed to a safe location. Some of the other protective features which are being promoted or in one case required by the 1973 Life Safety Code are discussed below.

Early warning smoke detectors would not have provided any significant benefit since there was no evidence that delayed alarm

transmission contributed to the loss. Fire tests have shown that a wooden wardrobe fire can develop very rapidly and involve an entire room within a few minutes.

Automatic door closers would have quickly dampened the fire and provided time to evacuate occupants if the door to the fire room was kept closed. This would have required both the staff and the fire department to refrain from extinguishing the fire until all occupants were removed to a place of safety.

Doors on the chapel, which are required under the 1973 Life Safety Code, would have impeded smoke entrance. I believe the chapel would have remained tenable if these doors remained closed and some chapel windows were opened. However, if either the staff or the fire department attempted to "rescue" the occupants of the chapel it would negate the benefit of the doors. In addition, "rescue" efforts would have required moving the patients toward the fire area.

A second exit stairway from the chapel would have been of little benefit since most patients could not have used it. It would have probably reduced the loss of life somewhat since rescue would have been easier.

Response of City of Chicago

The City of Chicago appointed a special panel to investigate the fire and recommend corrective legislation. The panel consisted of the city building commissioner, the city health commissioner, an architect and the retired head of an insurance inspection and rating bureau. A city council committee has held hearings on a sprinkler ordinance for Chicago nursing homes.

During my investigation I talked to the commissioner of buildings and gave him a copy of the report on "Fire Tests in a Nursing Home Patient Room." I pointed out the almost identical similarities to the Wincrest Fire and the test fires.

Gage-Babcock was not invited to testify before the City Council Committee.

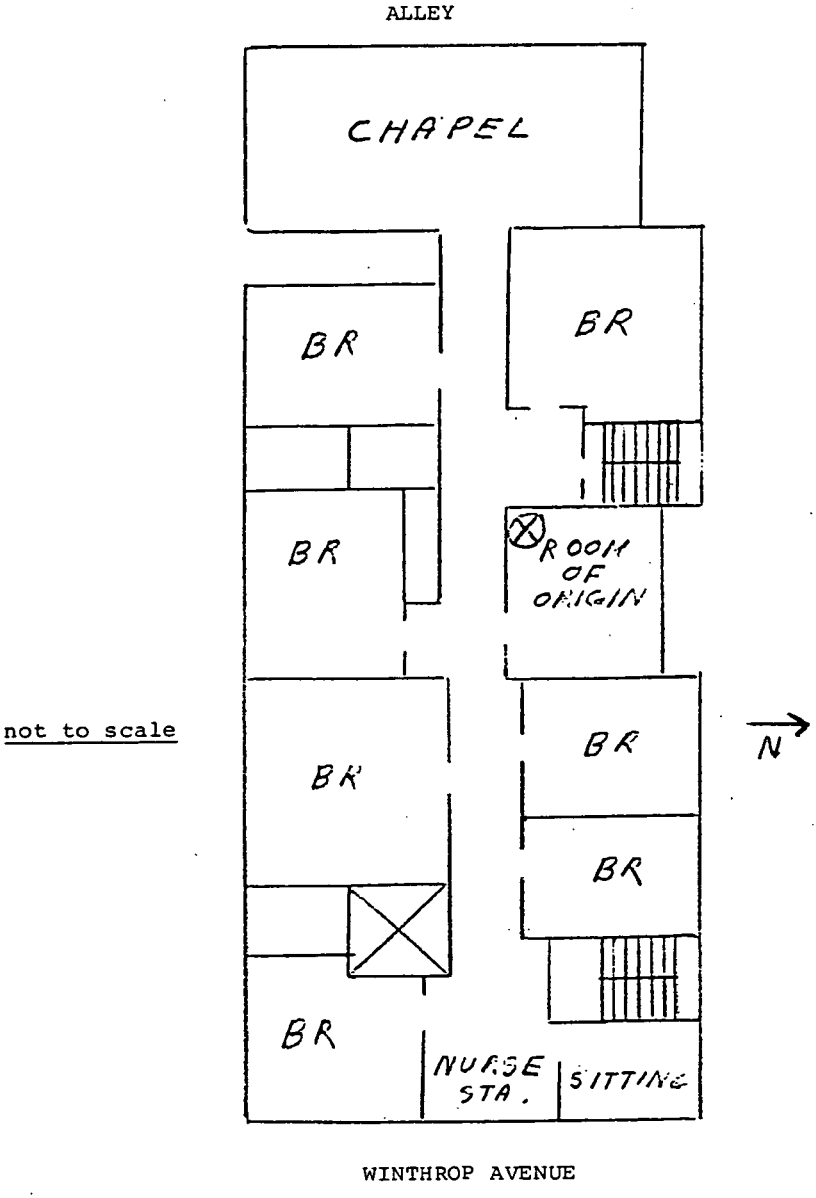

Fig. 1 APPROXIMATE ROOM ARRANGEMENT- WINCREST NURSING HOME

gage·babcock & associates, inc.
CHICAGO SAN FRANCISCO LOS ANGELES NEW YORK

March 1976

REPORT ON FIRE AT CERMAK HOUSE NURSING HOME Cicero, Illinois Feb. 4, 1976

Prepared for

American Health Care Association
Washington, D.C.

Prepared by

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John A. Campbell P.E.

Report on Fire at
Cermak House Nursing Home
Cicero, Illinois
Feb. 4, 1976

Introduction

In accordance with the request of the American Health Care Association, I investigated the fire which had occurred on the morning of February 4, 1976, at the Cermak House, a nursing home located in Cicero, Illinois. I visited the site on February 5, 1976 and discussed the fire with the assistant administrator and representatives of the State Fire Marshal's office.

The Cermak House was not a member of AHCA; the management was cooperative but they were very concerned about possible legal problems and publicity. Members of the news media had not been permitted to see the fire floor. The investigation was abbreviated when a group of attorneys arrived representing Cermak House's insurance carrier. The State Fire Marshal's office would not permit interior inspection of the room of origin, although with reluctance they gave permission to enter the room briefly to take photographs.

The fire occurred shortly before 7 a.m. on Wednesday, Feb. 4, 1976, in a 4th floor patient room. The fire was confined to the room of origin but heavy smoke spread throughout one wing of the hospital. Six victims were dead on arrival or shortly after arrival at local hospitals. Eighteen were reported injured. Two of these have since died. The State Fire Marshal's office stated the fire was of electrical origin.

Cermak House was of fire-resistive construction and there were no 1967 or 1973 Life Safety Code deficiencies noted that could be identified as contributing to the life loss. If the building had been of protected wood-frame construction the number of fatalities would have been the same. If the building were of wood-frame construction with plaster-on-wood lath interior but protected by automatic sprinklers, I believe there would have been no fatalities.

General Description

The Cermak House is a skilled and intermediate long term health care facility located at 5825 Cermak Road in Cicero, Illinois. Cicero is a town of about 67,000 population and has a full paid

fire department. Adjacent suburbs with full-paid fire departments and the City of Chicago are available for mutual aid although Chicago was not requested for this fire.

Cermak House is a 9 story, 160 ft. by 110 ft. U-shaped building of fire-resistive construction. Floors are poured concrete and interior partitions in the area of the fire were gypsum board on steel studs. Fiberglass batts with no vapor barrier were installed between the gypsum board in the partitions. Room and corridor partitions extended to the underside of the floor above; there was no suspended ceiling in the corridor or rooms in the fire area. Markings on the inside surface of the gypsum board did not indicate it was a fire-rated product. Interior wall and ceiling finish in the fire area was paint on concrete or gypsum board and carpeting on the floors.

Unit convectors under each window provided heating, cooling and fresh air. There were no HVAC ducts serving the patient rooms or corridors in the fire area. A typical patient floor contained 14 four-bed rooms, 10 one or two-bed patient rooms, two isolation rooms and living and dining area, Fig. 1. The floors were divided into 3 smoke zones by a pair of smoke-barrier doors located at each leg of the U. The smoke-stop barrier doors could be bypassed by going through the washroom. However, the washroom doors were self-closing so the barrier was effectively continuous. The center corridor between smoke doors was 115 ft. long and the length of each leg was about 63 ft. Dead end corridor lengths were approximately 30 ft. Three enclosed stairways served the upper floors, one of each being accessible from each smoke zone.

All patient rooms in the fire wing contained 4 beds. Furnishings included the beds, bed stands, table lamps, dressers and semi-built-in wooden wardrobes. The beds had a wooden headboard and an innerspring mattress with straw and cotton ticking. Mattresses had a thin plastic covering over the outside. There were no box springs. There was no sign of any significant amounts of polymeric materials in the furnishings.

The building had manual fire alarm pull stations by the stairways and smoke detectors in the corridor. The ground floor was protected by an automatic sprinkler system. The alarm system was directly connected to the Cicero Fire Department. In addition, the building was protected by a closed circuit television system which covered the corridors and exterior doors. The TV monitors were located at the switchboard operators station.

The Fire

The fire originated about 6:40 a.m. in room 421, a four-bed patient room containing 3 occupants. The staff was reportedly

alerted by a young blind female patient in the room. Flames were first observed around the base of a lamp on a nightstand. The fire was also reportedly sensed by a smoke detector which transmitted an alarm to the fire department.

The fire was confined to the room of origin. The combustible furnishings of the fire room were either destroyed by fire and/or thrown out during overhaul by the fire department. The 4 bed frames and springs, deeply charred wooden headboards on two of the beds, and the bottoms of a wooden wardrobe were the only identifiable furnishing items remaining. Gypsum board surfacing on parts of the walls had been pulled down, presumably during fire extinguishing operations.

The fire had been effectively confined by the walls of the room. There was no sign of heat or smoke damage on the interior surface of the gypsum board on the opposite face of the partitions except at one location where it appeared smoke and heat penetrated along a seam. However, there was no indication of impending penetration of the opposite face.

The corridor outside the fire room had heavy smoke and heat damage. One of the pair of smoke-stop doors, which were adjacent to the entrance of room 421 had heavy damage on both sides indicating it was open during part of the fire. The other door in the pair swung in the opposite direction so only one side would have been exposed to heat on one side regardless of whether it was in the open or closed position. There was light to moderate smoke damage and a slight amount of heat damage beyond the smoke doors and in line with the corridor leg. In the central corridor which runs at right angles to the leg, no smoke damage was noted.

On the fire side of the smoke-barrier doors, heavy smoke deposits covered the entire corridor ceiling and walls to within about 4 ft. of the floor. The carpeting appeared undamaged. Incandescent electrical light fixtures in the corridor ceiling, away from the fire room, were operating although the translucent enclosures were gone. The heat at the corridor ceiling had not been high enough to damage the wiring except near the room of origin.

Patient rooms in the fire wing that had open doors had moderately heavy smoke deposits on the ceilings, walls, bedding and furniture. Rooms which had closed doors were clean.

Fire had extended out of the fire room corridor and impinged on the wall and corridor of the room above. Although the window above the fire room was broken at the time of the investigation, I was informed it had not been penetrated by fire.

State Fire Marshal's office investigators stated they believed the fire was started as a result of an electrical fault in a

cord to a lamp on a nightstand. The cord was plugged in to a wall receptacle behind a bed. Repeated movements of the bed, such as during cleaning, bent the cord back over the plug damaging the insulation. The resultant electrical fault then ignited the insulation which burned rapidly spreading the fire up to the lamp.

I do not concur with this theory of ignition, although an electrical origin is possible. Electrical insulation burns very poorly, if at all, except when it has been preheated such as by excess current flow. An electrical fault at the plug would not cause excess current flow through the wires; however, a high resistance electrical fault in the lamp would.

I was surprised at the apparent rate that this fire developed. I would not have expected a fire involving these furnishings to involve the entire room in less than 15 minutes unless the wardrobe became involved early in the fire.

The three occupants of the room of origin were safety evacuated with only one receiving injuries. All the initial fatalities on the fifth floor were at the end of the hall about 60 ft. from the room of origin. Four died in room 425; the door had been left open and they had broken a window for fresh air which apparently drew smoke in through the open door. One victim was from room 424 which had a closed door and was very clean. I do not believe that a lethal level of smoke could have entered that room. In my opinion, the victim had to either have absorbed a lethal amount of smoke outside room 424 or that the trauma of the incident was a major contributor to the fatality. The sixth initial victim was on the 8th floor and it is assumed that death was caused by a heart attack. I have no information on the two victims that died of injuries.

There was no indication of any delay in discovery, fire department notification or fire department response. One Cicero town official was quoted in the newspapers as saying the fire department forgot to bring their aerial ladder truck with them. However, even if this were true, it would not have had any effect.

Discussion of Incident

The fire was very similar to the Wincrest Nursing Home Fire which occurred a few days earlier. Both buildings essentially conformed with Life Safety Code requirements; the fire was discovered promptly; there was no indication of delayed alarm; the staff concentrated on evacuation and extinguishment; the fire was confined to one room; victims were down the corridor from the fire room; and most of the occupants had to move toward the fire to evacuate. A major difference was that there were fewer people on the fire side of the smoke-barrier doors in the Cermak House than were in the chapel at Wincrest.

The smoke deposits in the distant corridor and in rooms with open doors were much heavier than those observed in the Wincrest fire. The furnishings were sufficiently similar so the difference would not have been caused by the materials that burned. This could have been the result of the efficiency of combustion or by more heat being vented out the larger window in the Cermak House.

The open smoke-barrier door or doors during part of the fire could have been the result of fire fighting actions or it could have been blocked open. There was no evidence that this contributed significantly to the fire loss since there was no noticeable smoke damage in the center corridor. I saw no sign of any hold-open device on the smoke doors, although one could have been destroyed by the fire or damaged and removed. However, the closed circuit TV camera locations suggested the possibility that the smoke doors were normally open.

Staff actions concentrated on evacuation of the patients and apparently extinguishing the fire. I was told the fire department found two empty extinguishers in the corridor. The fire room door was not closed after the patients were evacuated from it. Had it been closed and other patients secured in a safe location before any fire fighting was attempted, I believe there would have been no fire fatalities, although the trauma of the incident could have brought on heart attacks.

A nurses aid interviewed on television stated she was on the fifth floor in the wing above the fire room. They closed all patient room doors after the fire was discovered. When the fire department arrived they told them to evacuate all the patients to the center dining room.

The fire-resistive construction did not contain the fire any better than protected wood-frame construction would have. An automatic sprinkler system would have promptly suppressed this fire. Patient room door closers would have contained the fire and since all patients would have been in rooms behind closed doors, the life loss might have been prevented. This would have required that neither the staff nor the fire department would have evacuated patients until the fire was suppressed and the floor ventilated. In addition, the patient rooms near the fire room would have had to been ventilated to prevent buildup of smoke, which would come through the walls. There was time for all this to have been done by the staff instead of attempting evacuation. However, the universal tendency and training is, and probably will remain, to evacuate all occupants at least on the fire floor. As long as codes and training emphasize fire fighting and having ample fire extinguishers available, the staff will continue to attempt to extinguish fires rather than closing a fire room door.

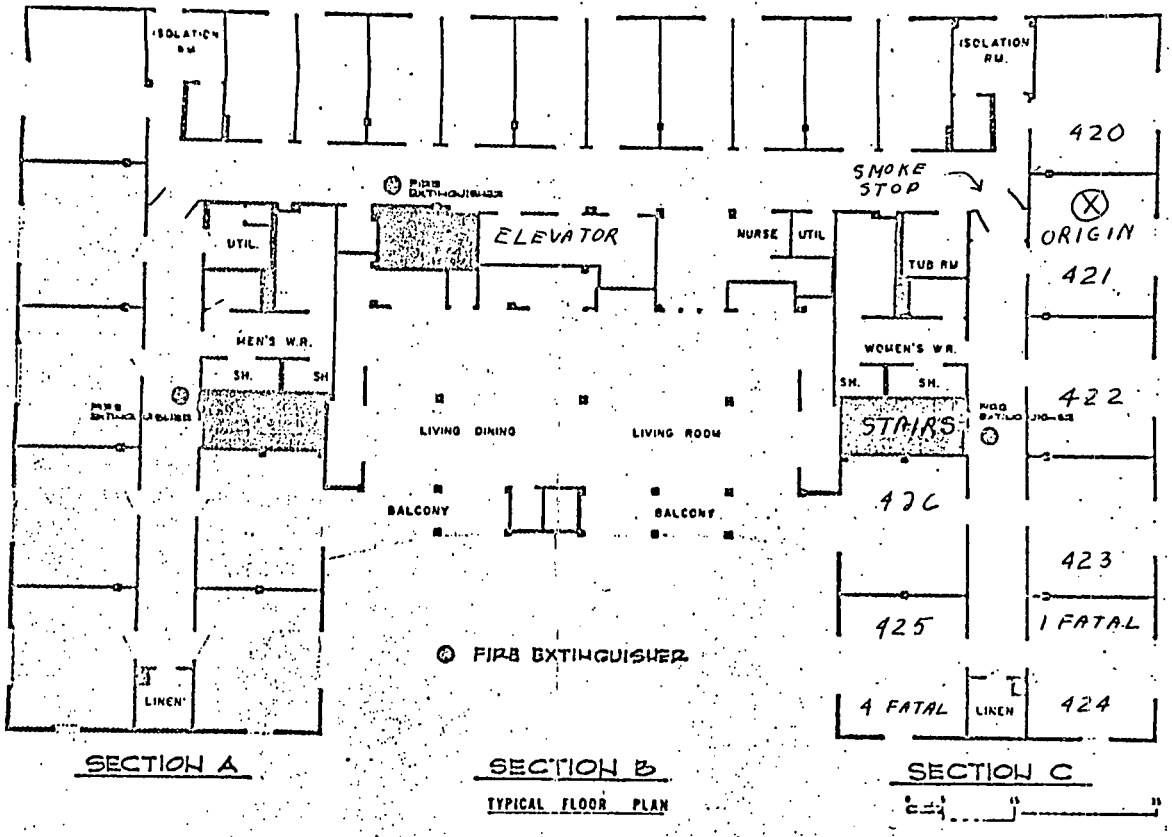


Fig. 1 Fourth Floor Plan of Cermak House Nursing Home

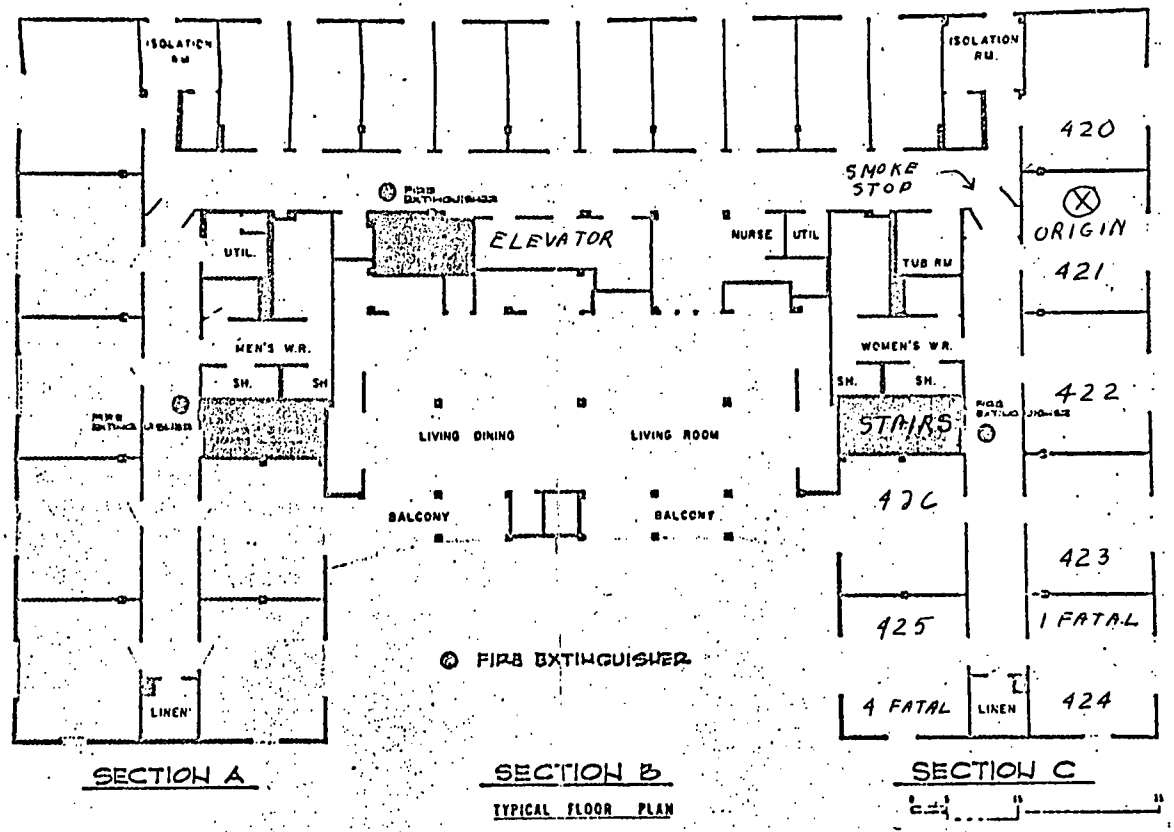


Fig. 1 Fourth Floor Plan of Cermak House Nursing Home

PREPARED STATEMENT OF HON. FRANK ANNUNZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman: I very much appreciate the opportunity to testify before this subcommittee today.

In my own City of Chicago last January the Wincrest Nursing home fire killed 23 people, elderly or disabled patients whose lives were helplessly and horribly snuffed out. Within a week, another nursing home fire at Cermack House just outside Chicago claimed the lives of eight more people.

Naturally these holocausts were investigated as to the cause and possible remedies -- they still are continuing. But as a result of these two nursing facility fires this Subcommittee requested a thorough investigation from GAO, the conclusions of which have just been published. The explanations for the fires were researched as well as possible actions to avoid similar situations.

According to the reports of the investigations:

-- multiple deaths occurred in these fires even though the buildings were of fire resistant construction and were in substantial compliance with the Federal fire safety requirements.

-- Deaths were caused by smoke and products of combustion rather by flames because the flames were confined to the rooms of origin.

-- Neither facility was fully protected with an automatic sprinkler designed to activate an alarm and begin fighting the fire immediately.

-- Although local fire departments responded promptly to both alarms, the fire departments were unable to prevent the deaths which occurred.

-- Even though the fire departments responded quickly to the blazes, the fire generated intense heat and considerable damage.

The experts concluded that an automatic sprinkler system would have put both the Chicago fires out and saved the lives. And the GAO report makes a strong recommendation that the Congress enact legislation which will require that all nursing facilities be fully protected with an automatic sprinkler system. Moreover, the Congress should also require HEW to establish rigid standards which must be met by nursing facilities requesting a waiver from the automatic sprinkler requirement.

We remember that P.L. 93-204 authorized government-insured loans for installing fire safety equipment in nursing homes and intermediate care facilities. The GAO report discovered that the Federal insurance programs for fire safety equipment loans has not been successful in assisting nursing homes in installing automatic sprinkler systems. Out of 159 initial inquiries from the Chicago region for this program, HEW received only 10 applications. And because of the bureaucracy and long processing times, none of these facilities received financing through P.L. 93-204. According to HUD officials, there have not been any loans approved under this law:

These facts lead me to one inescapable conclusion: the application of existing safety standards must be re-evaluated with a view toward requiring all nursing homes to install sprinkler systems throughout their facilities. This is not the first time we have come to these conclusions. But it is time we did something definitive about it.

PREPARED STATEMENT OF HON. PETE V. DOMENICI, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Mr. Chairman: I very much appreciate the opportunity to address the Committee today.

For too long, the Congress has stood by and held proposed safety standards in nursing homes in abeyance. Especially in terms of fire safety, too little has been done for too long, and we must act as soon as possible to protest the lives of nursing home patients.

It is, however, not that the issue hasn't been broached before. Hearings have been held, words have been spoken, but action has been continually delayed.

In 1972, the Committee on Government Operations published "Saving Lives in Nursing Home Fires" -- 92-1321. The 93rd Congess also held a series of hearings dealing with fire safety in nursing homes, and in 1974, another report was issued by the Committee on Government Operations, 93-1672, entitled "Fire Safety Deficiencies in Nursing Homes." Once again, recommendations were issued, and further action was urged. The Special Senate Committee on Aging also issued a report entitled, "Nursing Home Care in the United States: Failure in Public Policy" -- subtitled, I might add, "The Continuing Chronicle of Nursing Home Fires."

Meanwhile, the patients continue to be killed in nursing home fires. Fires in Chicago claimed a total of 30 lives in two code-certified nursing homes earlier this year. Investigations now continue into the fires that killed 23 patients of the Wincrest Nursing Home in Chicago and seven more lives lost at the Cermak House in suburban Chicago.

76-611 O - 76 - 8

P. L. 93-204 authorized government-insured loans for installing life safety equipment in SCF's and ICF's. But certain questions seem in order:

- Why is the law not being more fully implemented?
- Why are not State inspections procedures more uniform or complete?
- Are we positive about the qualifications of the inspectors?
- How do we measure the quality of training of the personnel who assist patients if, God forbid, a fire does occur in a nursing home?
- Has HEW been enforcing its life safety standards, and should they be stronger?

Should we, regardless of the expense, mandate that complete sprinkler systems are installed in all nursing homes? Perhaps the GAO report, to be released today, will address these questions. I certainly hope so.

Most experts agree that sprinklers would have put both the Chicago fires out and saved the lives. Unfortunately, the State of Illinois classified the facilities as being safe according to existing rules; the homes did not require sprinklers in order to be in technical compliance with the Life Safety Code.

There are other sad examples, Mr. Chairman, of many, many lost lives in nursing homes. In a great many instances, the patients are helpless, or mentally deficient. How can we hope that they will be able to help themselves?

It is obvious that the application of existing safety standards must be re-evaluated. We should seriously consider the possibility of requiring all nursing homes to install sprinkler systems throughout their facilities.

I am hoping we move with judicious speed. Our older citizens' lives are at stake.

First Ipswich Company
Leaders in Quality Health Care

July 30, 1976

The Honorable Claude Pepper, Chairman
United States House of Representatives
Select Committee on Aging
Subcommittee on Health and Long-term Care
715 House Office Building, Annex 1
Washington, D.C. 20515

Dear Representative Pepper:

I write you in connection with your bill, H.R. 14406.

Our nursing home group is comprised of some eight skilled nursing facilities, comprising nearly one thousand multi-level beds. All of the facilities are located in the state of Massachusetts.

I am in full support of the legislation you propose, being of the opinion that the installation of sprinkler systems are greatly reducing the threat of injury and death to our elderly residents in nursing homes. The Commonwealth requires automatic sprinkler systems in all such facilities, and each of our homes is in full compliance with the applicable statute.

However, I wish to bring to your attention what I believe to be a great misuse of Federal funds and an unjust burden upon nursing homes.

Our facilities have collectively been forced to expend funds in excess of $1,000,000.00 on safety improvements mandated by Life Safety Code Legislation. The improvements have been carried out under threat of loss of federal reimbursement under Titles XVIII and XIX of the Social Security Act. Many of these expensive improvements have been shown to be ineffective methods of protecting the elderly, as was tragically pointed out in the Chicago nursing home fires early this year.

Our attempts to finance these improvements through H.U.D. have not been fruitfull. We have to date, after three attempts, been unsuccessful in getting any useful information relative to loan applications. I understand this is due to the failure of H.U.D. to promulgate regulations to implement the legislation pursued some two years ago.

Fifty-One Summer Street Rowley, Massachusetts 01969 Telephone: (617) 948-7755

Our compliance with these mandated regulations has positioned our company in such a way that our viability as providers of quality health care has come into question.

It appears that the intent of Congress has been obstructed or at best impeded by the failure of the various Federal agencies to implement such legislation.

I therefore, ask your assistance in determining a worthwhile course of action to pursue in order to obtain much needed government assistance relative to these regulations.

I would be pleased to offer testimony and evidence, based on our experience, of the necessity of framing such legislation as you have proposed in H.R. 14406.

Thank you for the kind courtesies extended.

Yours truly,

FIRST IPSWICH COMPANY, INCORPORATED

Frank C. Romano, Jr.
President
/bs

CERTIFIED MAIL #334234

J. Brooks Semple

Fire Protection & Smoke Control Consultant

• 850 SOUTH NEW STREET
• WEST CHESTER, PA. 19380
• (215) 696-1354

11 June 1976

Senator Frank E. Moss
United States Senate
Washington, D.C. 20510

Subject: Joint Hearing, June 3, 1976
United States Senate Subcommittee on Long Term Care- Special Committee on Ageing
U.S. House of Representatives Subcommittee on Health Maintenance and Long-Term Care- Select Committee on Ageing

Dear Senator Moss:

We respectfully request that this letter and supporting material be included as part of the official transcript of the subject Joint Hearing. This information is being submitted on behalf of the Smoke Control Association, a newly formed group specifically concerned with the current inappropriate reaction to smoke inhalation injuries and fatalities (Appendix I Articles of Incorporation).

Having read the entire Report to the Congress by the Comptroller General of the United States and Statement of the American Health Care Association(including engineering reports on both the Wincrest and Cermak fires), we can present our position concisely by reference to these two sources:

1. Both Cermak and Wincrest had fatal fires, Plaza did not.

2. Both Cermak and Wincrest lacked sprinklers, Plaza did not.
   - But this was not the critical point, careful reading of the reports of all three fires reveals the critical difference:

3. In both Cermak and Wincrest the door to the room of fire origin was left open, in Plaza it was closed.
   - The importance of this simple fact is further substantiated by the answer to the question "Since Cermak had a greater fire floor occupancy and denser smoke than Wincrest, why were there only one-third as many fatalitites? "

4. In Cermak there were corridor smoke doors which were closed during most of the fire (opened for evacuation) which confined all the fire and nearly all of the smoke to a portion of the fire floor.

Facts three and four above dramatize the tremendous effect of just partial smoke control in saving lives. It must be emphasized that all fatalities were from smoke inhalation (plus one coronary), none from fire or heat.

We agree that sprinklers constitute the best fire control system which can be provided in almost any building. However, the critical fact is that no degree of fire control yet available is responsive quickly enough to prevent multiple fatalities from smoke and toxic gases.

Consideration should be given to all of the following facts in formulating a bill to provide additional life safety in any sleeping occupancy, particularly one housing non ambulatory individuals:

I. Sprinklers

A. They are capable of confining the fire to the room of origin; however, the Chicago and Cicero Fire Departments also demonstrated their equal capability in this regard.

B. They are only thermally responsive, but no one died of excess heat in the subject fires. A closed bedroom fire will often be self extinguishing due to oxygen depletion without producing sufficient heat to open an ordinary temperature (160° F) sprinkler head. This was demonstrated at the "Heart of Atlanta" Fire Tests of Motel Bedrooms, 25 July, 1973 (Appendix II).

The Public has been grossly mislead into thinking that sprinklers respond immediately upon air temperatures reaching the sprinkler rating. This is not true. Sprinklers' activating elements are fusible links or similar devices, all of which are tested to Underwriters Laboratories Standard for Fusible Links (UL33). That Standard requires operation of the link (sprinkler) at ±5o F of the temperature rating when tested in liquid. However, the Operation Air Oven Test permits any sprinkler link with a rating of 135oF to 170oF to rise to 290oF before operation and still receiving "Listing by UL" ! Furthermore, while the test temperature applied reaches 165oF in 15 seconds, the sprinkler link need not operate until 6 minutes, 30 seconds-the point at which the test temperature reaches 290oF. (Appendix III)

In many smoldering fires- typically small areas like bedrooms with closed doors- the ceiling temperature never reaches 290oF. This occurred in the first Atlanta test with the room door closed. The test report states "The fire was characteristic of a smoldering low heat fire that generated large volumes of smoke that completely filled the room. To expedite burning within the room, the exterior door was opened and additional fuel was supplied 17 minutes after ignition. Thirty-five (35) minutes after ignition, the sprinkler head fused; the water coverage adequately covered the entire room and extinguished the fire. The following CO (Carbon Monoxide) readings were obtained: 2400 PPM (10 minutes) and 5000 PPM (13 minutes)".

As a result of this first test experience it was found necessary to open every test bedroom door as soon as the bedroom became smoke filled (about 3 minutes) in order to provide enough fresh air to feed the fire to build up the heat to fuse the sprinkler. In short, in order to assume sprinkler operation in a bedroom, the bedroom door must be opened to let in fresh air by releasing smoke into the corridor!

II. Compartmentation

A. Sometimes this prinicipal alone can control fire by oxygen starvation (Atlanta Motel Fire Tests).

B. This principal alone can substantially impede smoke flow and reduce the death rate (Cermak vs. Wincrest).

C. Compartmentation with pressurization can confine both smoke and fire to the room of origin (Carlyle Apartment Fire-Appendix IV).

III. Cost Effectiveness

A. More lives can be saved by confing smoke to the room of origin.

B. Compartmentation/Pressurization (Smoke Control) systems cost no more, often much less than sprinkler systems because the pre-existing doors and air conditoining/ventilating systems are utilized.

C. A smoke control system, backed up by a sprinkler system is ideal, but the economic feasibility is questionable for widespread application.

D. Particle-of-Combustion Detector operated sprinklers are under development,are most effective, most expensive, but constitute the only system capable of providing reasonable life safety within the room of origin and without resorting to evacuation. Such a device exists experimentally (Appendix V), but detector false alarms could cause some water damage and major inconvenience and shock to the bedroom occupants.

IV. Conclusion

No thermal response nor human response can be relied upon to prevent smoke inhalation fatalities, therefore early warning detectors must automatically initiate any system designed to prevent fatalities in a sleeping occupancy.

Such a system should:

1. Automatically call the fire department-direct wire, no human judgement involved.

2. Notify the appropriate staff to evacuate the immediate fire area.

3. Automatically close all room doors.

4. Automatically pressurize the corridor outside the fire room to restrain any smoke from entering the corridor during evacuation and to act as a back up system to the bedroom door closers because some ambulatory patients will open their doors "to see what's happening".

Since smoke control systems can restrain the passage of smoke and fire for a period long enough for immediate area evacuation and fire department response, such systems must be the first line of defense where life safety considerations are greater (such as nursing homes) than property values (such as warehouses). On the other hand, since smoke control systems can not be relied upon in most cases to extinguish the fire, sprinkler systems should be considered whenever the cost can be justified for them as a back-up.

A few final considerations:

1. The normal response time of a modern fire department to a low rise facility (usually less then 5 minutes) coupled with an alarm sent by an early warning smoke detector is generally faster than the thermal initiation of the first sprinkler head installed in the room of fire origin. This will be the rule in smoldering fires (beds and clothing, doors closed) not so often the case in high fuel fires where wood clothes cabinets are permitted and doors are open.

2. All fire insurance deductions resulting from sprinkler installations are offset to some degree by the additional cost of water damage insurance.

3. If a smoke control system false alarms there will be no water damage, only minor inconvenience in manual resetting of the system.

There are lives to be saved as a result of sound legislation. It will take millions of dollars of public money. It is essential that a bill be drafted to save the greatest number at the lowest cost.

Sincerely,

J. Brooks Semple, P.E.

JBS:dws

Enc: (5)

ARTICLES OF ORGANIZATION APPENDIX I

Article 1. Name. The name of this corporation is SMOKE CONTROL ASSOCIATION.

Article 2. Purposes. The purposes of the corporation (hereinafter referred to as the Association) shall be to substantially reduce fire fatalities, injuries and property loss due to smoke/toxic gas/ heat development from hazardous heat or fire by:

a. Compiling and maintaining a central library of:
   1) Information on smoke control technology
   2) Problems associated with building fires, including accounts of both successful and unsuccessful control.
   3) Records of fire deaths and injuries from smoke/toxic gas inhalation or induced panic problems due to loss of visibility.

b. Disseminating to concerned publics and media perinent information and reports concerning smoke control problems and hazards as occur in real fires and fire research testing.

c. Encouraging engineering systems development among its members to produce early responsive, effective, highly reliable smoke control systems which will:
   1) Assure a high degree of occupant safety for all those inside and outside the room of fire and smoke origin.
   2) Reduce smoke damage losses.
   3) Bring together individuals and businesses whose personal knowledge of smoke control techniques and expertise can be utilized as a source for other organizations.

d. Encouraging construction and contents standards development and code promulgation organizations to assure that smoke/toxic gas control systems are a design part of all building construction.

e. Coordinating and reporting critical research programs designed to develop better smoke control.

Article 3. Nature of Organization. The Association is a membership corporation not organized for the purposes of realizing pecuniary profit or gain to its members, but the Association may pay reasonable compensation for services rendered and may indemnify the directors, officers, employees and agents of the Association from certain unexpected consequences of their actions or omissions in the affairs of the Association, to the extent provided from time to time by action of the Board of Directors. Through membership no member is pledged to any course of action.

Article 4. The corporation is organized upon a nonstock basis.

Article 5. Membership. The membership of the Association shall consist of such class or classes with such qualifications, rights and obligations as shall be set forth in the Bylaws of the Association as the same may from time to time be amended.

Article 6. The term for which the corporation is to exist is perpetual.

KOPLON - "Heart of Atlanta" - Summary of Results *APPENDIX II*

Room		Carbon Monoxide Time	CO
#7 -	1 Viking sidewall - 160° F	10:00 min:sec	2400 ppm
	Fire smoldered - 190° - 220° max.	13:00	5000
	Door opened in 17 minutes to add oxygen		
	Sprinkler fused - 35 minutes		
#8	1 Viking pendant 160° F	0:20	450
	More paper fuel	1:00	700
	Smoky but hotter	5:00	3700
	Sprinkler fused 3 min., water off 6 - still smolders	15:00	5000
#6	1 Viking pendant 160° F with ETSR	0:20	250
	limited paper fuel	1:30	1000
	Bedspread just started	4:00	200
	Sprinkler fused at 1:25	5:00	0
	Immediate extinguishment		

#2 Grinnell Aquamatic (CO not measured)
Fire load similar to Room #7 - 2 minutes - smoke filled, 3 1/2 minutes sprinkler actuation (disk facing fire - ceiling temperature only 135° F -- radiant energy?), 4 1/2 minutes - extinguishment, but still smoldered, 6 1/2 minutes sprinkler OFF - reignition - 265° F recorded and 4 minutes for actuation - 2 minutes flow before OFF

#1 1 Viking pendant 160° F
Identical with room #2 except different sprinkler. 3 minutes - smoke filled, 4 minutes - 340° F - sprinkler activation

#3/T1 1/2" PVC pipe - reduced water supply effective with incipient detection? Viking 160° F with ETSR, 2 minutes - actuation when only a slight haze of smoke was evident. Limited water supply was sufficient.

#3/T2 1/2" PVC - Viking 160° F
Fire started in adjoining, unsprinklered closet - loaded with fuel, 4 minutes actuation from heat through open door, sprinkler controlled spread but did not reach fire source to extinguish.

Conclusion

1. Domestic water source can provide economical protection for bedrooms, giving an opportunity to designers to go "beyond the code" to improve life safety.
2. One inch supply should be minimum size.
3. Considerable smoke and toxic products of combustion are generated before actuation of conventional sprinklers; the ETSR in conjunction with a smoke detector optomizes the philosophy of early smoke warning with effective fire suppression.
4. A complete envelope of protection in sleeping occupancies can be provided using domestic water for sprinkler supply and using a smoke detector to activate both individual sprinklers and a corridor pressurization system.

Operation — Air Oven

23. Fusible links shall operate with sharp, positive action under a test load equal to the manufacturer's minimum design load, but not less than 1 pound, with complete release of all operating parts when exposed to air within the temperature and time limits shown in Table II.

24. The operating temperatures of a given model and type of fusible link of like temperature rating shall not vary more than 20° F.

25. A coating, if used, shall not melt, run, or otherwise accumulate on parts at temperatures at or below the operating temperature, in a manner likely to impair operation.

TIME-TEMPERATURE CURVES FOR OVEN TESTS

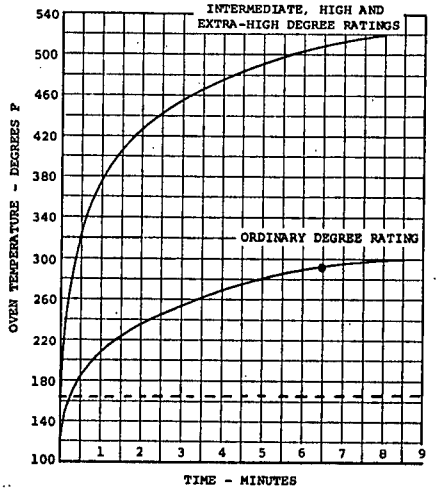


FIGURE 1

TABLE II

OPERATING TEMPERATURE RANGE

Temperature Ratings, Degrees F	Maximum Actual Operating Temperature, Degrees F	Maximum Actual Operating Time, Minutes : Seconds
125–130	245	2:30
135–170	290	6:30
175–225	445	2:30
250–300	475	4:00
325–375	505	6:30

26. At least ten samples of each size and temperature rating shall be subjected to this test.

27. An oven test is to provide for a means of subjecting samples to a rapidly rising air temperature environment where the temperature rise follows a prescribed time-temperature relationship; where the velocity and path of the air stream are controlled and are uniform in the vicinity of the sample; and where other factors influencing heat transfer, such as radiant walls, are maintained practically uniform in their effects.

28. The time-temperature relationships, as shown on the curves, such as those illustrated in Figure 1, are associated only with a particular oven design and method of test.

29. The ovens are made of copper and are provided with a water-circulating jacket. The body of each oven is cylindrical in shape with an internal diameter of 10 inches, an external diameter of 12 inches, and a height of 24 inches. Each oven is fitted with a movable lid which is 10 inches in diameter and 7½ inches in height. The natural-gas-fuel burners are manually controlled and are located at the bottom of the oven, which is open to allow air intake. Air is continuously released from the lid of the oven through a centrally located 3-inch-diameter hole. A 9½-inch-diameter baffle is located ⅝ inch above the air outlet hole to limit the air flow. The unshielded thermocouple used to record the temperature of the oven is made using No. 20 Awg wires, one chromel and one alumel, and is located centrally in the oven.

30. The fusible links are to be placed in the oven under the minimum design load, but not less than 1 pound. Starting from a prescribed ambient situation in the oven, the temperature of the oven is to be increased in the manner prescribed by the time-temperature curve applicable to the test.

31. Observations are to be made throughout the test for conformance with the requirements of paragraph 25. Coatings are to have been melted and run off or otherwise dissipated from the surfaces of operating parts at or below the operating temperature of the sample under test.

32. Observations are to be made and recorded of the time and temperature at which each sample operates and the manner in which the release of parts is accomplished.

APPENDIX III

THE CARLYLE APARTMENT FIRE:

STUDY OF A PRESSURIZED CORRIDOR

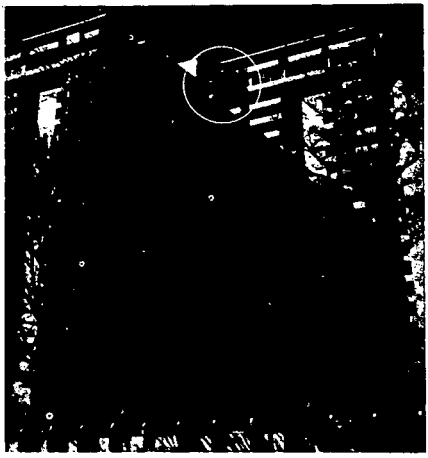


Fig. 1

With pressurization of stairwells and corridors, high-rise fires can be contained and controlled in compartmented buildings. Hopefully, such pressurization will be accepted by all concerned before another disaster occurs with old techniques. This paper was presented at the Symposium, Fire Technology Developments that affect the ASHRAE engineer, held during ASHRAE's 1975 Semiannual Meeting in Atlantic City, NJ. Other papers included: Evacuation and Other Fire Safety Measures in High-Rise Buildings, by Jacob L. Pauls, and Test Results of Duct Stairwell Pressurized System in a High-Rise Building, by Bayliss J. Erdelyi. The entire Symposium will be available on microfiche from ASHRAE Headquarters.

ROBERT E. TAYLOR
Affiliate ASHRAE

UNTIL recently, with few exceptions, if a fire department's ladders could reach the top floor of a building and the pumper could supply enough water for a deluge gun, that was all the pre-fire planning many cities thought necessary. Those life safety measures specified in NFPA 101 and learned through bitter experience were enforced by the building official when buildings were built, but seldom ever reviewed again until a fire occurred. Fire prevention was left to periodic cursory inspections. Then when a tragedy occurred, everybody pointed fingers and for awhile efforts at prevention were practiced.

R. E. Taylor is with Republic Steel Corp., Cleveland, OH.

However, in city after city, now that structures have grown in height far beyond the tallest ladder and in width so wide hose streams cannot span or are stopped by compartmentation, a cry of frustration by firefighters has risen. They ask: "How do we fight a working fire from inside a building and still move people out safely?" Some imply it can't be done.

The tendency is to reach back into the basket of time and pull out so-called tried and true methods of life safety protection such as sprinklers, hose cabinets, vented elevator shafts, and smoke-proof stair towers. Unfortunately, in many cases, practical reality indicates these approaches alone may not be an effective answer — or even a major part of the total answer. Expecially since toxic gases and smoke present an early evacuation life hazard, these methods have never controlled.

Building access, exterior and interior landscaping and design, interior contents, internal communications, available water pressure, fire department manning, automatic-detection — all play a role that needs careful assessment for every high-rise built. These basic points seldom concern themselves with how fast people can evacuate a building, or if evacuation is feasible or necessary. Furthermore, old approaches don't concern themselves with how quickly firemen can actually reach a fire above the 8th floor and still be in a physical condition to work — even under ideal conditions. What happens when people clog the stairs, when smoke and hot fire gases tear at the throat and obscure vision during an actual fire is yet another story.

Then, too, there is the current code tendency to lump all high-rise type of structures together — the apartment, hotel, office building, medical group — yet each is a separate and complex problem in itself. To lump them all under one heading isn't facing reality.

Use of a building's air system for fire fighting was virtually unheard of five years ago. Everyone knew that when a fire started you shut off the supply air and the exhaust. That would control the fire. However, the horrible record of major fires in this country has shown that this practice doesn't work. To give air to a fire was even more radical. You'd fan the flames. You'd see the fire.

Ask the veteran firefighter why he lost his battle in the big ones: Usually he's indicate he couldn't see the fire from the smoke — or couldn't find the fire because he couldn't get through the smoke and heat. He couldn't use the elevator because of "stack effect" rising heat and smoke. When he opened the stairway door (if he could) that was the end of the use of the stairway anywhere above as well.

Even if he could see the fire, he would still retort, "Well I'd like sprinklers up there — they'll handle it!" But he didn't reckon with many of today's materials which, unlike the wood age, often ignore water and go right on burning underneath and filling the air with smoke and very hazardous gases at a rate-of-smoke release far in excess of what wood and celtulosic materials give off.

What does it take to prove that air — working much as a cold front moves against a warm front — can perhaps be the best fire control measure ever designed into a building? Actual experience can. And that's what this fire report is about. A working fire that destroyed 80 percent of the interior of a luxury apartment on the 20th floor of a Lakewood, Ohio, condominium.

The fire occurred at approximately 4:30 a.m. the morning of March 7, 1974. When he discovered the fire, the occupant ran from his apartment with no clothes on and closed the door behind him. What he did for approximately 30 to 40 minutes* no one knows. But during that time, the wood door and wood door frame to the corridor burned off. He finally pounded on some doors and sounded the alarm. He was sitting on the window ledge in the corridor near the elevators when the firemen found him. Everyone

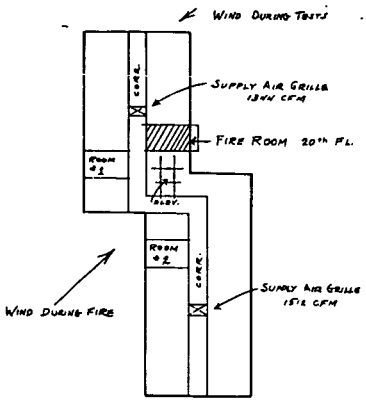


Fig. 2

evacuated safely. In fact, some people walked right by the fire room door and looked in "to see what was burning." Prior to the fire department's arrival, some even took elevators, even though they had been told not to do so in building fire procedure bulletins. Data developed after the fire shows that decision could have been fatal because the fire burned out the elevator control wiring, erroneously placed in his suite instead of the shaft.

A delayed alarm of as much as 40 minutes was involved. Lakewood firefighters had the fire under control 15 minutes after the alarm was sounded. Firemen were able to walk right up to the door of the apartment and attack the blaze using two 1½ inch fog lines.

Unusual was the tightness of the corridor and the almost complete burnout of the suite which occurred with almost no communication to the corridor.

THE FIRE

Let us review the site and see what the fire actually did. Then, we will look at the lessons we have learned from this fire. Fig. 1 shows the exterior view of the 20th floor fire location in the Carlyle. You are looking west.

Fig. 2 is a floor diagram showing the apartment of burnout in relation to the elevators and the other wing of the building. The pressure measurements taken the day after the fire were on the other side of the building in a comparable apartment location due to a 180° wind switch.

Fig. 3 is a close-up layout of the room of origin. Cause was never officially determined, although it was probably in the corner next to the elevator shaft.

Note how the wood door to the fire room burned off. The wood door frame was extensively burned. Wallpaper over the door in the corridor burned. There was almost no extension of fire or smoke into the plenum through the lay-in type ceiling tile fastened in place with hold-down clips (Fig. 4).

Escape of smoke into the corridor did little smoke damage.

* From nature of fire damage to the suite.

Note door width radiant heat marks on the wall across from fire room (Fig. 5).

Wallboard and studs against the elevator shaft in the kitchen were very heavily damaged. The EMT conduit and steel pipe were not damaged. Zinc couplings used with the EMT conduit disappeared (Fig. 6).

The living room alcove was extensively damaged (Fig. 7). Fire extended through the hole in ceiling corner to the suite above after the ceiling tile failed.

Fig. 8 shows that the insulated piping did not fail. The interior partition wall surrounding the pipe and separating the living room from the bedroom was 90 per cent destroyed. This wall was gypsum board on wood studs.

Glass fiber ductwork used with the kitchen fan failed even though glass fiber batting used for fire stopping around the vertical pipe stayed in place (Fig. 9).

The north corner of the balcony separation wall suffered severe concrete spalling. The aluminum window frames and glass virtually disappeared.

Our next step was to run static pressure tests on various floors under as comparable wind and temperature conditions as we could get to approximate conditions existing the night of the fire. Pressure differentials were taken in the fire room and at a comparable location in the next wing the day after the fire. There was a difference in measurements taken the day of the fire and several days later.

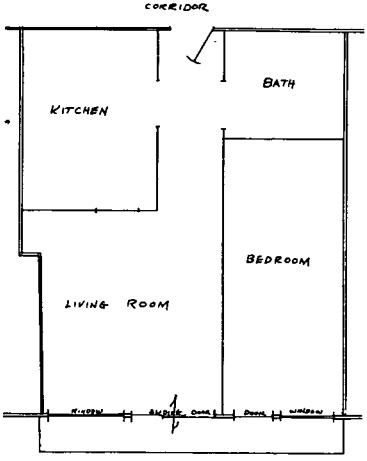


Fig. 3

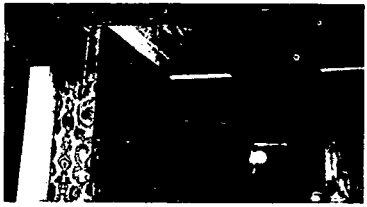


Fig. 5

Fig. 6

Fig. 4

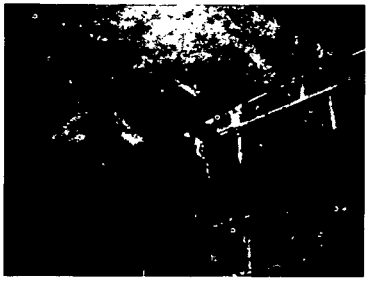


Fig. 7

On the day of the fire, air pressure differentials were taken at the former window ledge dividing the balcony from the living room. A pressure of 0.11 inches water column was developed with the fire room door open to the corridor and the plywood window coverings in place.

To approximate the volume of airflow through the fire room door the night of the fire, air velocity readings (in feet per minute) across the open doorway of an intact room in the other wing of the 20th floor were taken. The airflow was between 200 and 450 feet per minute measured at three heights with the window door to the suite open and the corridor door open.

Fig. 8

Fig. 9

THE LESSONS LEARNED

At a later date, pressures were taken on the 4th floor and 20th floor to confirm our findings. This is what we found:

- The 4th floor static pressure was .035" w.c. between the outside and the corridor, with the corridor being *low* pressure (negative).
- The 20th floor pressure was .030" w.c. between the corridor and the outside, with the corridor being *high* pressure (positive).
- The make-up air system on the 4th floor delivered 356 cfm with all doors closed. When one room was opened to the outside, the flow reversed and air flowing through the room from the outside was entrained into the make-up air system in the corridor.
- The make-up air system delivered 1329 cfm to the 20th floor with all doors closed. With one room open to the outside, the supply air increased to 1563 cfm.

This data tends to confirm work done by the Canadian Building Research Council and others. It shows:

- Fire on a lower floor below the neutral plane can be spread into a corridor by the airflow.
- Smoke from floors below the neutral plane can be spread to upper floors by entertainment into the supply air system if the system is not balanced to provide a positive supply to all floors under all conditions.
- Fire on upper floors can be contained in the fire room of origin by the airflow from a positively pressurized corridor.
- Smoke on upper floors will be forced outside.
- Comparison of later test data to data the day of the fire indicates that weather can have significant effect on the pressures in the building.

From this study it would appear that:

1. Positive pressurized corridors using a "make-up" air system can contain a fire within a suite if:
   (a) The system is properly balanced, or
   (b) The fire occured in a suite above the neutral plane.

The system should be designed to serve only a few floors at a time. Stacking 10, 20, or more floors on a common shaft probably would not be practical since effective balancing for both fire and non-fire conditions may be impossible to achieve.

2. With pressurized corridors the following are essential:
   (a) Stairwells should be pressurized more than corridors to keep smoke and fire gases out of stairwells. Vents at the top of the elevator shafts should be closed.
   (b) Noncombustible corridor construction, including doors, door frames, door hardware, acoustical ceilings, wall coverings and service conduit and pipe is critical since radiant heat is a factor despite pressurization.
   (c) Corridor exhaust systems should be of a noncombustible material.
   (d) Suite exhaust systems should be noncombustible if not going directly to the outside.
   (e) All corridor doors should have automatic self-closers.
   (f) Each fire compartment should have exterior windows or vents.

This study also indicated that sprinklers would be of dubious value in a properly pressurized corridor.

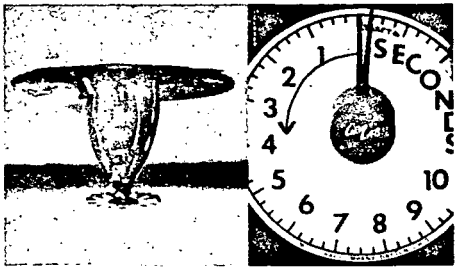
Positive air supply at approximately 0.10 inches of water pressure kept this fire out of the corridor even though the door had failed. It may be that requirements for 0.15 inches of water may be excessive in such buildings.

The best confirmation that corridor pressurization works comes from the firemen themselves. Lakewood firemen walked right up to this fire, watched it for a moment, then put it out. In a non-pressurized corridor, this fire could have spread to the entire 20th floor and to the several penthouses above.

Several months later in a fire at the apartment next door on the roof (or 31st floor), it took almost 30 self-contained breathing air packs for the firemen to get up the stairs to a fire in a storage room due to heavy smoke. They now know the difference that air — properly used — can make in controlling severe fires. They are now believers.

A great deal of further work needs to be done. But the day when turning off the air as a fire alarm goes off hopefully is near an end. With pressurization of stairwells and corridors, high-rise fires can be contained and controlled in compartmented buildings. Hopefully, such pressurization will be accepted by all concerned before another disaster occurs with old techniques. We have much of the answer — and a better answer from a life-safety standpoint. Isn't it time it is used more widely? □□

"HOT HEAD"

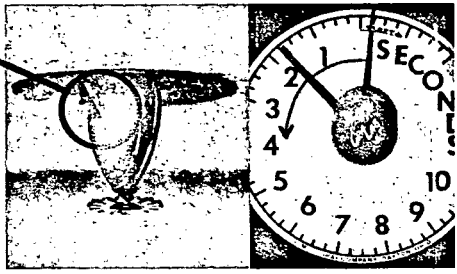


WHO?

All of you. All of us must be more concerned about life safety in buildings because of lethal gasses released from heating and burning contemporary furniture and building materials.

WHAT?

An electrically initiated chemical reactor to melt the sprinkler fusible element.

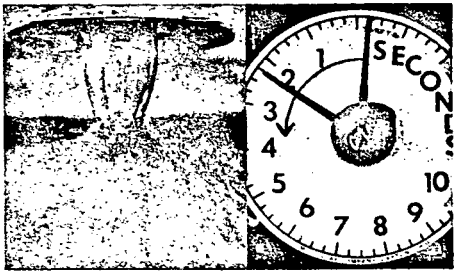


WHY?

To extinguish fires upon smoke detection, long before smoke kills and fire grows enough to fuse the sprinkler.

WHEN?

Within three seconds after the detector senses an incipient fire.



WHERE?

Wherever concern for life safety exceeds potential losses from water damage.

S•R products inc. p. o. box 308, mendenhall, pennsylvania 19357/(215) 388-7661

THE CHALLENGE

Report to the Safety to Life Committee (NFPA Std 101) by Sectional Committee on Institutional Occupancies
(Underlining by S R Products)

Selected Findings:

"We did find many instances of single fire death losses in all institutions whether they were in complete conformance with the code or whether they had a complete automatic sprinkler system or not."

"Smoke and toxic gasses, rather than burns, cause by far the greater majority of deaths in institutions."

"No building is fireproof. They can all burn, or at least their finishes, furnishings, decorations and other contents can, thereby affecting the life safety of occupants."

"Many fires result in loss of life because fires were not immediately detected, or because life saving measures and fire suppression were commenced too late."

"Evacuation cannot be relied upon in institutions as a satisfactory means of protecting life safety from fires."

A Few Conclusions:

"The majority of institutional occupants should be protected in their own rooms."

"Compartmentation is a highly effective means of preventing multiple loss of life due to fires."

"Complete automatic extinguishment systems are also highly effective in preventing multiple fire death losses."

"To require both strict compartmentation and complete automatic extinguishment would not only be redundant, but would lead to greatly increased costs. Trade-offs are, therefore, of great importance.

"Neither system will protect against the single fire death loss."

"A reasonable compromise would be to require a system of early warning detection which reacts to products of combustion, other than heat."

Implementation:

"The next chore of the Sectional Committee was to determine how much life safety would be enhanced by installation of a complete automatic extinguishing system in nursing homes and in other health care institutions. Its investigations gave clear evidence that smoky fires, as in mattresses or upholstery, have burned for periods on the order of an hour, producing lethal quantities of smoke with heavy proportions of carbon monoxide without enough heat development to actuate a sprinkler head. It concluded that one ideal solution would be a system that could detect products of combustion (other than heat) for the actuation of only the sprinkler head immediately over the smoldering source of smoke, without flooding other areas, a technically feasible but not economically nor industrially available product."

"Nevertheless, the Sectional Committee accepted the fact that ordinary automatic extinguishment is desirable when it can be made economically attractive. Therefore, with encouragement from the Committee on Safety to Lief, the Sectional Committee set out to find safe ways to maintain performance capabilities of required barriers to smoke and fire spread that would result in construction savings to help pay for a complete approved system of fire extinguishment. It concluded that its decision had to be based on the life protection integrity of the residual quality of compartmentation balanced against the calculated effectiveness of fire suppression by the extinguishment system supplied in lieu of the reduced compartmentation requirements."

THE RESPONSE

The Hot Head® was developed specifically to fill the need to economically protect against the single life loss, hitherto unprotectable. It is a high intensity jet arranged to activate standard sprinkler heads by the use of a smoke detector or any other electrical switching device. Electrical response to the signal is instantaneous, initiating a chemical reaction which melts the sprinkler's fusible element within three seconds. Any smoke, heat, rate of rise, ionization detector or any other switch may be used to control it.

The Hot Head is compatable with all major upright, pendant and sidewall sprinkler designs. The operating range is 6 to 30 volts AC or DC, one ampere trip current required, with a 2 millisecond (.002) response at 24 volts. It will operate sprinkler ranges from 135°F to 212°F (57°C to 100°C) yet, if there is no electrical signal, the sprinkler will operate in its normal, thermal manner with no interference from the Hot Head. It is installed "dry", after the sprinkler system is installed and pressure tested. The sprinkler system, new or existing, is always "on stream" during the installation of Hot Heads. The Hot Head has been tested to operate from —40°F to +175°F (—40°C to +80°C) and it meets Underwriters' Laboratories, Inc. Standard for Sprinklers (UL199) in respect to Operation, Distribution, Corrosion and Vibration.

S•R products inc. p. o. box 308, mendenhall, pennsylvania 19357/(215) 388-7661 ETSR 474-5M

APPENDIX II

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Federal Fire Safety Requirements Do Not Insure Life Safety In Nursing Home Fires

Department of Health, Education, and Welfare

Two Chicago nursing home fires killed 31 people during early 1976. GAO was asked to investigate reasons for the severity of the fires and to suggest possible actions to avoid similar situations.

GAO reported that experts said automatic sprinkler systems would have extinguished the fires and saved lives. GAO recommends that the Congress enact legislation requiring all nursing homes to be fully protected with automatic sprinkler systems.

MWD-76-136

JUNE 3,1976

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses Federal fire safety requirements for nursing homes participating in Medicare and Medicaid.

We made our review at the request of Claude Pepper, Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging. The Chairman's request was prompted by 2 nursing home fires in the Chicago area early in 1976 in which 31 patients died.

Two recommendations for legislative action are included in the report.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; and the Secretary of the Department of Housing and Urban Development.

ACTING Comptroller General
of the United States

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HUD	Department of Housing and Urban Development
ICF	intermediate care facility
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

FEDERAL FIRE SAFETY REQUIREMENTS DO NOT INSURE LIFE SAFETY IN NURSING HOME FIRES

Social and Rehabilitation Service
Department of Health, Education, and Welfare

D I G E S T

As a result of two nursing facility fires that killed 31 people during early 1976, the Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked GAO to investigate reasons for the severity of the fires and to suggest possible actions to avoid similar situations. (See app. I.)

According to reports of investigations:

--Multiple deaths occurred in these and several fires in prior years even though the buildings were of fire resistive construction and were in substantial compliance with the Federal fire safety requirements. (See p. 11 and app. III.)

--Deaths were caused by smoke and products of combustion rather than by flames because the flames were confined to the rooms of origin. (See p. 9.)

--Neither facility was fully protected with an automatic sprinkler system designed to activate an alarm and begin fighting the fire immediately. (See pp. 5, 6, and 7.)

--Although local fire departments responded promptly to both alarms, the fire departments were unable to prevent the deaths which occurred. (See pp. 6, 7, and 8.)

--Facility employees tried to evacuate residents and extinguish the fires, but in neither case were they successful in preventing death or extinguishing the fires. (See pp. 6 and 8.)

--Although a short period of time elapsed from the identification of the fires to

the arrival of the fire departments, the fires generated intense heat, resulting in considerable fire damage to the rooms in which the fires originated. (See pp. 7 and 9.)

--Experts said automatic sprinklers would have prevented the deaths in these homes. (See p. 12.)

Studies by congressional committees, a fire safety engineering firm, a special investigative committee, and others have pointed out the need for and the benefits of automatic sprinkler systems in nursing facilities. (See pp. 12, 15, 16, and 18.)

GAO determined that the cost of sprinkler system installations ranged from $393 to $625 a bed. The amortized cost of $625 over a 20-year period with a 9-1/4 percent interest rate is $5.57 a bed each month, or about 19¢ a bed each day. (See pp. 19 and 20.)

With the installation of a sprinkler system, savings on nursing facility fire insurance premiums are possible on both the building and its contents. Through reimbursement for depreciation and interest, Medicare and Medicaid will pay for part of the cost of sprinkler system installation. (See pp. 20, 21, and 22.)

The program which authorized the Department of Housing and Urban Development to provide Federal loan insurance for the installation of fire safety equipment has not been utilized. GAO believes that excessive processing time by HEW and the Department of Housing and Urban Development procedures, which prohibit loan insurance after work has begun, contribute to the problems facing nursing facilities applying for loan insurance. (See pp. 25 and 26.)

GAO recommends that the Secretary of HEW minimize the problem of excessive processing time by establishing procedures which make better use of existing survey and certification documents. (See p. 32.)

GAO recommends that the Secretary of Housing and Urban Development

--establish regulations to permit fire safety equipment loan insurance after work has begun (see p. 33) and

--publicize the availability of the fire safety equipment loan insurance program by revising the nursing home brochure dealing with nursing home mortgage insurance (see p. 33).

Because congressional hearings were scheduled, the chairman's office requested that GAO not delay the report to get formal comments from HEW and the Department of Housing and Urban Development. Informal comments from agency officials were considered where appropriate in this report. The National Fire Protection Association and the National Fire Prevention and Control Administration of the Department of Commerce agreed with GAO's recommendations to the Congress. (See apps. VI and VII.)

RECOMMENDATIONS TO THE CONGRESS

GAO believes that a strong case can be made for requiring that all nursing facilities be fully protected with automatic sprinkler systems. Therefore, in line with previous recommendations of congressional committees, we recommend that the Congress enact legislation which will require that all nursing facilities be fully protected with an automatic sprinkler system. The Congress should require HEW to establish rigid standards which must be met by nursing facilities requesting waiver from the automatic sprinkler requirement. (See pp. 22 and 23.)

CHAPTER 1

INTRODUCTION

In January 1976 a Chicago nursing home fire killed 23 people. Within a week, another nursing home fire just outside Chicago claimed the lives of eight people.

In his letter of February 20, 1976, the Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked us to investigate reasons for the severity of the fires and to suggest possible actions to avoid similar situations. He also asked us to investigate:

--The fires and determine if automatic sprinkler systems would have put out the fires or lessened their severity in these facilities.

--The facilities in Chicago and determine if they met the Life Safety Code requirements for participation in federally financed health programs.

--The Department of Health, Education, and Welfare's (HEW's) enforcement of fire safety standards in Chicago and elsewhere.

--The State inspections of the Chicago facilities in question and HEW's validation of those inspections.

--The State inspection procedures including the qualifications of the inspectors.

--The quality of trained personnel assisting patients during the fires.

--The implementation of Public Law 93-204, approved December 28, 1973, which authorized federally insured loans to provide fire safety equipment for nursing homes and intermediate care facilities.

NURSING HOMES IN FEDERAL PROGRAMS

There are about 16,500 nursing homes, referred to as skilled nursing facilities (SNFs) or intermediate care facilities (ICFs), depending on the level of care provided, participating in the Medicare and Medicaid programs.

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program in which the Federal Government pays part of the costs (50 to 78 percent) incurred by States in providing medical services to persons

who are unable to pay. At the Federal level the Medicaid program is administered by the Social and Rehabilitation Service (SRS) within HEW.

States have the primary responsibility for initiating and administering their Medicaid program under the Social Security Act. The act requires that State Medicaid programs provide SNF services. However, services in ICFs which provide care to patients that do not require skilled nursing services are an optional Medicaid service.

Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also pays for all covered services in a SNF for the first 20 days after a hospital stay and all but a certain amount a day, up to 80 additional days, during a benefit period. ICFs do not participate in Medicare.

About 7,500 SNFs are participating in Medicaid, about 4,300 of which also participate in Medicare. In addition, about 9,000 ICFs participate in Medicaid. During fiscal year 1975, Federal and State Medicaid payments for SNF and ICF services were $4.6 billion, and Medicare payments for SNF services were $257 million.

CERTIFICATION PROCEDURES

Standards have been established by law and regulation which must be met by all nursing facilities participating in Medicare or Medicaid. The Federal requirements on fire safety have incorporated the Life Safety Code, established by the National Fire Protection Association.

HEW regulations require that each nursing facility certified for Medicare or Medicaid be inspected at least annually by State inspectors (employed by State agencies having contracts with the Federal Government) to determine whether the facility is in compliance with Federal requirements, including the Life Safety Code. Facilities not in full compliance with the fire safety standards may be certified for limited periods under both programs while corrections are being made.

Current HEW regulations for both Medicare and Medicaid provide for canceling a nursing facility's certification if deficiencies noted during the inspections have not been corrected within a specified time, including approved extensions.

THE LIFE SAFETY CODE

The Life Safety Code is established by the National Fire Protection Association. The primary function of the Association's Committee on Safety to Life has been to study and analyze the causes of fires involving loss of life. The code, which is based on established standards for various types of construction, is revised periodically. The latest edition was published in 1973.

The Social Security Amendments of 1967, effective January 1, 1970, require SNFs to comply with the 1967 edition of the Life Safety Code to participate in Medicaid. In October 1971 HEW extended that requirement to Medicare SNFs. Public Law 92-603, enacted October 30, 1972, incorporated in titles XVIII and XIX of the Social Security Act the requirement that Medicare and Medicaid SNFs comply with the 1967 Life Safety Code. Federal regulations requiring ICFs to meet this code became effective March 18, 1974. Nursing facilities entering the program on or after June 1, 1976, are required to meet the 1973 edition of the code, as provided in Public Law 94-182, enacted December 31, 1975.

The code requires automatic sprinkler protection throughout all nursing facilities, except those of 2-hour 1/ fire resistive construction or one story, 1-hour protected noncombustible construction. The fire resistance rating of building construction varies with the susceptibility to fire damage of the building materials used and the degree of fire protection provided for the structural members.

A building classified as 2-hour fire resistive construction is one in which the structural members, including walls, partitions, columns, floors, and roofs, are of materials having fire resistance ratings ranging from 1-1/2 to 4 hours as required by the National Fire Protection Association standards.

A building may be classified as 1-hour protected noncombustible if it is constructed of materials having a minimum fire resistance rating ranging from 1 to 2 hours.

1/The National Fire Protection Association defines the ratings of building materials in terms of hours. The ratings are the result of standard fire tests in which the materials are subjected to controlled fire conditions. The performance is based on the length of time the materials maintain their structural integrity and expressed as 2-hour, 6-hour, 1/2-hour, etc.

The requirements for these two classifications are directed toward limiting the spread of fire and maintaining the building structure to permit adequate time to safely evacuate nursing home patients.

The Social Security Amendments of 1967 permit a waiver, in accordance with regulations established by the Secretary of HEW, of specific Life Safety Code provisions, including the automatic sprinkler requirement. A waiver may be issued for specific Life Safety Code provisions which, if rigidly applied, would result in unreasonable hardship on a nursing home. Such a waiver, however, will be granted only if it will not adversely affect the health and safety of the patients.

SNF waivers under Medicare have always been issued by HEW. Initially, waivers of the Life Safety Code standards for Medicaid facilities were issued by State Medicaid agencies in accordance with HEW criteria. The Social Security Amendments of 1972, however, transferred this authority to HEW.

Under current procedures the States make recommendations for both Medicare and Medicaid SNF waivers relating to fire safety standards, but HEW regional directors make the final decisions. Waivers of Life Safety Code standards are issued by State agencies for ICFs.

Federal loan insurance for nursing home fire safety equipment

The Congress enacted Public Law 93-204 on December 28, 1973, which authorized the Secretary of the Department of Housing and Urban Development (HUD) to insure loans made to nursing facilities for purchasing and installing fire safety equipment, including automatic sprinkler systems.

SCOPE OF REVIEW

Our review included work at the regional offices of HEW and HUD in Chicago, Illinois; the Illinois State Fire Marshal's office; and the Illinois State Medicaid Agency. Work was also done at HEW and HUD headquarters in Washington, D.C.

In addition to the two nursing home fires in the Chicago area, we obtained information on other nursing home fires for comparison. We also obtained information from various other studies and reports on nursing home fires and fire safety.

CHAPTER 2

NURSING FACILITY FIRES

IN CHICAGO

On January 30, 1976, and February 4, 1976, fires occurred at the Wincrest and Cermak nursing facilities, respectively, which resulted in the deaths of 31 patients. Both institutions were intermediate care facilities participating in Medicaid. According to reports of investigations, these deaths occurred even though

--the nursing facilities substantially met Federal fire safety requirements,

--the fire departments responded promptly to the alarms, and

--the construction of the buildings adequately confined the flames to the rooms of origin.

The deaths were reported to be caused by smoke and toxic gases rather than by flames. No fatalities occurred in the rooms of fire origin. Investigators of these fires stated that sprinkler systems would have prevented deaths in these nursing facilities; however, both facilities were classified as fire resistive and, under the Life Safety Code, were exempt from the automatic sprinkler requirement.

WINCREST

The Wincrest Nursing Home fire occurred on the third floor of the facility during the morning of January 30, 1976. (See app. IV.) Wincrest, an ICF in Chicago, has 28 sleeping rooms which can accommodate 88 permanent residents. The residents included Medicaid patients.

At the time of the fire, Wincrest had the following fire safety devices (see app. IV):

--Three alarm systems: (1) pull box, (2) heat detectors (both of which activate alarms to the Chicago Fire Department and to the nursing home staff) and (3) smoke detectors which activate an alarm only to the nursing home staff. The three alarm systems were activated at approximately the same time.

--Three portable fire extinguishers.

--A public address system.

--A battery-operated emergency lighting system (not a significant factor because the fire occurred during daylight hours). The system reportedly would not have functioned properly because smoke residue covered and the heat had melted the plastic hoods on the lights.

--Solid core doors to residents' rooms--authorities considered these adequate to stop the fire, heat, and smoke if the doors were closed.

--Fire resistive floors, walls, and ceilings. These were not penetrated by the fire, although the wall coverings did burn.

At the time of the fire, 83 aged residents (many confined to wheelchairs) occupied the home. When the fire occurred, five nursing home attendents, a priest, and 40 residents were on the third floor of the home. Approximately 28 of the 40 residents were attending a religious service in the third floor lounge-chapel. The lounge-chapel did not have a door and was open to the corridor. (See app. IV.)

A nurse's aid discovered the fire in room 306, at the approximate center of the single corridor which serves the third floor (see app. IV), at about 11:40 a.m., summoned the priest, and activated a pull-box fire alarm. Initially the priest, and later two maintenance men and an administrator, attempted to put out the fire with fire extinguishers but could not contain the fire. Intense smoke and heat forced them to abandon the room after attempting to close the door to the corridor. The attendants and others began concentrating on evacuating residents from the lounge-chapel and the third floor.

The Chicago Fire Department arrived at about 11:46 a.m., approximately 3 minutes and 40 seconds after it received the alarm. In response to the first alarm, the fire department dispatched 39 firemen with 7 trucks (4 pumpers, 2 hook and ladders, and 1 snorkel). Upon arrival of the fire department, intense smoke on the third floor was already affecting elderly residents (some residents were gasping or unconscious). In response to a special call, 18 more firemen arrived at 12:01 p.m. with special equipment including another snorkel truck. In response to a second alarm, 44 firemen arrived at 12:04 p.m. with 1 helicopter, 1 communication van, and 8 trucks (4 pumpers, 2 hook and ladders, and 2 water cannon turrets).

In response to special calls, the fire and police departments and private organizations dispatched 10 ambulances to the home. The ambulances and four fire department automobiles transported the injured to hospitals.

As of February 20, 1976, 23 nursing home residents had died from smoke inhalation. The majority of which were in the lounge-chapel area at the time of the fire.

The fire destroyed room 306 and caused significant damage in the corridor. Moderate fire and intense smoke and heat damaged the corridor, the lounge-chapel (which did not have doors) and sleeping rooms in which the doors were open during the fire. Sleeping rooms in which the doors were closed during the fire did not incur smoke or heat damage.

CERMAK HOUSE

The Cermak House Nursing Home fire occurred in room 421 on the fourth floor early in the morning of February 4, 1976. (See app. V.) Cermak House is an ICF in Cicero, Illinois, adjacent to Chicago, and can accommodate 618 residents. The residents included Medicaid patients.

At the time of the fire, Cermak House had fire safety devices which included (see app. V):

--Two alarm systems: (1) pull-box and (2) smoke detectors (both of which were wired to activate alarms to the Cicero Fire Department). The smoke detectors automatically closed hall smoke doors.

--Fire extinguishers and fire hoses on each floor. Because of operator error, the fire hose on the fourth floor did not operate.

--A public address system which was used to notify nursing home staff of the fire and its location.

--Solid core doors to residents' rooms--authorities considered these adequate to stop the fire, heat, and smoke if the doors were closed.

--A sprinkler system on the first floor, with vertical pipes to the other eight floors. According to a Cermak House official, horizontal pipes and sprinkler heads of the upper floors had not been installed because of financial consideration.

According to a patient census the previous night, 460 persons occupied the nursing facility; 24 persons could have been accommodated in the fourth floor west wing in which room 421 was located.

At about 6:30 a.m. a nurse and a nurse's aide heard screams and discovered the fire in room 421. While the aide activated the pull-box alarm, the nurse evacuated two of the residents from the room. The third occupant was not in the room at the time of the fire. A security guard who responded to the alarm attempted to extinguish the fire--first with a fire extinguisher and second with a hose which he did not operate properly--but abandoned the attempt when he was overcome by smoke. Two maintenance employees directed water on the fire from a hose operated through a fifth floor window but they could not extinguish the blaze.

The Cicero Fire Department arrived promptly at 6:44 a.m. to the alarm activated by smoke detectors on the fourth floor.

The smoke detectors automatically closed smoke doors at the entrance to the corridor and contained the heat and smoke in the west wing of the nursing home. Although room 421 was adjacent to the smoke doors, residents did not sustain injuries nor did damage occur outside the smoke barrier on the west wing. Eight residents died from smoke inhalation in west wing sleeping rooms where doors to the rooms were open at the time of the fire. Smoke and heat damage also occurred in these rooms and in the corridor. In another west wing sleeping room where the door was closed during the fire, residents did not sustain injuries and little property was damaged.

Officials of the Illinois Fire Marshal's office initially attributed the fire to a faulty electric cord on a nightstand lamp and, at the time of our fieldwork, were continuing to investigate other possible causes.

SEVERITY OF THE FIRES

An official of the Illinois Fire Marshal's office attributed the severity of the fires at Wincrest and Cermak to (1) steadily burning fires, (2) combustion of gases trapped by the upper walls and ceilings in the fire rooms (flashovers), and (3) ejection of flames and lethal smoke from burning plastic and vinyl in the rooms where the fires originated.

At both Wincrest and Cermak, steadily burning fires in freestanding wood wardrobes generated intense heat, resulting in considerable fire damage to the rooms in which the

fires originated. Heavy smoke damaged the corridors, lounge-chapel at Wincrest, and resident rooms with open doors.

At Wincrest most of the fatalities occurred in the lounge-chapel area which did not have a door and into which lethal smoke traveled. The lounge-chapel was not damaged by flames; however, the plastic covers on the ceiling light fixtures were melted by heat.

At Cermak, the fatalities and damage occurred in resident rooms with doors open to the corridor.

The fires at both facilities burned material which generated toxic smoke. At Wincrest, the fire burned vinyl chloride wall and mattress covers. Combustion of vinyl covers generated hydrogen chloride gas, which sears lung tissue. At Cermak, the fire burned polyurethane foam (foam rubber) mattresses. Combustion of foam rubber generates hydrogen cyanide gas. According to experts of the National Fire Prevention and Control Administration of the Department of Commerce, all common combustible materials can generate lethal quantities of carbon monoxide when subjected to fire. Medical evidence was not available to us which could identify the specific products of combustion that were primarily responsible for the deaths.

According to a study made by a nursing home association and an engineering firm under contract to the Department of Health, Education, and Welfare, wood wardrobe fires in simulated nursing facility rooms can cause flashovers within 5 minutes after ignition. The nursing home association and engineering firm based this conclusion on an experiment which they conducted for HEW to test the 1967 Life Safety Code.

COMPLIANCE WITH FIRE SAFETY STANDARDS

In Illinois, the State Fire Marshal's office surveys skilled nursing facilities and the Department of Public Health surveys ICFs for fire safety.

The Illinois Fire Marshal's office has a staff of 44 inspectors to survey SNFs. The inspectors have fire-related backgrounds, such as work experience as firemen or a degree in fire technology. New inspectors receive classroom and on-the-job training, including training in the Life Safety Code, before making inspections. All inspectors receive fire safety training each month.

Inspectors normally spend 1 to 1-1/2 days annually inspecting SNFs for compliance with the Life Safety Code and

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State laws. Inspectors followup on deficiencies at 30-day intervals until they have been corrected.

The Illinois Department of Public Health inspectors make annual health and safety surveys of ICFs. The Department's architectural section has 14 registered architects and 2 engineers who make fire safety surveys. The Department trains its inspectors, using the Life Safety Code, and gives them on-the-job training before placing them in charge of inspections.

While we did not evaluate the quality of the State inspections or the adequacy of training provided to inspectors, we believe that these areas are critical in the enforcement of fire safety requirements in nursing homes, as pointed out in our report, "Many Medicare and Medicaid Nursing Homes Do Not Meet Federal Fire Safety Requirements," MWD-75-46, dated March 18, 1975.

Inspectors usually inspect a facility in 1 day and revisit facilities within a specified period to verify correction of serious deficiencies. Inspectors followup on minor deficiencies by correspondence or during the next annual inspection.

The HEW regional office conducts validation reviews, which are surveys of facilities to insure the adequacy of the State inspections. These validation reviews are made in facilities selected at random. The HEW regional office has one team which surveys, on a random basis, selected facilities from the 3,600 SNFs and ICFs in the region.

The regional office team did not survey either Wincrest or Cermak House because neither home had been included in the survey sample.

In addition, the City of Chicago makes fire safety inspections of SNFs and ICFs. The Chicago Fire Department, Bureau of Fire Prevention, is responsible for inspecting the 129 SNFs, ICFs (including Wincrest), and other types of nursing homes in Chicago. The department uses the Chicago Municipal Code for fire prevention rather than the Life Safety Code. Within the Bureau a specially trained department captain and 11 lieutenants are responsible for inspecting institutional facilities, such as hospitals and nursing homes. The fire department requires lieutenants who are assigned to the Bureau of Fire Prevention to attend a fire safety course at the Chicago Fire Academy.

The results of recent State inspections at Wincrest and Cermak House indicated that both facilities were in substantial compliance with existing fire safety standards.

Wincrest

The Illinois Department of Public Health noted two deficiencies at the Wincrest ICF in its December 1974 fire safety survey. According to Department documents, Wincrest corrected both of the deficiencies in April 1975. Department officials told us in February 1976 that Wincrest had substantially complied with the Life Safety Code at the time of the fire.

The Chicago Fire Department's Bureau of Fire Prevention inspected Wincrest six times in 1975, noted two deficiencies which were corrected in October 1975, and did not note any further fire safety violations in the October, November, and December inspections. According to Bureau officials, Wincrest had no known deficiencies at the time of the fire. The Mayor of Chicago's special investigation committee concluded that Wincrest had complied with exising regulations.

Nurses, nurse's aides, the administrator, two maintenance men, and a priest assisted Wincrest residents during the fire. According to an Illinois Department of Public Health report, Wincrest holds a minimum of 12 fire drills annually, including simulated fire conditions and transmission of fire alarms. According to Chicago Fire Department officials, Wincrest employees responded properly to a simulated fire emergency situation during the December 1975 inspection.

Cermak House

The Illinois Department of Public Health noted 10 deficiencies at Cermak House in its December 1975 fire safety survey. On February 7, 1976, 3 days after the fire, the Illinois Fire Marshal officials, in a special investigation of Cermak House, noted 5 deficiencies under the Life Safety Code and 27 conditions which needed to be corrected under Illinois rules and regulations.

According to Illinois Department of Public Health and Fire Marshal officials, the deficiencies noted in the inspections before and after the fire did not contribute to the ignition or the severity of the fire.

A nurse and nurse's aide, two maintenance men and others assisted residents during the fire.

According to the Illinois Department of Public Health and the Fire Marshal's surveys, Cermak House holds a minimum of 12 fire drills annually, including simulations of emergency fire conditions and transmission of fire alarms.

INVESTIGATION FINDINGS ON SPRINKLER SYSTEMS AND OTHER FIRE SAFETY MEASURES

Sprinkler systems

According to officials of the Illinois Fire Marshal's office, sprinkler systems prevent flashovers because they prevent the accumulation of excessive heat on the upper walls and ceiling. In the opinion of Chicago Fire Department officials, sprinkler systems provide the best fire protection because they signal the fire location and immediately spray 22 gallons of water a minute on fires which activate the system. Fire department officials believe sprinkler systems would have extinguished the fires at Wincrest and Cermak and prevented deaths.

After its investigation of the Wincrest fire, a special panel appointed by the Mayor of Chicago recommended that new requirements immediately be made part of the Building and Fire Ordinance of the City. One requirement was that sprinkler systems be installed in all new and existing nursing homes and be electrically interconnected with the fire alarm system.

On February 4, 1976, the Mayor of Chicago asked the City Council to require all nursing homes to have automatic sprinkler systems. The ordinance was introduced only a few hours after the Cermak fire. On April 7, 1976, this ordinance was approved by the City Council. It requires all Chicago nursing homes to install sprinkler systems by February 1977.

According to an HEW engineer's report on the Wincrest fire, "the only alternative to a well trained staff is a complete sprinkler system, smoke compartments, and smoke detectors." Of the two Chicago area fires, another HEW report stated:

> "The facilities in each case were of fire resistive construction, but failed to provide reasonable protection. There is a need for several fire safety measures which exceed current regulations."

Furnishings

According to a report by an official of the Illinois Fire Marshal's office which was presented at hearings in Illinois, "the Wincrest and Cermak House fires demonstrate that ignition of coverings and furnishings can turn nursing facilities into gas chambers." Other Illinois officials indicated that Federal standards are needed to regulate furnishings used in nursing facilities.

Fire emergency training

Illinois and local (Chicago) municipal officials emphasized the importance of fire emergency training of nursing facility employees. The committee, appointed by the Mayor of Chicago, recommended that nursing facility employees, in addition to existing training programs, be required to participate in formal fire department emergency training every 6 months.

CONCLUSIONS

--Both nursing homes substantially met the Federal fire safety requirements and were classified as fire resistive, but people still died as a result of the fires.

--The building construction adequately confined the flames to the rooms of origin.

--The deaths were caused by smoke and other products of combustion rather than flames.

--The fire departments, which responded promptly to the alarms, were unable to prevent the nursing home deaths.

--Efforts by nursing home staffs to extinguish the fires and prevent the loss of lives were unsuccessful.

--The fires created a lethal environment in a very short time.

--Experts investigating the tragedies said that automatic sprinkler systems would have saved lives in these fires.

CHAPTER 3

AUTOMATIC SPRINKLER SYSTEMS PUT OUT FIRES AND SAVE LIVES

Many studies and reports have concluded that automatic sprinkler systems are effective in putting out fires and saving lives. About one-half of the nursing homes participating in Medicare and Medicaid are not required, because of construction classification, to be protected with automatic sprinkler systems. Historically, nursing home fires resulting in multiple deaths have had two conditions similar to the Wincrest and Cermak House fires--the primary causes of death were smoke and other gaseous products of combustion, and the facilities did not have complete automatic sprinkler systems. Since 1972 several congressional committee reports have recommended that all nursing facilities be fully protected with automatic sprinkler systems. We believe that a strong case can be made for adopting such a proposal.

The cost of installing automatic sprinkler systems will vary with factors such as building size, type of construction, method of installation, and whether installation is in existing buildings or those under construction. In several installations during 1975, the cost ranged from $393 to $625 a bed. The monthly cost of amortizing $625 a bed over a 20-year period at a 9-1/4 percent interest rate is $5.57 a bed each month, or about 19¢ a bed each day.

By installing an automatic sprinkler system, some savings are possible on fire insurance for both the building and its contents. In the Washington, D.C., area, estimates on these savings are up to 30 percent on building coverage and 50 percent on contents insurance, depending on type of construction. In addition, Medicare and Medicaid will bear a share of the cost of sprinkler systems through payments on behalf of program beneficiaries.

CURRENT FEDERAL STANDARDS AND AUTOMATIC SPRINKLERS

The Life Safety Code requires, with some exceptions, that all nursing facilities be fully protected by automatic sprinkler systems. Those nursing facilities classified as 2-hour fire resistive construction or one-story, 1-hour protected noncombustible construction are exempt of the sprinkler requirements. As a result, only about half of the nursing facilities are required by the Life Safety Code to have automatic sprinklers. As pointed out in the previous chapter, both the Wincrest and Cermak House nursing facilities

were classified as having fire resistive construction and, therefore, were exempt from the automatic sprinkler requirements.

As of March 1976, the Department of Health, Education, and Welfare estimated that of the 16,500 nursing facilities participating in either Medicare or Medicaid, about 8,580 were not required to be fully protected with automatic sprinkler systems because of their construction classification, although some facilities might have installed them.

In addition to the exemptions, HEW also has the authority under the Social Security Act to waive the automatic sprinkler requirement in any nursing facility regardless of construction type.

The Office of Nursing Home Affairs could not tell us how many facilities were waived from the automatic sprinkler requirement as of April 1976 because information on such waivers is maintained at the regional offices.

Our report entitled "Many Medicare and Medicaid Nursing Homes Do Not Meet Federal Fire Safety Requirements," (MWD-75-46) dated March 18, 1975, pointed out many problems associated with the waiver procedures. We reported that, of our sample of nursing homes inspected, over 79 percent of the nursing homes granted waivers from the automatic sprinkler requirement did not meet the HEW standards for such a waiver.

We reported that the HEW waiver standards, designed to insure a level of safety equivalent to that provided by automatic sprinklers, have not been established for any type of nursing home, except those of one-story protected wood frame construction. We recommended that HEW establish waiver standards for all types of nursing homes to insure, as required by the Social Security Act, that waivers from the automatic sprinkler requirement would not adversely affect patient safety. HEW did not accept this recommendation on the basis that the propriety of a waiver should be left to the discretion of the State with the approval of the HEW regional office.

STUDIES AND COMMENTS ON THE VALUE OF SPRINKLERS

The National Safety Council and American Nursing Home Association's "Safety Manual for Nursing Homes and Homes for the Aged" states that:

> "Automatic sprinkler systems provide the greatest 'safety to life' feature available in the fire protection field. Not only can they

> automatically sound an alarm, but they will immediately start fighting the fire when activated. Automatic sprinklers are by far the most reliable and effective means of fire extinguishment. Other forms of protective equipment, as well as automatic alarms, have their special place, but none can ever be an effective substitute for automatic sprinkler systems."

According to the National Fire Protection Association, there is no record of a multiple death fire in any nursing home fully protected with an automatic sprinkler system.

During the summer of 1974, the American Health Care Association (formerly the American Nursing Home Association), under contract to HEW, made a series of monitored fire tests, some of which were carried out in an abandoned nursing home near Gary, Indiana. The tests were conducted by a fire safety engineering firm. The purpose of the contract, according to an HEW official, was to validate specific fire protection requirements contained in the 1967 edition of the Life Safety Code applicable to nursing homes.

According to an HEW official, the tests were also intended to provide the basis for policy modifications regarding fire safety standards, for making recommendations for action by HEW, and for suggesting legislative amendments.

During one of the fire tests, with fire department personnel stationed throughout the building, a fire started in a wooden wardrobe burned out of control and destroyed the building. According to the project engineer for the fire safety engineering firm, as the fire developed it traveled into the concealed spaces near the roof, and the fire department could not contain it. It gradually spread through the concealed spaces, then down to the second floor, and eventually worked its way completely through the building. The engineer pointed out that fire in concealed spaces can be very difficult to reach. He said buildings have been lost this way many times throughout the country.

The HEW officials noted that automatic fire sprinklers were not in use for the specific test which resulted in destroying the building. The project engineer pointed out a number of conclusions from the various tests, including:

--Smoke barrier doors were effective.

--Many of the ordinary doors, such as might be found in typical nursing homes, do a good job of containing fires for a short time.

--Automatic sprinklers generally did a good job of controlling and containing the fires. Even where it was arranged so the water from sprinklers could not hit the fires directly, the sprinklers still contained them.

--The fires did not last long enough to be affected even by combustible wall paneling and ceiling tiles when automatic sprinklers were used.

Fire in another Illinois nursing home with sprinklers did not result in deaths

The Plaza Nursing Home fire occurred on February 18, 1976. The Plaza Nursing Home, a skilled nursing facility in Niles, Illinois, can accommodate 300 residents. At the time of the fire, 224 residents, including both Medicare and Medicaid patients, occupied the home.

A nurse's aide noted smoke and a burning mattress in room 421 (no one was in the bed) and, with a nurse's assistance, evacuated the three occupants of the room. The nurse activated a pull-box alarm and closed the room door. The fire activated one of two sprinklers in the room which sprayed water on the fire. The sprinkler extinguished the fire before the firemen arrived, which was shortly after the alarm.

The fire did not cause any deaths or injuries to residents at the Plaza Nursing Home. Fire damage was confined to the mattress and little, if any, heat or smoke damage occurred.

The Fire Chief attributed the absence of injuries and the prompt control of the fire to the sprinkler system and the quick employee response. Because the fire was promptly controlled, it did not generate sufficient heat (160 degrees Fahrenheit) to activate the second sprinkler in the room.

An official of the Illinois Fire Marshal's office attributed the cause of the fire to the careless use of smoking materials by a resident.

FIRE RESISTIVE NURSING HOMES DO NOT INSURE LIFE SAFETY

The two nursing home fires in the Chicago area demonstrate that deaths do occur because of fire, even in fire resistive buildings. Moreover, there are other examples of fire resistive nursing homes which have had fires resulting in multiple deaths. Congressional committees have investigated these fires and used this information as the basis for

their recommendations for automatic sprinklers. (See apps. II and III.)

Causes of death in nursing home fires

The causes of death in the Wincrest and Cermak House fires were the same as other fires involving multiple deaths--smoke and toxic gases. There were similarities between these two fires and four other nursing facility fires in Marietta, Ohio; Buechel, Kentucky; Madison, Wisconsin; and Wayne, Pennsylvania, studied by the Senate Subcommittee on Long-Term Care. (See app. III.) All of these facilities were classified as fire resistive and smoke and other products of combustion, rather than flames, caused multiple deaths.

In 1972, after its investigation of multiple death nursing facility fires, the House Committee on Government Operations reported in House Report 92-1321 that most fire deaths in nursing homes were caused by asphyxiation resulting from toxic gases, rather than actual burns. In 1975 the Senate Special Committee on Aging reported in Senate Report 94-00 that nursing home patients present a particular problem because of their reduced tolerance to heat, smoke, and gases and that many patients are under sedation or bound with restraints. The Senate Committee reported that despite the importance of smoke as the major cause of fire deaths in the United States, there are no national standards governing the smoke generation properties of furnishings, including carpets and floor coverings. (See app. II.)

Following the January 1970 Marietta fire, the following quote was included in the "Fire Journal": "Had the building been equipped with an automatic sprinkler system, all the victims could have been saved." After the Buechel fire, the publication stated: "If the entire building (not just the rubbish and laundry chutes) had been protected with an automatic sprinkler system, the fire could have been confined to the room of origin, with very little smoke or fire damage."

CONGRESSIONAL COMMITTEES HAVE RECOMMENDED SPRINKLERS IN NURSING HOMES SINCE 1972

The matter of the safety of elderly and disabled patients in nursing facilities has been a subject of considerable congressional concern for many years. Congressional committees studying this problem have historically advocated a requirement that all long-term care facilities be fully protected with automatic sprinkler systems. (See app. II.)

In its report of August 9, 1972 (House Report 92-1321), the House Committee on Government Operations concluded that the best means of avoiding multiple death fires is to construct complete automatic sprinkler systems which will also transmit an alarm to the nearest fire service.

Based on its investigation and conclusions, the Committee recommended legislation requiring all nursing facilities, as a condition for eligibility under Medicare and Medicaid, to be equipped with an automatic sprinkler system.

Upon completion of additional studies of nursing home fire safety, the House Committee on Government Operations issued a second report (House Report 93-1627) on December 18, 1974, which reiterated its earlier recommendation that all nursing homes, regardless of the type of construction, be equipped with automatic sprinklers.

The Senate Special Committee on Aging issued a report (Senate Report 94-00) on nursing home fires in August 1975. The report recommended that all States should enact legislation requiring automatic sprinkler systems in each of their long-term care facilities.

THE COST OF AUTOMATIC SPRINKLER SYSTEMS

The cost of installing an automatic sprinkler system will vary with the size and type of facility and depend on whether it is of new or existing construction. However, to examine the impact of requiring all nursing homes to install sprinkler systems, we are presenting general data obtained regarding the cost of sprinklers. In February 1976 we discussed the cost of installing a complete sprinkler system with a representative of the National Automatic Sprinkler and Fire Control Association. According to the representative, the installation of a complete sprinkler system, including pumps, valves, piping, and alarms, would cost from 75¢ to $1.25 a square foot while constructing a building. Installation in an existing building would cost from $1 to $1.50 a square foot. Variables include whether the pipes were to be concealed or exposed, whether the sprinkler heads were to be recessed, and the availability of a water supply (that is, is a reservoir necessary), etc. In April 1976 we obtained data from seven sprinkler installation companies in the Washington-Baltimore area. According to their estimates, a sprinkler system might cost between 50¢ and $1.75 a square foot in an existing facility. Actual installations during 1975 in four existing nursing facilities, three in Ohio, and one in Minnesota, showed costs ranging from $393 to $625 a bed, as follows:

Facility	Number of beds	Square feet	Total HEW approved cost of sprinkler system	Cost per bed	Cost per square foot
1	30	12,100	$18,744	$625	$1.55
2	34	16,481	20,070	590	1.22
3	100	35,484	42,850	429	1.21
4	150	48,040	58,917	393	1.23

Sprinkler systems may cost about $5.57 a bed each month

Using the highest actual cost per bed, the monthly cost of amortizing $625 a bed over a 20-year period with a 9-1/4 percent interest rate is $5.57 a bed each month, or about 19¢ a bed each day.

According to the National Fire Protection Association, automatic sprinkler heads need replacement at the end of 50 years. However, financing sprinkler system installation over a period of more than 20 years does not seem likely. Consequently, our computation shows the monthly payment expected over the term of a 20-year loan.

Savings for nursing facilities with sprinkler systems

Although fire insurance rates vary among States, savings are possible on both building coverage and contents insurance when nursing facilities are protected by automatic sprinkler systems. We obtained information on the general rates in Maryland and Washington, D.C., and found that savings of about 30 percent are possible on building coverage and 50 percent on contents insurance.

According to a representative of the Insurance Services Office of Maryland, a rating bureau under the jurisdiction of the State Insurance Commission, fire insurance premiums would be less because of the installation of automatic sprinklers in nursing facilities. With regard to fire insurance on the building, he said the rate per $100 of insurance is about 8¢ without sprinklers in ordinary construction and about 6¢ with sprinklers, for a reduction of about 25 percent. In protected wood frame construction, he said the fire insurance rate per $100 of insurance is about 16¢ without sprinklers and about 11¢ with sprinklers, for a savings of about 30 percent.

According to a representative of the Insurance Rating Bureau of Washington, D.C., building contents insurance

premiums could be reduced by as much as 50 percent by installing automatic sprinkler systems. He quoted rates for nursing facilities of frame, ordinary, and fire resistive construction. He stated that in buildings of frame construction, the building contents insurance rate per $100 of insurance is about 71¢ without sprinklers and 45¢ with sprinklers, for a reduction of about 37 percent. In ordinary construction, he said the building contents rate per $100 of insurance is about 50¢ without sprinklers in contrast to about 30¢ with sprinklers, for a savings of about 40 percent. For fire resistive construction, he quoted a building contents insurance rate per $100 of insurance of about 20¢ without sprinklers and 10¢ with sprinklers, for a reduction of about 50 percent.

To illustrate the annual savings on fire insurance premiums due to the installation of an automatic sprinkler system, consider a hypothetical example of a protected wood frame facility insured for $500,000 on the building and $100,000 on the contents. Without a sprinkler system the facility would pay about $800 for building insurance at 16¢ per $100 of coverage and about $710 for contents insurance at 71¢ per $100 of coverage, for a total annual cost of about $1,510. With a sprinkler system the facility would pay about $550 for building insurance at 11¢ per $100 of coverage and about $450 for contents insurance at 45¢ per $100 of coverage, for a total annual cost of about $1,000. In this hypothetical example, the installation of an automatic sprinkler system would result in annual savings for fire insurance in excess of $500.

Medicare and Medicaid will help pay for automatic sprinklers

Nursing facilities participating in either Medicare or Medicaid will be reimbursed for part of the cost of automatic sprinkler systems through interest and depreciation.

Medicare facilities receive reimbursement for all allowable costs associated with the use of the facilities by Medicare patients. Medicare regulations (20 CFR 405.415) provide that an appropriate allowance for depreciation on building and equipment is an allowable cost. Consequently, Medicare will reimburse facilities for the cost of automatic sprinkler systems over a period of time, suggested as 25 years, based on the number of Medicare patients. In addition, Medicare regulations (20 CFR 405.419) provide that interest on both current and capital indebtedness is an allowable cost. As a result, part of the interest paid each year on sprinkler system loans can be reimbursed under Medicare.

Medicaid is required to reimburse facilities on a cost-related basis as of July 1, 1976. Under HEW proposed regulations, dated April 7, 1976, to implement this requirement, depreciation and interest may be included in the determination of costs, based on Medicaid patient utilization of the facility.

Over the long run, since depreciation and interest are allowable costs under both Medicare and Medicaid, part of the costs of installing automatic sprinkler systems in nursing facilities will be paid by Medicare and Medicaid. Medicare is all federally funded and Medicaid is funded by Federal, State, and local governments.

The actual amounts to be paid by Medicare and Medicaid will vary among facilities depending on the number of residents covered by the programs. However, according to a report from the Social Security Administration, Medicare and Medicaid paid over 55 percent of the national health expenditures for nursing home care during fiscal year 1975.

These expenditures include services in SNFs, ICFs, and all other homes providing nursing care.

CONCLUSIONS AND RECOMMENDATIONS TO THE CONGRESS

As a result of the investigations of multiple death nursing facility fires, a strong case can be made for a requirement that all nursing facilities, regardless of construction type, be fully protected with an automatic sprinkler system. Therefore, we recommend that the Congress enact legislation which will require that all nursing facilities be fully protected with an automatic sprinkler system.

From a practical perspective, however, we recognize that in some cases, such a requirement could result in unreasonable hardships, and some facilities may be unable to comply with a requirement for automatic sprinklers. Since such factors may exist, the waiver provision of the Social Security Act should be applied only in specific cases and only when approved by personnel qualified in fire protection engineering. HEW policy should be to make every effort to avoid waivers and to assure installation of complete sprinkler protection in all nursing homes.

The waiver provision of the Social Security Act allows a waiver if the enforcement of the fire safety requirement would result in an unreasonable hardship, but only if the waiver would not adversely affect patient health and safety.

Because of HEW's improper treatment of its existing waiver authority, as discussed in our 1975 report, and its lack of acceptance of the need for waiver standards for all types of construction, the Congress should require that HEW establish waiver standards which must be rigidly enforced before a waiver may be granted to any facility, regardless of construction type. This should help insure that the waiver will not adversely affect patient health and safety and will be applied in a uniform manner throughout the country.

CHAPTER 4

LITTLE USE MADE OF FEDERAL LOAN INSURANCE PROGRAM FOR NURSING HOME FIRE SAFETY EQUIPMENT

There are a number of ways nursing home owners can finance the cost of installing automatic sprinkler systems, including equity capital of the owner, commercial borrowing, mortgage financing, and federally insured loans. While we do not know why the federally insured loan program has not been successful, we believe that the Department of Health, Education, and Welfare's long processing time and the Department of Housing and Urban Development's position of not insuring loans for projects which have already started contribute to the problems facing nursing facilities applying for Federal loan insurance.

FEDERAL LOAN INSURANCE PROGRAM HAS NOT BEEN UTILIZED

In its August 9, 1972, report (House Report 92-1321), the House Committee on Government Operations concluded that, unless the Federal Government provided a mechanism for insuring loans for automatic sprinkler systems, not all facilities would be able to finance such systems. The Committee recommended that the appropriate congressional committees consider legislation to provide insurance for long-term loans made for installations of sprinkler systems as a means of assisting facilities in obtaining such financing.

As a result, on December 28, 1973, Public Law 93-204 was enacted, which authorized the Secretary of HUD to insure loans made to nursing facilities for the purchase and installation of fire safety equipment. This law amended section 232 of the National Housing Act which is designed to provide mortgage insurance for nursing homes.

In October 1974, 10 months after the law was approved, the Secretary of HUD and the Acting Secretary of HEW entered into an agreement for administering this section of the National Housing Act. HUD and HEW agreed to the allocation of functions, as well as policies, procedures, and joint working arrangements, for administering the loan insurance program. Applications for insurance would be processed as follows:

--HEW would furnish HUD a copy of the approved architectural exhibits and a determination that, with the installation of the equipment, the facility would meet the Life Safety Code or any other code required for Medicare or Medicaid certifications.

--HEW would advise HUD that the proposed cost of the installation of the fire safety equipment was reasonable.

--HUD would process the applications and issue a commitment and insure the loan on the basis of the analysis of the HUD underwriting staff.

--HEW would inspect the installation and notify HUD that the improvements had been satisfactorily completed.

--HUD would reimburse HEW for the services rendered under the agreement.

According to HUD, the following terms had been established for insuring such loans:

--$10,000 minimum loan.

--Annual interest rate not in excess of 9-1/4 percent.

--Annual loan insurance premium of 1 percent.

--Maturities of 5, 10, or 15 years. On loans of $50,000 or more, a maturity period of 20 years.

In a March 12, 1975, letter to all approved lenders, HUD pointed out that "it is crucial that this program be implemented quickly." The letter said "the program needs the support of the financial community to make the important goals of this new law a reality. Processing of these loans by our field offices will be given prompt attention."

According to HUD officials, there have not been any loans approved under Public Law 93-204. As of late April 1976, only one application had been sent to HUD and this was disapproved because the facility did not meet HUD financial requirements (relating to loan repayment).

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Little interest in the loan insurance program

According to HEW officials, there has been relatively little interest in the Federal loan insurance program for fire safety equipment. The following table reflects the low interest level and shows a concentration of inquiries in the Chicago region. This region includes Ohio which, on December 30, 1972, enacted a State law requiring nursing homes to install automatic sprinkler systems by January 1, 1975 (later extended to Janaury 1, 1976). This data, as of April 1976 (except for the Chicago regional office which was September 1975), was provided by HEW for 5 of its 10 regions. Information on the other regions was not available.

	HEW Regions				
	Boston	Philadelphia	Atlanta	Chicago	San Francisco
Number of inquiries to HEW	5	2	9	159	27
Number of applications received by HEW	0	0	2	10	11
Number of applications sent to HUD	0	0	1	a/4	0
Number of applications not approved by HEW	0	0	b/1	b/6	b/11
Number ot applications disapproved by HUD	0	0	1	0	0

a/In each of these cases the applicant withdrew before the application had been processed through the lender. HUD does not begin its processing until it receives an application from an approved lending institution.

b/These applications were not approved by HEW because work had begun and HUD would not insure loans for such projects.

HEW officials told us that the only application HUD acted on resulted in a disapproval because the facility did not meet HUD financial requirements relating to the ability of the nursing facility to repay the loan. Applications received by HEW and not forwarded to HUD were applicants who withdrew. The reason for the withdrawal was that they had begun work and HUD would not provide loan insurance for projects already begun.

According to HEW officials, nursing facilities did not apply, or withdrew their applications, because the program offered no advantage over conventional loans and involved much more paperwork and time. These officials said the insured loan program came too late to be helpful because most nursing facilities had already begun to make the necessary corrections as a result of the HEW and State enforcement efforts. They pointed out that HEW had been insisting on the correction of serious fire safety deficiencies before the enactment of the loan insurance program.

These officials said that because the interest rate on these loans was no better than could be obtained without the HUD guarantee, nursing facilities obtained needed financing through conventional means.

The HEW officials told us that it is unlikely that many nursing facilities will use the program in the future unless there are clear advantages, such as low interest rates. If the program is used in the future, they said it could be improved by simplifying the process of obtaining HEW and HUD approval.

HEW processing time

According to the Associate Director of the HEW Office of Nursing Home Affairs, it takes HEW more than 3 months to process applications for insured loans. This, he said, is too long for the nursing home operators to wait to begin loan negotiations with lending institutions. The official said the time period was long because HEW engineers needed to obtain all necessary information, to review and approve architectural plans, and to evaluate cost estimates. He pointed out that each regional office has a limited number of engineers and much demand for their services; the regional offices are simply overloaded with other work. Accordingly, the regional office staffs have been slow in processing applications for insured loans.

He also pointed out that the number of applications to HEW for such insured loans has been limited. Although a

number of inquiries have been received, very few result in actual applications for the program.

We examined the number of applications received in the Chicago regional office of HEW. Of approximately 159 inquiries, as of September 1975, in the program, HEW received only 10 applications. In six of the cases, HEW refused to process the applications because the nursing home owners had already started to correct their fire safety deficiencies.

According to a January 28, 1975, HUD memorandum to the Director of the HEW Office of Nursing Home Affairs, HUD would not insure a loan after work had started on installing the fire safety equipment or in making repairs.

The remaining four cases all resulted in the installation of sprinkler systems, but not with HUD-insured loans. In two cases, the owners told us that they became so frustrated because of the time HEW was taking to process the applications that they went ahead and obtained commercial financing. In another case, the owner told us that he could not find a lending institution willing to make the insured loan because the insured loan interest rate was too low at the time, and the banks were reluctant to make such loans to a nursing home. The owner then obtained an adjustment to his existing mortgage to finance the sprinkler system. In the fourth case, the owner said HUD wanted him to make extensive repairs to the roof which were not required by HEW. According to HUD officials, the repairs were suggested rather than required, and they were willing to begin processing the loan guarantee without such repairs. However, the owner withdrew his application and obtained financing elsewhere.

In all four cases the processing time by the HEW Chicago regional office took from 6 to 8 months as shown on the following page.

Long processing time can be a problem

HEW regulations provide that a nursing facility's certification will be automatically canceled no later than 60 days after the date established for the correction of health or safety deficiencies unless all deficiencies are corrected or substantial progress has been made in correcting the deficiencies. HEW guidelines define "substantial progress" to mean that corrections are well underway and that there is tangible and visible evidence of progress made. If the only progress by the facility has been a loan application,

according to the guidelines, this would not be substantial progress sufficient to prevent the automatic cancellation.

Facility	Date of application	Date of HEW approval	Approximate processing time
Nursing Facility A (30 bed ICF) Felicity, Ohio	1-13-75	7-21-75	6 months
Nursing Facility B (100 bed SNF) East Cleveland, Ohio	12-09-74	7-31-75	8 months
Nursing Facility C (150 bed SNF/ICF) Cincinanti, Ohio	2-04-75	8-15-75	7 months
Nursing Facility D (34 bed ICF/MR) Minneapolis, Minnesota	2-03-75	8-20-75	7 months

According to the HUD procedures, a loan cannot be insured under the program after work has started. An official said HUD believes that the law establishing the loan insurance program does not authorize insurance for loans for previously purchased fire safety equipment. He said that if work had begun, the purchase was considered to have been made and the loan would be for a retroactive project.

An illustration of the problems facing nursing facilities is the actual case of nursing facility D in Minneapolis. In January 1975 the facility was cited by the State survey agency as requiring an automatic sprinkler system to be in compliance with Federal fire safety requirements. At that time, an automatic cancellation date was established as September 1975, which was 60 days after the planned correction date. In February 1975 the facility applied through HEW for a federally insured loan to pay for the sprinkler installation. HEW approval of the loan insurance application was not received until mid-August 1975. Very little time remained for the facility to locate a lending institution, negotiate a loan, process the HUD application, obtain a sprinkler contractor, and begin work before the certification of the facility would be automatically canceled in September. Because of the long processing time, the facility obtained financing through other means during September 1975.

Causes of delays in HEW processing

The Deputy Director, HEW Chicago regional Office of Long-Term Care said the office believes that it is necessary for HEW engineers to physically inspect the facilities before the loan insurance applications can be processed to certify to HUD that the facility will meet Federal fire safety requirements. She said that because of past experience with the quality of State inspections in Ohio and Minnesota, HEW engineers were reluctant to rely on the State Life Safety Code surveyors. She pointed out that neither Ohio nor Minnesota use engineers or architects to make fire safety inspections. In the cases of the four facilities approved by HEW for HUD-insured loans, deficiencies were found at each facility by HEW engineers which were not identified by the State inspectors. At nursing facilities B and C, the State inspectors identified no fire safety deficiencies, although the HEW engineers noted several deficiencies in meeting the fire safety requirements. At facilities A and D, the State inspectors cited some fire safety deficiencies; the HEW engineers found several additional deficiencies.

She said also that the processing time by HEW includes the onsite inspection by HEW engineers and evaluation of architectural drawings and exhibits. In addition, HEW evaluates cost estimates from sprinkler contractors. These documents must be obtained from the facilities. In the four cases reviewed by the Chicago office, several letters were sent to the facilities requesting this information, which delayed the final approval of the applications.

HUD did not publicize the loan program

In April 1975 HUD published a brochure entitled, "Nursing Home Mortgage Insurance," which explains that the program under section 232 of the National Housing Act is designed to foster the construction of new nursing homes and the rehabilitation of existing ones. The brochure did not mention the availability of loan insurance for the purchase and installation of fire safety equipment as provided in section 232(i) of the act. The brochure did not publicize the loan insurance program or explain the eligibility requirements, the amounts available, the conditions, fees and charges, special requirements, and application instructions.

We believe that the brochure should have included a section explaining the availability of insurance for loans for fire safety equipment.

HOW TO IMPROVE THE
LOAN INSURANCE PROGRAM

The HUD loan insurance program could be a viable source of assistance to nursing facility owners in obtaining financing for automatic sprinkler systems. We believe the problems encountered in the loan insurance program for fire safety equipment rests both with HEW's processing procedures and HUD's position of not insuring loans on projects which have already been started.

To alleviate the difficulties encountered by HEW, we believe that both HEW and HUD should evaluate the loan application processing procedures to reduce the need for HEW's detailed review and inspection.

Currently, HEW receives copies of the State inspection reports which indicate nursing facility deficiencies in the fire safety requirements. In addition, HEW receives copies of the plans for correction, which, when completed, should bring the facility into compliance with Federal fire safety requirements. Consequently, it seems that these documents could satisfy the need to certify that correction of the fire safety deficiencies should result in compliance with Federal fire safety requirements because Medicare and Medicaid certification is contingent upon the approved correction of such deficiencies. With regard to the certification of reasonable cost estimates by HEW, it seems that this function could be more efficiently accomplished by HUD personnel, since they deal with estimating costs in other types of construction projects. The certification of reasonable cost could be made part of the HUD underwriting procedures and thereby reduce HEW's processing time.

To solve the problem experienced by nursing facilities denied loan insurance applications because work has previously started, we believe HUD should reconsider its position of not insuring loans for ongoing work. Nursing facilities can be under strict time constraints to correct fire safety deficiencies or be faced with the possibility of having their certification canceled. It would seem to be in the interest of patient safety to have the corrections made as soon as possible. In some cases work could be started while the loan insurance application is being processed.

The Chairman of the House Committee on Banking and Currency pointed out in a letter that the Housing and Community Development Act of 1974 (Public Law 93-383) provided additional statutory authority to HUD to assist in the

financing of fire safety equipment. He stated that in his opinion, the authority contained in section 309 of the 1974 Act could be used to assist in the financing of fire safety equipment which has been, or is in the process of being, installed. A HUD attorney told us that the provision cited by the Chairman was not operational because implementing regulations have not been published.

Title I, section 2 of the National Housing Act authorizes the Secretary of HUD to insure loans made by approved lending institutions for financing alterations, repairs, and improvements on or in existing structures. The Housing and Community Development Act of 1974, section 309, added fire safety equipment to eligible improvements. This section further specifies fire safety equipment in nursing facilities. Based on our review of this section, we believe that it permits the Secretary to insure loans already in existence for work which has begun or been completed.

CONCLUSIONS

The Federal insurance program for fire safety equipment loans has not been successful in assisting nursing homes in installing automatic sprinkler systems. The program could be more effective if HEW and HUD establish procedures to minimize loan insurance eligibility processing time and encourage lenders to make fire safety equipment loans. HEW and HUD should publicize the Federal loan insurance program.

RECOMMENDATIONS

We recommend that the Secretary of HEW:

--Review the current loan application processing procedures with HUD and establish procedures for HEW to provide HUD with:

  (1) Copies of State inspection reports to substantiate the violations of Federal fire safety requirements and the need for correction.

  (2) Copies of the approved plans for correction, which should indicate that correction of the cited deficiencies should bring the facility into compliance with Federal fire safety requirements.

--Eliminate the need for HEW to certify the reasonableness of the cost estimate for the installation of fire safety equipment.

We recommend that the Secretary of HUD:

--Establish regulations to permit fire safety equipment loan insurance after the work has begun.

--Publicize the availability of the fire safety equipment loan insurance program by revising the nursing home brochure dealing with nursing home mortgage insurance.

AGENCY COMMENTS

Because congressional hearings were scheduled, the Chairman's office requested that we not delay the report to get formal comments from HEW and HUD. However, we did give both agencies an opportunity to review our findings, conclusions, and recommendations. Informal comments from agency officials were considered where appropriate in this report.

In addition, we discussed the contents of the report with representatives of the National Fire Protection Association and the Department of Commerce's National Fire Prevention and Control Administration who agreed with our recommendations to the Congress. Their comments are included in appendixes VI and VII.

APPENDIX I

APPENDIX I

U.S. House of Representatives
SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
715 HOUSE OFFICE BUILDING ANNEX 1
Washington, D.C. 20515
(202) 225-2381

February 20, 1976

Mr. Elmer B. Staats
Comptroller General
General Accounting Office
441 G Street
Washington, D. C. 20548

Dear Mr. Staats:

Our Subcommittee and the Senate Subcommittee on Long-Term Care intend to hold a hearing in Chicago on the recent tragic nursing home fires in that city killing approximately 20 persons. Your recent reports on the subject of nursing home fires and your staff's expertise in this area are well known to me.

I would greatly appreciate your assistance in investigating the reasons for the severity of the fires and your suggestions as to possible curative actions to avoid future similar situations. In addition, please investigate:

--- whether a sprinkler system throughout the facilities would have put out the fires or lessened the severity;

--- whether the facilities in Chicago meet the life safety code requirements for participation in the Medicare program;

--- H.E.W.'s enforcement of fire safety standards in Chicago and elsewhere;

--- the accuracy of state inspections of the Chicago facilities in question and of H.E.W.'s validation;

--- the state inspection procedure, including the qualifications of the inspectors;

--- the quality of trained personnel assisting patients during the fires;

--- H.U.D.'s implementation of P.L. 93-204, authorizing insured loans to provide fire safety equipment for nursing homes and intermediate care facilities, both in Chicago and elsewhere;

APPENDIX I

--- finally, any additional matters which, in your judgement, would assist our Subcommittee in its assessment of the fires and possible action.

Kindest regards, and

Believe me,

Always sincerely,

Claude Pepper
Chairman
Subcommittee on Health and Long-Term Care

CP:ke

SUMMARY OF PERTINENT CONGRESSIONAL COMMITTEE REPORTS ON FIRE SAFETY IN NURSING HOMES

HOUSE COMMITTEE ON GOVERNMENT OPERATIONS--1972

House Report 92-1321, "Saving Lives in Nursing Home Fires," published August 9, 1972, by the House Committee on Government Operations was a part of the study on the problems of the aging begun in the latter part of 1971 by the Special Studies Subcommittee. The findings reported by the Committee included:

--In the 20 years from 1951 through 1970 a total of 496 deaths in nursing home fires were reported where multiple deaths occurred, for an annual average of 25 deaths. In 1971 there were 38 such deaths and for the first half of 1972, 30 deaths had occurred.

--The combination of a sparse night staff and aged residents, of whom 50 percent are disoriented and 40 percent are partially or totally nonambulatory, renders infeasible the successful evacuation of residents in case of a fire at night.

--The use of a fire detection alarm system connected to the nearest fire department may serve to avoid a total loss of life, but it still does not prevent, as recent fires had shown, a large number of deaths occurring, notwithstanding an extremely prompt response by the alerted fire department.

--Even fire resistive or protected noncombustible construction does not prevent contents fires in such structures. In fact, if such construction is not carefully executed, or if at the time of a fire, doors are not closed, then such construction will not stop a fire from spreading, as demonstrated by the nursing home fires in Marietta, Ohio, in 1970 and in Buechel, Kentucky, in 1971.

--Since most fire deaths in homes for the aged are caused by asphyxiation resulting from toxic gases rather than being caused by actual burns, the increased use of fire retardant materials and substances, which basically result in incomplete combustion produce toxic gases, may in the opinion of one

expert, increase the hazard of death in fires rather than reducing it.

--According to the National Safety Council and the American Nursing Home Association, automatic sprinkler systems installed throughout a facility, not only in hazardous areas, provide the greatest "safety to life" factor available in the fire protection field, because they can automatically sound an alarm and immediately start fighting the fire when activated. When activated, they are the most reliable and effective means of fire extinguishment. Other forms of protective equipment, including automatic alarms, are not effective substitutes for automatic sprinkler systems.

--This is basically the position of the National Fire Protection Association, which has voted to require early warning detection and automatic sprinklers in all new and existing nursing homes, regardless of the type of construction.

--The Fire Marshals Association of North America, which has within its membership all of the State Fire Marshals as well as those serving local government, adopted a resolution in its 1965 convention endorsing the principle of complete automatic sprinkler systems for all institutions and homes caring for the aged, regardless of construction type, detection systems, or other protection.

--The Joint Commission on Accreditation of Hospitals, in its standards of accreditation for nursing care and resident care facilities, agrees with this view and recommends that every facility be provided with a complete automatic sprinkler system.

--The best means of avoiding multiple death fires is the construction of complete automatic sprinkler systems which will also transmit an alarm to the nearest fire service.

--The cost of installing an automatic sprinkler system in an existing structure will necessarily be more than the cost of including it in new construction. The Committee has, from figures received by it, concluded that the average installation cost will be about $800 a bed for existing construction. Amortization of such installation costs on a 20-year basis, at 8 percent, comes to an annual charge of approximately $80.

--Unless the Federal Government provides a mechanism for insuring such loans, not all facilities will be able to finance sprinkler system installation costs.

Recommendations

The House Committee on Government Operations made specific recommendations in its August 9, 1972, report (House Report 92-1321) including:

--The appropriate congressional committees should consider legislation requiring that, as a condition for eligibility under Medicare or Medicaid or for housing the aged receiving old age assistance payments, each institutional facility for the aged (no matter what its name and even if not licensed under State law as a nursing home or related health care facility of some type) must have a complete automatic sprinkler system which will also transmit an alarm to the nearest fire service. No facility should be deprived of its existing Medicare or Medicaid eligibility unless it fails to comply within a reasonable period of time.

--The appropriate congressional committees should consider legislation to provide insurance for long-term loans made for installations of such sprinkler systems as a means of assisting facilities in obtaining such financing. (This legislation was enacted as Public Law 93-204, approved Dec. 28, 1973.)

HOUSE COMMITTEE ON GOVERNMENT OPERATIONS--1974

House Report 93-1627, "Fire Safety Deficiencies in Nursing Homes," published December 18, 1974, by the House Committee on Government Operations, was a continuing part of the study of problems of the aging by the Special Studies Subcommittee. The findings reported by the Committee included:

--A staff survey of Medicare facilities disclosed that half of the "unsprinklered" protected ordinary construction nursing homes housed above the street level floor, contrary to HEW regulations, blind nonambulatory or physically disabled patients. It also showed that two-thirds of the unsprinklered protected noncombustible homes also housed such patients above the street level floor.

--Under its authority to grant waivers of certain requirements under the Life Safety Code, HEW had adopted a system that had resulted in nursing facilities

receiving Federal funds, even though they had not met statutory safety requirements.

--HEW prescribed sprinkler equivalency standards in 1972 for only one class of construction--protected wood frame--leaving the granting of a waiver a matter of discretion for other types of construction. Protected ordinary construction alone accounts for almost one-third of the unsprinklered Medicare homes on HEW's Bureau of Health Insurance records.

--A sampling of homes operating under a waiver of the sprinkler requirement disclosed that 85 percent did not meet the four equivalency standards prescribed in HEW regulations.

--The same survey found that homes were granted waivers on the basis of plans to meet the HEW requirements, even though HEW policy is to grant waivers only when the four equivalency requirements are satisfied.

Recommendations

The House Committee on Government Operations made specific recommendations in its December 18, 1974, report (House Report 93-1627) including:

--The Committee reiterates its earlier recommendation that all nursing homes, regardless of the type of construction, be equipped with automatic sprinklers.

--Pending sprinklering of all such facilities, HEW should act to insure that homes presently permitted to operate without sprinklers because of construction type actually meet the Life Safety Code requirements for such construction type.

--Likewise, nonambulatory, blind, or physically disabled patients should not be housed above the first floor of any non-fire resistive structure which does not have an automatic sprinkler system.

--Waivers permitting homes to operate without sprinkler systems should not be granted to any facility, regardless of construction type, that does not meet the HEW equivalency standards.

SENATE SUBCOMMITTEE ON
LONG-TERM CARE--1975

Senate Report 94-00, "Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 5, the Continuing Chronicle of Nursing Home Fires," published in August 1975 by the Subcommittee on Long-Term Care, Senate Special Committee on Aging, stated:

--Older Americans make up 10 percent of the population but 30 percent of the deaths by fire. They are involved in 59 percent of all clothing fires, having a 73 percent mortality rate in such fires, as compared to 23 percent for younger persons.

--Nursing home patients present a particular problem because of several factors: (1) their advanced age (average 82), (2) their failing health (average four disabilities), (3) their mental disabilities (55 percent are mentally impaired), (4) their reduced mobility (less than half can walk), (5) their sensory impairment (loss of hearing, vision, or smell), (6) their reduced tolerance to heat, smoke, and gases, and (7) their greater susceptibility to shock.

--Despite much progress in recent years, nursing homes and related facilities still rank number one on the list of unsafe places to be in case of a fire.

--In 1973 there were 6,400 nursing home fires (17.5 each day of the year), causing $3.6 million in damage. An estimated 500 persons lost their lives in single death institutional fires. Fifty-one persons lost their lives in multiple death fires (those killing three or more). These figures represent sharp increases from 1971, when there were 4,800 fires and 31 persons killed in multiple death fires.

--Because nursing home patients often cannot take action to protect themselves in case of fire, they must rely upon the help of others. In most cases such help has not been available. There are few nursing personnel available (particularly at night), and most are untrained in rescue and firefighting techniques. Compounding the problem, many patients are under sedation or bound with restraints.

--Because the elderly cannot protect themselves and because nursing home personnel often prove incapable of taking action to save them in case of fire, automatic

detection, alarm, and extinguishment equipment are recommended. Sprinkler systems, while far from a panacea, are, by and large, the difference between life and death.

--Greater emphasis must be placed on the installation of fire-retardant furnishings. Too often fire resistive buildings are constructed only to be filled with flammable carpets, curtains, vinyl upholstery, and the like. There is no emphasis on the hazard of smoke production or on the effect of toxic gases on humans. Recent research demonstrates that deadly gases such as phosgene and cyanide are released when various plastics, acrylics, and nylons are burned. Many such products are found in nursing homes.

--Over the years, 33 percent of all nursing home fires have been caused by smoking or matches; heating or electrical problems followed next with 18 and 15 percent, respectively. Eight percent were labeled "suspicious"--a suggestion that arson was the fire's cause. Fires most frequently begin in patient rooms (35 percent) and most often take place from midnight to 6 a.m. (42 percent). About 35 percent of all nursing home fires occur in wood frame buildings; only 3 percent occur in fire resistive buildings.

Recommendations

In its August 1975 report, (Senate Report 94-00) the Senate Special Committee on Aging made several recommendations, including:

--Nursing home providers and State and Federal Government officials must work together to create an all-out effort to eliminate serious fire loss in nursing homes and related facilities. This coordinated attack must proceed on every level, encompassing the latest technology with respect to fire prevention, detection and alarm, and confinement and control.

--HEW needs to insure that States follow its procedures in recommending waivers.

--All States should enact legislation requiring automatic sprinkler systems in each of their long-term care facilities.

--Legislation should be enacted to help nursing homes repair and renovate to meet Federal minimum standards.

--State and Federal fire safety officials should place greater emphasis on the flammability of nursing home furnishings.

--A greater research effort is needed with respect to the adequacy and appropriateness of current fire safety protection for nursing home patients. Smoke production standards should be created. State and Federal policymakers should place much greater emphasis on the toxicological effects of fire on humans.

DETAILS OF OTHER FIRE RESISTIVE NURSING FACILITY FIRES INVOLVING MULTIPLE DEATHS

The 1975 report (Senate Report 94-00) by the Senate Special Committee on Aging included the following examples of fires which resulted in multiple deaths even though the nursing homes were classified as fire resistive.

Marietta, Ohio--January 9, 1970

The Harmer House Convalescent Home was an unlikely site for a tragic nursing home fire. This relatively new (built in 1966), noncombustible structure boasted the most advanced technology, design, and building materials. The latter included solid core doors, brick veneer, gypsum-board walls, roof of plywood on steel stresses, concrete floor covered with noncombustible tile and/or nylon carpet with sponge-rubber backing. This home also had rate-of-rise and fixed-temperature heat detectors connected to an internal alarm system with manual pull stops. There were no sprinklers or smoke detectors, and the alarm system was not tied in to the fire department. Of the 46 residents, 32 died of smoke inhalation, even though there were 4 regular employees and 2 private-duty nurses in the home when the fire broke out at 9:57 p.m. The probable cause of the fire was a cigarette thrown into a trash-filled plastic wastebasket which, in turn, ignited the sponge-rubber carpet backing, causing considerable smoke throughout the building. The fire department's relatively late arrival (10:15) was due, in part, to the fact that the employees tried to fight the fire and evacuate residents before calling for assistance.

Buechel, Kentucky--January 14, 1971

Westminster Terrace Presbyterian Home for Senior Citizens was a modern, four-story, fire resistive building. It was made of 8-inch concrete block with 4-inch brick veneer and equipped with rate-of-rise and fixed-temparature heat detection devices and automatic smoke-stop partitions. Sprinklers were installed in laundry and rubbish areas. There was a manual alarm but no direct tie to the fire department. Two nurses were on duty at 2:23 p.m. when the fire began, and the fire department responded in less than 3 minutes. Some 13 firetrucks, 150 firefighters, and 46 emergency vehicles responded to the blaze. In spite of these efforts, 10 of the 94 residents perished. The cause of the fire is not known but experts have labeled the fire "suspicious"--indicating that arson is suspected. This fire demonstrates the folly of constructing fireproof buildings and filling them with flammable

furnishings and combustible interior finishes. The House Committee on Government Operations reported that a postfire investigation revealed that on the first floor the smokestop partitions extended only to the suspended ceiling, and utility piping pierced the concrete floor slabs so that openings were left through which smoke could travel from floor to floor. Smoke apparently traveled to the rest of the building through these gaps in the fire resistive construction and, to a lesser extent, through the building's ventilation system.

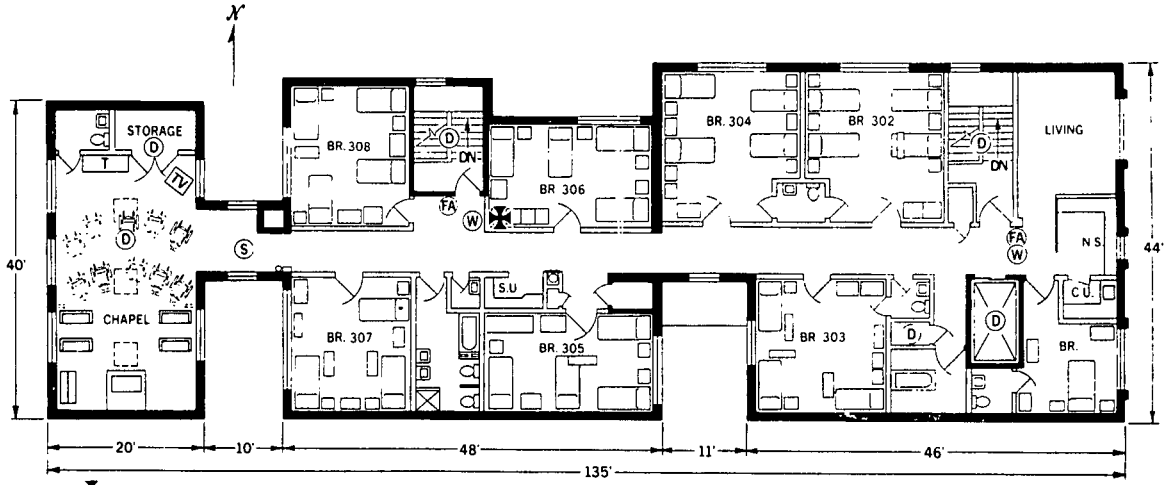
Madison, Wisconsin--January 8, 1973

Three of the 75 residents in this comparatively new ten-story (10 year old) fire resistive apartment house with residential care facilities died in the fire. The cause of the fire was smoking in bed. In fact, 3 months before, the same occupant had been blamed for a mattress fire which caused $100 damage. The building was equipped with fire extinguishers, a manual alarm system, a public address system, posted evacuation plans, and sprinklers in stairways of the 1st-2d and 10th story levels. A switchboard operator alerted a new part-time employee that one of the residents had complained of fire. The student went to investigate; consequently there was delay in reporting. The fire department did not reach the fire which began at 9:58 until 10:15 p.m.

Wayne, Pennsylvania--December 4, 1973

On July 12 an inspection by the Pennsylvania Department of Labor and Industry revealed 13 violations of the Life Safety Code in the Caley Nursing and Rehabilitation Center which was given 6 months to comply to the code. The fire that began at 8:57 a.m. in a clothes closet killed 15 people. The fire department responded within 4 minutes. Several employees were on duty, including a physician who pulled the manual alarm to report the fire. The facility was also equipped with heat detectors. The building was a three-story, converted attic mansion of cut stone with wood frame interior walls. It had been used as a nursing home since 1951. An addition was added in 1966, largely of noncombustible material such as concrete floors and a steel-deck roof. The critical defect was the lack of sprinklers. The facility was classified as fire resistive; however, during an investigation by the Special Studies Subcommittee, House Government Operations, it was found to be improperly classified. According to a National Fire Protection Association specialist, one of the fire safety code violations noted was a lack of fire doors in the communicating openings between the new and old sections of the building. This single violation

appeared to have been most critical, since smoke movement through the new section of the second floor was significant. Of the 15 fatalities, 8 were in the new section. Had the doors been provided, the degree of smoke migration would have been significantly reduced, and the possibility of fatalities would have been proportionally reduced. Important too was the lack of automatic sprinklers, which probably would have controlled the fire early, preventing loss of life.



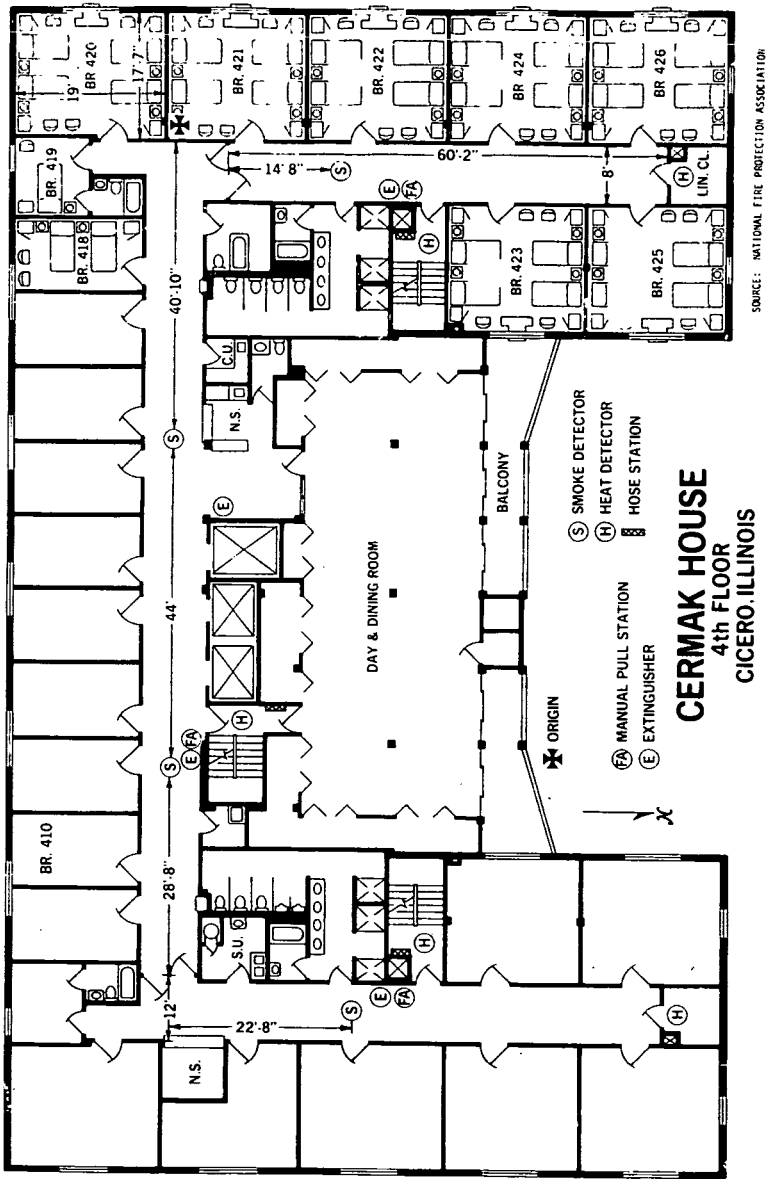
ORIGIN
FA MANUAL PULL STATION
W PRESSURIZED H_2O EXT.
D HEAT DETECTOR
S SMOKE DETECTOR

WINCREST NURSING HOME
THIRD FLOOR
CHICAGO, ILL.

SOURCE: NATIONAL FIRE PROTECTION ASSOCIATION

APPENDIX V

APPENDIX V



APPENDIX VI

NFPA
"Moving Mankind Toward Safety From Fire"

NATIONAL FIRE PROTECTION ASSOCIATION
INTERNATIONAL

May 24, 1976

Mr. Alan S. Zipp
General Accounting Office
330 C Street, S.W. Room 1126
Washington, D.C. 20201

Dear Mr. Zipp:

Thank you for permitting us to review and comment on the draft report of the Controller General to Congress on Federal Fire Safety Requirements for Nursing Homes, as produced by the Department of Health, Education and Welfare. We are glad to have the opportunity to comment on the proposals for automatic sprinkler protection of nursing homes.

The Life Safety Code developed and recommended by this Association, which, as you know, is widely enforced throughout the country, calls for the installation of automatic sprinkler systems in all nursing homes of other than "fire resistive" and one-story "protected non-combustible" construction. Further, the Life Safety Code encourages the installation of such systems in nursing homes of fire resistive and non-combustible construction by offering design trade-offs which recognize the increased safety to life provided by automatic sprinklers.

There can be no question that life safety will be considerably enhanced by the installation of complete automatic sprinkler protection in any nursing home of whatever construction and thus, on purely humanitarian grounds, deserves every encouragement. The economic assistance being made available to proprietors through HEW programs should overcome many obstacles to full automatic sprinkler protection and your recommendations for a progressive yet practical approach to this matter are to be commended.

Very truly yours,

Charles S. Morgan
President

APPENDIX VII

UNITED STATES DEPARTMENT OF COMMERCE
National Fire Prevention and Control Administration
Washington, D.C. 20230

May 26, 1976

Mr. Alan S. Zipp, CPA
Supervisory Auditor
U. S. General Accounting Office
Room 1126
330 C Street, S.W.
Washington, D. C. 20201

Dear Mr. Zipp:

We appreciate the opportunity to comment on the subject of fire safety in nursing homes as it relates to the GAO studies of Federal fire safety requirements for these facilities under the Medicare and Medicaid programs.

We strongly advocate that all nursing homes should be provided with automatic sprinkler systems throughout in accordance with the national consensus standard for sprinkler systems of the National Fire Protection Association (NFPA No. 13). We also urge that "trade-offs" in building construction and equipment be encouraged when automatic sprinklers are provided as specified in the Life Safety Code also produced by the National Fire Protection Association (NFPA No. 101).

The GAO is to be congratulated for its efforts.

Sincerely,

Howard D. Tipton
Administrator

OTHER NURSING HOME-RELATED REPORTS

ISSUED BY GAO SINCE 1972

Report title	Number	Date issued
Improvements Needed in the Managing and Monitoring of Patients' Funds Maintained by Skilled Nursing Facilities and Intermediate Care Facilities	MWD-76-102	3-18-76
VA Community Nursing Home Program	MWD-76-97	3-08-76
Error in Veterans Administration's Calculation of Community Nursing Home Rates in Medical District 5	MWD-76-50	10-24-75
Increased Compliance Needed with Nursing Home Health and Sanitary Standards	MWD-76-8	8-18-75
Many Medicare and Medicaid Nursing Homes Do Not Meet Federal Fire Safety Requirements	MWD-75-46	3-18-75
Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid	B-164031(4)	8-16-74
Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans	B-167656	4-11-73
Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program	B-164031(3)	4-19-72
Summary of Reviews of Planning, Construction, and Use of Medical Facilities at Selected Locations	B-167966	3-07-72
Drugs Provided to Elderly Persons in Nursing Homes Under the Medicaid Program	B-164031(3)	1-05-72

APPENDIX IX

APPENDIX IX

PRINCIPAL HEW AND HUD OFFICIALS RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
F. David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
DIRECTOR, OFFICE OF NURSING HOME AFFAIRS:		
Dr. Faye G. Abdellah	Nov. 1973	Present
Ernest Michelson (acting)	Sept. 1973	Oct. 1973
SPECIAL ASSISTANT FOR NURSING HOME AFFAIRS:		
Marie Callender	Nov. 1971	Aug. 1973
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1976	Present
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969

APPENDIX IX

	Tenure of office	
	From	To
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (con't.)		
COMMISSIONER, SOCIAL SECURITY ADMINISTRATION:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973
DIRECTOR, BUREAU OF HEALTH INSURANCE:		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967
DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT		
SECRETARY, HOUSING AND URBAN DEVELOPMENT:		
Carla A. Hills	Mar. 1975	Present
James T. Lynn	Feb. 1973	Feb. 1975
ASSISTANT SECRETARY FOR HOUSING PRODUCTION AND MORTGAGE CREDIT AND FEDERAL HOUSING ADMINISTRATION COMMISSIONER:		
David S. Cook	Aug. 1975	Present
David DeWilde (acting)	Nov. 1974	Aug. 1975
Sheldon B. Lubar	July 1973	Nov. 1974

BUREAU OF STANDARDS LETTER TO HEW ON PROPOSED CHANGES TO NURSING HOME REQUIREMENTS

UNITED STATES DEPARTMENT OF COMMERCE
National Bureau of Standards
Washington, D.C. 20234

March 25, 1976

Mr. Donald Brooks
Office of Facility Engineering
and Property Management
Department of Health, Education & Welfare
7th and D Street, S.W.
Washington, DC

Dear Mr. Brooks:

This is in response to your memorandum of March 9, 1976 requesting comments relative to the proposed changes to nursing home requirements resulting from the recent fires in Chicago.

An analysis of the memorandum attached to your correspondence indicates that the various recommendations and comments can be readily discussed in approximately 5 categories. These are: 1) Compartmentation to confine fire or smoke; 2) Fire and smoke detection; 3) Automatic extinguishment; 4) Fuel control, and 5) Staff capabilities.

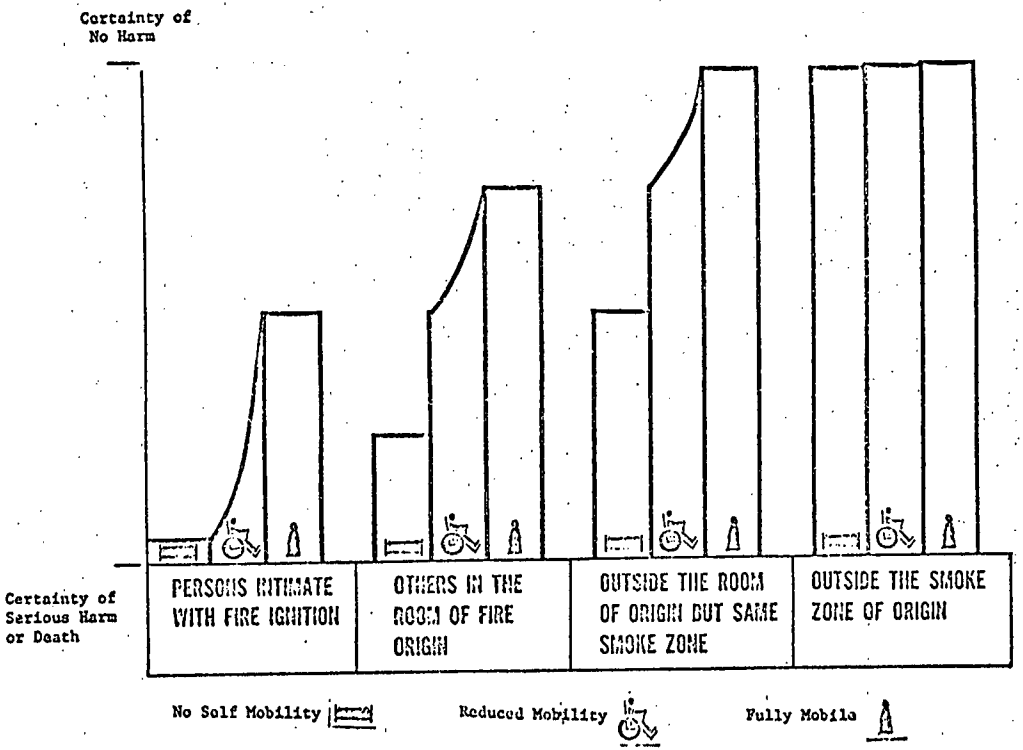
Background Statement

Every set of codes, criteria or other requirements result in some level of protection from harm. No set of documents provides complete protection. It is our belief that a health care facility conforming with the requirements of the Life Safety Code, 1973 edition, would result in protection in case of fire to the approximate degrees shown in Figure 1. (See Appendix A for a discussion of the elements and considerations in Figure 1). Throughout the rest of the discussion, we will use the comparison to the Life Safety Code (i.e., Figure 1) as the base line for discussion of the merit and impact of the fire safety recommendations and considerations being presented.

Compartmentation

The points raised on compartmentation logically divide into two areas: those related to proposals to upgrade the hardware (closers) on patient room doors to increase the security of the existing bedroom as a safe compartment; and those relating to the provision of additional compartmentation in the form of smoke barriers and cut off doors for day room activities.

FIGURE 1. APPARENT LIFE SAFETY OBJECTIVES OF THE LIFE SAFETY CODE (NFPA 101 - 1973)



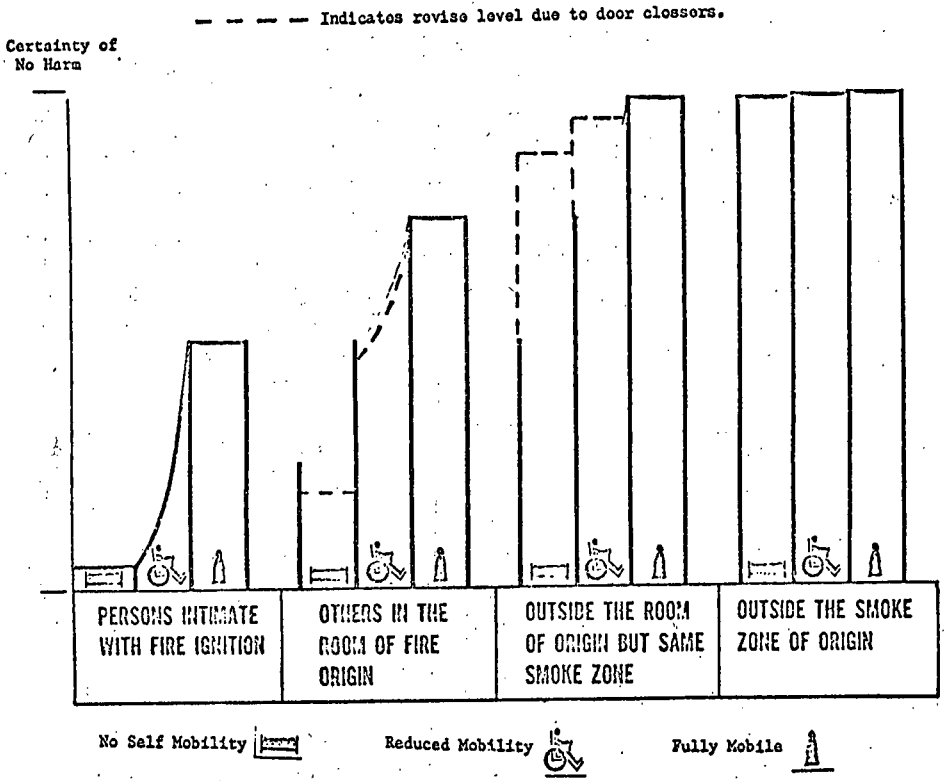
A. Provision of smoke operated door closers on patient room doors. Figure 2 demonstrates the manner in which the provision of smoke operated door closers on every patient room door could affect the overall safety of occupants in nursing homes. The result would produce no measured safety for the person intimate with the fire ignition. There may be some reduction in the safety of immobile occupants in the room of origin due to the potential interference with rescue operations should the door automatically close before the patients are removed. The protection of persons outside the room of origin but inside the same smoke zone would increase significantly, particularly the protection of the immobile persons who are dependent upon rescue or protection in their beds. There would of course be no measurable change in safety outside the smoke zone of origin. The help in confining the fire to the room of origin would of course potentially reduce the risk to the entire building. The level of protection devices specified by the Life Safety Code and the amount of redundancy in the code, however, provide such a high level of protection outside the smoke zone of origin that this would not show any increase in safety.

In considering these devices there are several items that are of important note. First in regard to the fire in the Wincrest and Cermack house our information is slightly different than that upon which Mr. Fisher and Mr. Hitt apparently based their proposals. In both cases, the door to the room of fire origin was originally closed. At the Wincrest house it was closed early in the fire by a nurse's aid. In the Cermack house it appears that it was closed at the time of fire ignitiation. In each case the door was opened. In the Wincrest house to attack the fire with fire extinguishers; and in the Cermack house to rescue the two patients that were still in the room. In each case the staff apparently knew that it was important to close the door after they had failed to extinguish the fire or had completed rescuing the patients. In each case, however, they claim they were unable to do it because of the ferocity of the fire. In line with Mssrs. Fisher and Hitt, however, the staff apparently never attempted to close any other doors. Detectors on the doors to the occupied rooms particularly at the Cermack house might have well closed the doors prior to the entry of lethal smoke.

Our estimate on costs suggests that the figure quoted by Mr. Hitt would be proper only if the door closers were designed in a new construction project. The estimates we have suggest $400 to $500 per door for a retrofit job in an existing building: more if the devices on all doors are interconnected so as to either sound an alarm or so that all doors will operate if one detects smoke.

We also do not have any reliable data on either the long term reliability or maintenance problems associated with these somewhat complex door closers. They represent a new technology and in all probability

FIGURE 2. PROVISION OF SMOKE OPERATED DOOR CLOSERS ON PATIENT ROOM DOORS



there will be some problems. The type of devices being proposed have been on the market in modest numbers for five to ten years and the limited experience has been quite variable. If HEW were to mandate such door closers, it should be expected that there would be reliability and use problems in the first five to ten years.

At this time we also do not have any data regarding the capability of the door closer on the room of origin if the door should be opened during the fire sequence in attempts to rescue or fight the fire. Warping the door or bending of the hinges however would be expected to be a significant factor on reclosing the door.

The statements in some of the letters regarding the use of self closing doors in the codes are not quite correct. For example, any new building built in communities following the Uniform Building Code requires that patient room doors have either smoke operated door closers or self closing doors. Self closing doors may for all intents and purposes be impracticable and its doubtful if any facility could live with doors that close as soon as the person passing through them lets loose of the door or its handle.

B. Increasing the amount of compartmentation. Two recommendations are included in the proposals of Mssrs. Fisher and Hitt: first to require that every floor have at least one smoke division regardless of the number of patients on that floor; and second to require that day rooms or other assembly areas have doors. The adoption of these proposals would not change the levels of protection as depicted in Figure 1; but, would change the amount or number of persons in each group. In the Wincrest home, the provision of a smoke barrier would have probably had little impact on the outcome. The logical place to establish a smoke area would have been the point where the building narrowed between rooms 303 and 305. The effect of this would have been to have four bedrooms on each side of the smoke barrier. Bedroom 306 (the room of fire origin) and the chapel would still have been on the same side of the smoke barrier. This does not decrease the worth of Mr. Fisher's recommendation. It only points out that the provision of smoke barriers in small buildings tends to reduce the number of people in immediate danger but not eliminate the danger. Some of the codes, by the way, say that if there are more than 5 occupants per floor the smoke barrier should be used.

The point on providing doors for chapels or other day rooms is very pertinent and appropriate. In the Life Safety Code (1973) such doors are required on all day rooms over 250 square feet in new buildings. They are not, however, required in existing buildings. The extension of this to existing buildings, would in many cases, be quite practical as it would have been at the Wincrest installation. There are undoubtedly, however, numerous floor plans in which such enclosures

may be difficult. In such cases other alternate schemes of protection (total sprinklers, wide-scale use of detectors, may reasonably be considered instead). The protection of such areas, however, is a very important consideration as was emphasized in the Wincrest disaster. There are periods of time in which considerable numbers of patients are collected together in recreation, eating, religous, or other gatherings. This would appear to be more attuned to long term care installations than critical medical hospitals. In these situations, large groups are subjective to a common tradegy. We would strongly endorse this recommendation.

Fire and Smoke Detection

Three points are considered. These include smoke detectors in the corridor as specified for new buildings in the Life Safety Code, 1973, smoke detectors in every room, and heat detectors. Figure 3 plots the estimated increase in safety that would result from these three approaches. These conclusions are more tentative than some of the others; and are based on the assumption that proper response will be made after the detector alarms. The series of full scale burns to be run at the NBS site during the next 12 months are specifically aimed at getting better answers on the degree of safety lead time provided by various types of detectors in various locations. It is expected that the initial series of tests will give relatively quick data on detectors in the room of origin. It is expected that more extensive and possibly some follow up testing will be needed before firmer statements can be made on the value of detectors in the corridor.

The provision of smoke detectors in every room would increase possibly by a factor of two or three the level of safety for immobile person intimate with fire ignition. The safety here would primarily be that for a smouldering fire. In such case a smoke detector in a room has a good possibility of detecting the fire before serious harm is done to the patient. If the fire is an open flaming fire, however, the possibility of reaching an invalid patient before he or she has received serious harm is low. Corridor smoke detectors and to a greater extent a smoke detector in each room would, of course, increase the level of safety for others than those in the room of fire origin; and they would be most effective at night. Where corridor smoke detectors are involved, the aerodynamics of the air handling systems in the building would be of extreme importance in determining their location and effectiveness. The main point of concern is the lead time which these type of detectors would provide for the responding nursing staff. They fall short of total protection because some fires, particularly those which rapidly develop in an open flaming mode, would progress with such speed that the lead time between the operation of the detector and the development of lethal conditions would be too short to effect any positive actions. The heat detector has no value because the lead time it can provide is so little as to be of virtually no use to increase safety for those in the same room of the fire.

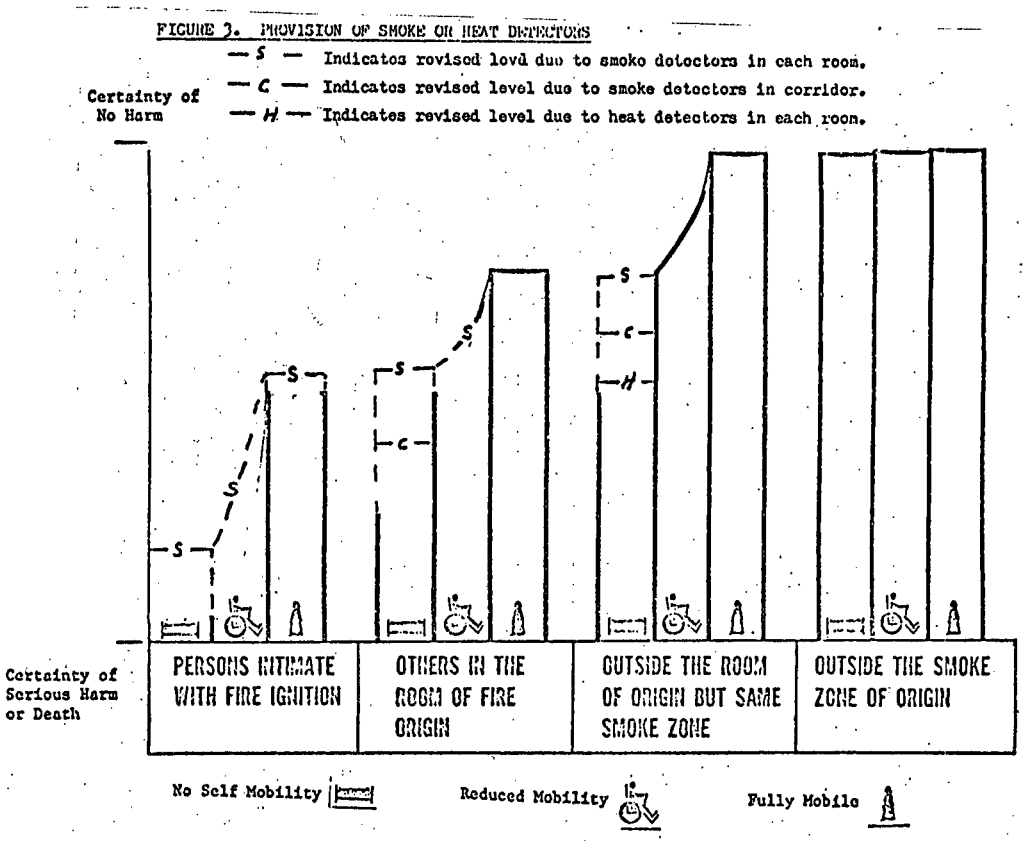


FIGURE 3. PROVISION OF SMOKE OR HEAT DETECTORS
— S — Indicates revised level due to smoke detectors in each room.
— C — Indicates revised level due to smoke detectors in corridor.
— H — Indicates revised level due to heat detectors in each room.
Certainty of No Harm
S
C
H
Certainty of Serious Harm or Death
PERSONS INTIMATE WITH FIRE IGNITION
OTHERS IN THE ROOM OF FIRE ORIGIN
OUTSIDE THE ROOM OF ORIGIN BUT SAME SMOKE ZONE
OUTSIDE THE SMOKE ZONE OF ORIGIN
No Self Mobility
Reduced Mobility
Fully Mobile

Protection provided outside the room of origin but in the same smoke zone has a similar distribution of increased protection over the basic NFPA 101, 1973 level. An increase in safety with corridor detectors is shown above the basic level shown in Figure 1, since for the existing building situation no corridor detectors are required. Heat detectors in each room shows a small positive value, to indicate the worth of such protection in the specific condition where the door to the room of origin is closed. For this situation, heat detection would provide information on a concealed fire that might otherwise go undetected. The value of a heat detector in a room with the door open is considered to be negligible. At the more extensive levels of exposure, the value of the detectors decreases because the inherent capabilities of the basic fire protection system function well in these areas and the impact of the detectors is redundant to the other protection systems.

Automatic Extinguishment

Consistently the question of sprinkler protection arises. Sprinkler protection can be either total (covering every room, closet, toilet, passage, etc.) or partial. Figure 4 gives the estimated level of protection provided at each degree of exposure to the fire by several approaches to increased automatic sprinkler protection. The three approaches considered are 1) total sprinkler protection; 2) the provision of a sprinkler head in the corridor outside of each patient room, and the location of at least one sprinkler head in each patient room; and 3) the provision of a sprinkler head in the corridor outside each patient room without any sprinklers in the individual patient rooms.

Again there are some unanswered questions regarding the type of product gases that can be produced during sprinkler operation particularly if the fire involved is being controlled by the sprinklers rather than extinguished. Sprinkler installations are also limited by the reliability of the sprinkler. This, of course, is true for detectors, door closers, and essentially all of the mechanical protection devices available to increase the level of safety above that inherently provided by the rigid building structure. The patient room burn tests which will be run at NBS are being carefully instrumented to provide measurements of the gases emitted from patient room doors with and without sprinkler protection, to increase the knowledge in this area. Until that data is developed, the question on the effluent during sprinkler operation will remain unanswered. Sprinkler operation from any of the three approaches covered can be expected to mitigate the overall fire situation and control the fire to where it is possible for the staff to close the door on the room of fire origin.

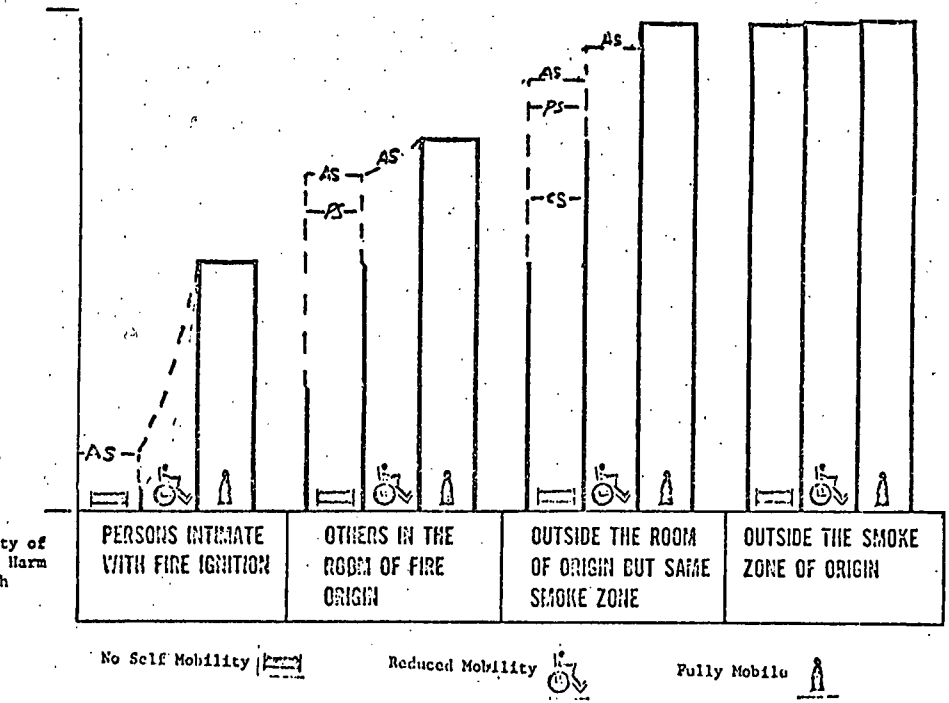
The installation of sprinkler protection retrofit situation can be quite expensive. The principle economy factors are choice of system

FIGURE 4. PROVISION OF TOTAL AUTOMATIC SPRINKLER PROTECTION

— AS — Indicates revised level due to total sprinkler protection

— PS — Indicates level due to sprinklers in rooms and corridors.

— CS — Indicates level due to sprinklers in corridors at patient room doors.



(i.e. total or partial) and the level of decor. If the sprinkler system is run exposed under the existing ceiling, the cost is greatly reduced. If the decor demands that the sprinklers be concealed above the ceiling space, a major increase of costs in the order of two to three times will occur due to the cost of removing portions of the ceiling to insert the sprinkler piping and then replacing it. If an exposed system is acceptable in a building, the cost of installing the sprinkler system could well be the same order of magnitude as the cost of installing detector operated self closers on each door. The comparison in this case, of course, is dependent on the number of doors versus the total size of the patient rooms. A principle value of total sprinkler protection, not readily apparent in Figure 4, is their capabilities of controlling the overall energy within the fire zone, and thereby protecting areas outside the smoke zone of origin. This is not an important need if a building currently meeting all of the stringent structural requirements prescribed in the Life Safety Code in either the 1967 or 1973 editions; but will provide a backup if some of the requirements are not adequately met. In considering alternatives to building deficiencies, it is common to allow total sprinkler protection to compensate for some degree of structural shortcomings in nonconforming buildings. In larger buildings where smoke control systems beyond simple doors become important the provisions of sprinklers will also reduce the requirements on the smoke control system and increase the probability of its effective operation.

The mention of sprinkler protection other than complete coverage is a break with tradition. The rationale for raising the potential of such systems is based on the success of such partial systems in extensive tests conducted at NBS over the past two years and the substantial cost difference between total systems and either of the other approaches. The type of partial sprinkler protection systems discussed here must include specifically engineered positioning of sprinkler heads on the basis of discharge patterns in line with the NBS research results. While the less than total approaches provide somewhat less safety, they do, as shown in Figure 4, result in significant safety increases over the present requirements. This is particularly true in terms of protecting those outside the room of fire origin but in the same smoke zone.

Fuel Control

Both Mssrs. Fisher and Hitt mentioned the value of controlling fuel. Mr. Fisher specifically discusses the wood wardrobe where the fire in the Wincrest house almost certainly initiated. We have not plotted a risk figure to show the impact of fuel control. If fuel could be completely controlled, the risk of fire would be eliminated, but this type of control is not possible. For example, with

wardrobe or other clothes containers it is important to recognize that the material inside the storage unit and the position of the door can be a greater factor than the actual construction of the compartment. The same risk can occur from a closet built into a room. The reduction of room furniture and the control of bedding can greatly reduce the fire problem. This was pointed out to some degree in the tests conducted at Beverly Shores. The tests to be conducted at NBS are even more directed at evaluating the differences that can occur from the fuels that relate to the bedding and the interior finish. At this time we know of no practical way to totally control the fuel in furniture used in a health care facility. We expect that the tests that we are going to conduct may point out some areas such as mattresses where a direct attack can be made. A long term program to discourage wooden furniture, improved closet or wardrobe design, and eliminate highly combustible mattresses and related bedding would be meritous but expensive. At NBS there are several long range programs running parallel to the HEW project which are aimed at improved mechanisms in evaluating the hazard of furniture. These, however, are several years from developing mechanisms that could be effectively used as procurement controls.

Improving Staff (and Patient) Capabilities

The question of staff training and capabilities is interesting. It is impossible to put this on a graphic presentation. In the Wincrest home, our interviews left the impression that the staff operated as a reasonable organized team, though they were disrupted in their efforts by the abortive action of an outsider. At the Cermack house, the impression of our investigators was that the staff did not operate as a team but each member did what he or she felt best at that time. In each case, the entire team directed their attentions more towards the extinguishment of the fire than removal of the patients. In each of these cases and in other case histories that we have been studying, we sensed a repitition of underestimation of the level of impact, speed of development, and lethalness to the patients of the fire situation being faced. In this area we are developing two approaches which may be of help in the reasonable future. One involves the development of educational material abstracted from fire histories and our fire research data to better educate the nursing profession in the real nature of the threat of fire. This sort of information could be carried from job to job and would be important in any instant of a fire threat. The second area is one in which we are just now considering. In this case, we are considering an investigation on the relevance of behavior in emergencies to the type of planning, training programs, and drills involved in nursing homes. The initial study will be one of modest depth. If it shows great worth, additional follow up will be made. In the meantime, it does not appear that

anyone has a solid proposal of a mechanism to improve training other than an attempt to try to do more of the same and we question the value of "more of the same."

Summary Statement

As can be seen from the various Figures, the improvement or addition of protection items and mechanisms can raise the safety in nursing homes. The raising of the level of safety will in each case be costly. In general, the mechanisms are only modestly additive. For practical purposes if one considers the simultaneous use of more than one of these protection systems the end result could be considered at each level of exposure as equal to the better of the two, but not equal to the sum. We would not recommend without further study the requirements for both door closers and sprinklers. In general, either one could contribute to life safety with the sprinklers probably making the greater contribution. But, we question the cost benefit of using both together. Of the protection mechanisms proposed, sprinkler protection by its capability of reducing the basic fire threat offers the major potential for "trade-off" or the acceptance of deficient buildings. Figure 5 is a composite of Figures 1-4.

We also strongly endorse the requirement for a door at the entrance to all lounge, assembly or recreational area.

It is suggested that the level of protection that would be provided by compliance with the existing requirements in the Life Safety Code be reviewed and a determination made as to whether this level meets the fire safety objectives of HEW in its nursing home activities. If it is felt necessary to raise the safety level, then the type of analysis provided here can demonstrate both the requirements and options available.

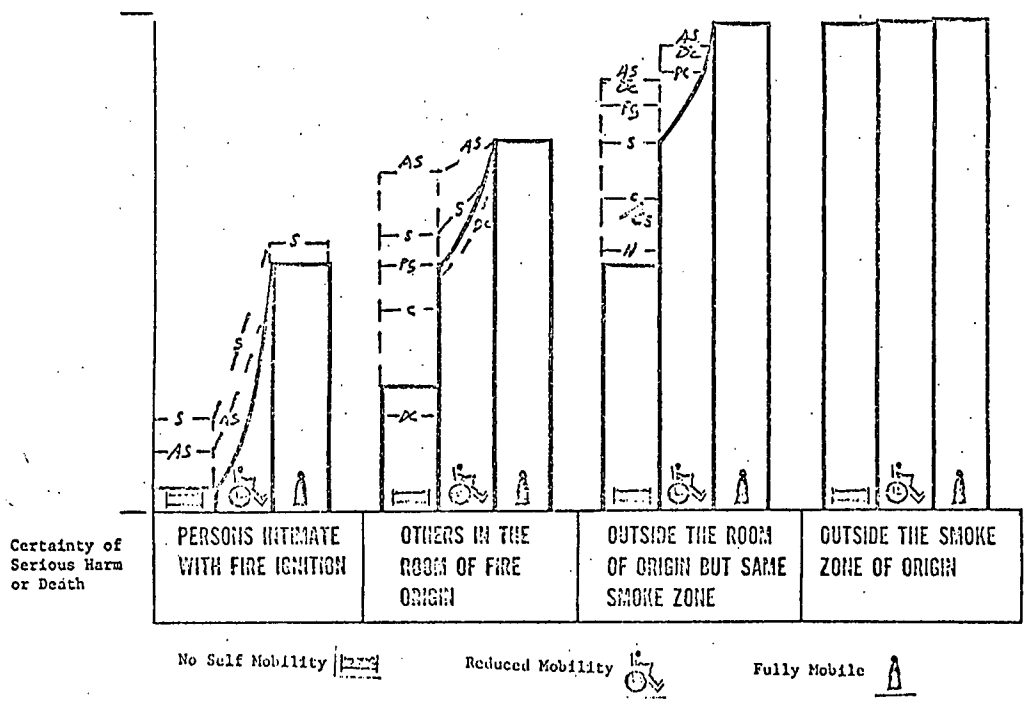
We would be pleased to meet with the OFEPM Committee or any other persons in HEW to discuss the points in this letter or other factors related to nursing home and other health care facility fire safety.

Sincerely,

H. E. Nelson, Chief
Program for Design Concepts
Center for Fire Research

FIGURE 5. COMPOSITE VIEW OF FIRE PROTECTION APPROACHES

DC = Smoke operated door closers on patient rooms. AS = Total automatic sprinkler protection.
S = Smoke detectors in each room. H = Heat detectors in each room. C = Smoke detectors in corridor.
PS = Sprinklers in rooms and corridors. CS = Sprinklers in corridors at patient room doors.



APPENDIX A. Apparent Life Safety Objectives of the Life Safety Code (NFPA 101-1973)

Figure 1 is an expression of an evaluation of the life safety objectives for health care facilities that would be achieved by full compliance with NFPA 101-73. To develop this figure, we have divided the occupants of the health care facility in two ways. The first consideration is the proximity of the exposed person to the point of fire origin. We have divided it into four classes consisting of 1) persons intimate with the fire ignition (ignition of their clothing, bedding, or other material in direct contact with them); 2) persons in the room of fire origin other than anyone who may be intimate with fire ignition; 3) any persons outside the room of origin but within the same smoke zone; and those persons outside the smoke zone of origin (if the floor is divided into separate smoke zones these persons can be on the same floor with fire origin. If, however, the floor is not so divided than this would apply only to persons on different floors).

Secondly, we have divided the character of the occupants by mobility consisting of 1) those who are not capable of any mobility without outside assistance. In this category, we include bedridden patients, patients under sedation, and those patients which might become mobile if someone were to assist them, as into a wheelchair; but can not initiate their mobility on their own. These are depicted on the graph by a cartoon of a person in bed. 2) Those persons who are partially mobile. We define these people as ones having an ability to initiate their own action for evacuation or other self preservation, but an inability to move or operate with the speed or assurance of a totally mobile person. The degree of mobility, of course, can vary from very slight mobility to almost as capable as a fully mobile person. The graph accounts to this by the sloping character of the line used to indicate safety of such persons. This is depicted by a patient in a wheelchair. 3) Those fully mobile persons, indicated by an erect figure.

The current Life Safety Code does not attempt to protect any person if their clothing, bed, or chair becomes ignited. The safety of these people depends upon either shedding the burning clothing or bedding, etc., or getting the fire promptly extinguished. The immobile patient is almost entirely dependent upon outside assistance and, as indicated, has a very low probability of survival under such case. With the person who is fully capable their percentage of survival rises. This difference, however, is based on the difference in their ability to take care of themselves rather than on anything related to the Code.

For other persons in the room of origin the Life Safety Code also provides relatively little protection. The primary activity in the Code in this area is to constrain the flammability of the interior finish; and for new buildings to specify detectors in the corridors, which may or may not provide detection early enough to help a person

in the room. In this case, inmobile patients are dependent upon obtaining assistance to remove them from the room of origin or on having the fire extinguished prior to any toxic impositions. The mobile person on the other hand has the ability to leave the room. The rates of development of fire in health care facilities while sometimes rather quick are not normally so speedy as to prevent the fully mobile person from leaving the room. In the Carmack house fire, at least one patient in the room of fire origin obtained the assistance necessary to get herself removed by shouting for help.

The Life Safety Code specifies the patient room enclosure in such a manner that the room is a separate entity from the corridor and reasonable separate from adjacent patient rooms. The concept is to provide a first line of defense at the patient room door. The Code, however,, depends upon staff to assure that the door is closed. While no statistics are solidly available, it is roughly estimated that somewhere in the range of 50% of the time that the staff will close the door to a room containing a fire and that it will be kept closed. Experience seems to indicate a lesser assurity that doors on other patient rooms will be closed by the staff or by mobile occupants in that room. Again the immobile person is almost entirely dependent upon the closing of these doors. The times involved in evacuation or relocation of such persons is such that in the majority of fire incidents immobile persons in their beds must obtain protection from fire in the place. Where they are in wheelchairs or geriatric chairs, the possibility of movement is increased if a place of safety is obtainable on the same floor. The level of safety for ambulatory and fully mobile persons outside the room of fire origin is very high, as they can either evacuate under their own ability or take refuge behind the doors to their rooms. If the doors are not automatically operating they are capable of closing them. It is felt that the Life Safety Code provides an extremely high level of safety for these persons.

For persons outside the smoke zone of origin, including, of course, those on other floors or other fire segments of the building, the Life Safety Code provides a near certain level of protection for all, regardless of their degree of mobility. The Life Safety Code in fact provides significant redundancies in providing structural soundness, protection of high hazard locations, subdivision of floors, and compartmentation which tends to limit the impact of the exposing fire.

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

TOTAL

FACILITIES		BEDS
7326		537983

IDENTIFICATION		NOT MET FACILITIES		NOT MET BEDS
I	FEDERAL, STATE, LOCAL LAWS	70		4411
1A	LICENSURE	20		1335
1B	LICENSURE OR REGISTRATION OF PERSONNEL	98	1%	6404
1C	CONFORMITY WITH OTHER LAWS	895	12%	68828
II	GOVERNING BODY	76	1%	5294
2A	DISCLOSURE OF OWNERSHIP	20		1579
2B	STAFFING PATTERNS	21		1264
2C	BYLAWS	279	3%	21011
2C	F20-BYLAWS&PATIENT CARE POLICIES	101	1%	7016
2C	F21-BYLAWS&OPERATIONS POLICIES	68		5127
2C	F22-BYLAWS&WRITTEN POLICIES	94	1%	6351
2C	F23-BYLAWS&REVIEWED AND REVISED	128	1%	6861
2D	MEDICAL REVIEW	229	3%	14915
2E	ADMINISTRATOR	154	2%	11958
2E	F26-QUALIFIED ADMINISTRATOR	31		2544
2E	F27-ENFORCES RULES AND REGULATIONS	59		4266
2E	F28-DIRECTS DELEGATED RESPONSIBILITIES	29		2653
2E	F29-LIAISON AMONG STAFF	42		3325
2E	F30-ACTS ON COMMITTEE RECOMMENDATIONS	55		4217
2E	F31-EMPLOYEE AVAILABLE TO SUBSTITUTE	104	1%	7908

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
2F	INSTITUTIONAL PLANNING	349	4%	26900
2F-1	INSTITUTIONAL PLANS BUDGET	260	3%	21341
2F-2	CAPITAL EXPENDITURES PLAN	360	4%	28285
2F-3	PREPARATION OF PLAN AND BUDGET	402	5%	30876
2F-4	ANNUAL REVIEW OF PLAN AND BUDGET	357	4%	26753
2G	PERSONNEL POLICIES AND PROCEDURES	578	7%	52742
2G	F42-WRITTEN PERSONNEL POLICIES	133	1%	10215
2G	F43-CURRENT EMPLOYEE PERSONNEL RECORDS	251	3%	17574
2G	F44-WRITTEN COMMUNICABLE DISEASE CONTROL POLICY	565	7%	40904
2G	F45-PERSONNEL ENVIRONMENT	71		5949
2G	F46-REVIEW OF ACCIDENTS	97	1%	6441
2G	F47-PERIODIC HEALTH EXAM	655	8%	60748
2H	STAFF DEVELOPMENT	527	7%	39324
2H	F49-ONGOING EDUCATIONAL/ TRAINING PROGRAM	231	3%	17332
2H	F50-EMPLOYEE ORIENTATION	508	6%	37445
2H	F51-INSERVICE TRAINING	389	5%	29700
2H	F52-RECORDS OF STAFF DEVELOPMENT PROGRAMS	291	3%	20764
2I	USE OF OUTSIDE RESOURCES	597	8%	43560
2I	F54-CONSULTANT AGREEMENTS	111	1%	7899
2I	F55-WRITTEN AGREEMENTS	452	6%	34447
2I	F56-FACILITY RETAINS RESPONSIBILITY	546	7%	39138
2I	F57-WRITTEN REPORTS TO ADMINISTRATOR	206	2%	15024
2I	F58-FOLLOWUP ACTION ON REPORTS	145	1%	10947

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
2J	NOTIFICATION OF CHANGES IN PATIENT STATUS	156	2%	11041
2J	F60-PHYSICIAN NOTIFIED OF CHANGES	107	1%	7659
2J	F61-PATIENT CONSULTED	48		2993
2K	PATIENTS RIGHTS	383	5%	26954
2K	F63-WRITTEN POLICIES	244	3%	16566
2K	F64-ADMINISTRATOR IS RESPONSIBLE	272	3%	18648
2K	F65-POLICIES ARE AVAILABLE	304	4%	22067
2K	F66-STAFF IS TRAINED	448	6%	33145
2K-1	PATIENT IS FULLY INFORMED OF RIGHTS	437	5%	31743
2K-2	PATIENT IS INFORMED OF SERVICE AND CHARGES	255	3%	18083
2K-3	PATIENT IS INFORMED OF MEDICAL CONDITION	289	3%	20021
2K-4	ORDERLY TRANSFER OR DISCHARGE	228	3%	16017
2K-5	ENCOURAGED TO EXERCISE RIGHTS	267	3%	18638
2K-6	MANAGES PERSONAL AFFAIRS	351	4%	26049
2K-7	FREE FROM MENTAL AND PHYSICAL ABUSE	275	3%	18910
2K-8	CONFIDENTIAL TREATMENT OF RECORDS	216	2%	14443
2K-9	TREATED WITH CONSIDERATION	204	2%	14278
2K-10	SERVICES NOT IN PLAN OF CARE	256	3%	17262
2K-11	PERSONAL COMMUNICATIONS	223	3%	15274
2K-12	PERSONAL ACTIVITIES	213	2%	13524
2K-13	PERSONAL POSSESSIONS	218	2%	13688
2K-14	PRIVACY FOR MARITAL VISITS	289	3%	19149
2L	PATIENT CARE POLICIES	493	6%	35237

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

		NOT MET		
		FACILITIES		BEDS
IDENTIFICATION		257	3%	18166
2L	F82-POLICIES DEVELOPED BY PROFESSIONALS	433	5%	31392
2L	F83-POLICIES MEET PATIENT NEEDS	157	2%	10655
2L	F84-PROTECTS PATIENTS RIGHTS	293	3%	21276
2L	F85-RECORDS REFLECT PATIENT CARE	224	3%	16494
2L	F86-COMPLIANCE WITH UR COMMITTEE	237	3%	15803
2L	F88-EXECUTION OF PATIENT CARE POLICIES	89	1%	5759
2L	F89-RESPONSIBILITY FOR POLICY EXECUTION	100	1%	7010
III	MEDICAL DIRECTION	158	2%	11834
3A	COORDINATION OF MEDICAL CARE	190	2%	13657
3A	F95-DIRECTOR RESPONSIBLE FOR WRITTEN POLICIES	163	2%	11592
3A	F96-COORDINATION INCLUDES LIAISON	171	2%	12782
3B	RESPONSIBILITIES TO THE FACILITY	201	2%	14508
3B	F98-ACCIDENTS ARE REVIEWED	168	2%	11773
3B	F99-ADMINISTRATOR IS INFORMED	178	2%	12518
3B	F100-DIRECTOR RESPONSIBLE FOR EXECUTION OF POLICIES	60		4342
IV	PHYSICIAN SERVICES	299	4%	21396
4A	MEDICAL FINDINGS/PHYSICIANS ORDERS AT TIME OF ADMISSION	113	1%	8070
4A	F103-PATIENT INFORMATION OF ADMISSION	352	4%	24533
4A	F104-REHABILITATION INFORMATION	562	7%	44384
4B	PATIENT SUPERVISION BY PHYSICIAN	25		1854
4B	F106-PHYSICIAN SUPERVISION POLICY	243	3%	19331
4B	F107-PHYSICIAN PLANS PATIENT CARE	81	1%	5225
4B	F108-ABSENCE OF PHYSICIAN			

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
4B	F109-PHYSICAL EXAM	321	4%	26229
4B	F110-PHYSICIAN S VISITS-30 DAYS	242	3%	16853
4B	F111-TOTAL CARE REVIEWED	512	6%	37257
4B	F112-SIGNS ORDERS AND PROGRESS NOTES	496	6%	38874
4B	F113-ALTERNATE SCHEDULE OF VISITS	123	1%	9565
4B	F114-EXCEPTIONS TO ALTERNATE SCHEDULE	54		4571
4B	F115-MAXIMUM 60 DAY CYCLE OF VISITS	78	1%	5935
4B	F116-ALTERNATE SCHEDULE ACTIONS	88	1%	6744
4B	F117-UR COMMITTEE MUST CONCUR	68		5173
4C	AVAILABILITY OF PHYSICIANS FOR EMERGENCY PATIENT CARE	67		4559
V	NURSING SERVICES	162	2%	10781
5A	DIRECTOR OF NURSING SERVICES	232	3%	16407
5A	F125-QUALIFIED RN DIRECTOR	70		3908
5A	F126-AUTHORITY OF DIRECTOR	103	1%	6703
5A	F127-QUALIFIED ASSISTANT DIRECTOR	93	1%	5541
5A	F128-RESPONSIBILITY OF DIRECTOR	332	4%	25842
5B	CHARGE NURSE	212	2%	15807
5B	F130-QUALIFIED CHARGE NURSE	131	1%	10297
5B	F131-SUPERVISION RESPONSIBILITY	71		6118
5B	F132-CHARGE NURSE IS NOT DIRECTOR	119	1%	8863
5B	F133-DELEGATION OF RESPONSIBILITY	105	1%	8810
5C	24-HOUR NURSING SERVICE	693	9%	56512
5C	F135-24-HOUR NURSING SERVICE	257	3%	20929

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
5C	F136-PROPER CARE	328	4%	28332
5C	F137-PROPER STAFF ASSIGNMENTS	288	3%	19654
5C	F138-WEEKLY SCHEDULE	60		4824
5D	PATIENT CARE PLAN	829	11%	64975
5D	F170-WRITTEN PATIENT CARE PLAN	525	7%	39549
5D	F171-CARE, GOALS, RESPONSIBILITY	1016	13%	79738
5D	F172-PLAN IS REVIEWED AND UPDATED	1009	13%	79595
5E	REHABILITATIVE NURSING CARE	583	7%	48881
5E	F174-REHABILITATIVE NURSING TRAINING	150	2%	12137
5E	F175-ACTIVE PROGRAM OF REHABILITATIVE CARE	280	3%	23367
5E	F176-PERFORMED DAILY AND RECORDED	352	4%	30431
5F	SUPERVISION OF PATIENT NUTRITION	211	2%	18197
5F	F178-AWARE OF NUTRITIONAL NEEDS	160	2%	14360
5F	F179-DIETETIC INFORMATIONAL PROCEDURE	137	1%	10833
5F	F180-PATIENT INTAKE DEVIATIONS	226	3%	20243
5G	ADMINISTRATION OF DRUGS	432	5%	35033
5G	F182-COMPLIANCE WITH STATE AND LOCAL LAWS	74	1%	5416
5G	F183-PROCEDURES ESTABLISHED	320	4%	23560
5G	F184-IDENTIFICATION OF PATIENTS	212	2%	15286
5G	F185-INDIVIDUAL MEDICAL RECORD	5		372
5G	F186-DOSAGE PROPERLY RECORDED	229	3%	17303
5G	F187-PROMPTLY ADMINISTERED	153	2%	12006
5G	E188-SAME PERSON	93	1%	7083

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

NOT MET

		FACILITIES		BEDS
IDENTIFICATION				
5H	CONFORMANCE WITH PHYSICIANS DRUG ORDERS	569	7%	46173
5H	F190-ADMINISTERED IN ACCORDANCE WITH WRITTEN ORDERS	485	6%	39987
5H	F191-AUTOMATIC STOP ORDERS	400	5%	30033
5H	F192-VERBAL ORDERS RECORDED AND SIGNED	172	2%	14921
5H	F193-COUNTERSIGNED ORDERS	373	5%	30331
5H	F194-ATTENDING PHYSICIAN NOTIFIED	233	3%	17497
5I	STORAGE OF DRUGS AND BIOLOGICALS	470	6%	35266
5I	F202-ESTABLISHED PROCEDURES FOR STORING DRUGS	486	6%	36892
5I	F203-LOCKED COMPARTMENTS	165	2%	13386
5I	F204-AUTHORIZED ACCESS	32		2323
5I	F205-SEPARATELY LOCKED STORAGE OF CONTROLLED DRUGS	184	2%	13764
5I	F206-EMERGENCY MEDICATION KIT	337	4%	24258
VI	DIETETIC SERVICES	97	1%	8063
6A	STAFFING	770	10%	61606
6A	F209-FULL-TIME DIETETIC SUPERVISOR	917	12%	67644
6A	F210-CONSULTATION WITH QUALIFIED DIETITIAN	431	5%	33342
6A	F211-SUFFICIENT SUPPORTIVE PERSONNEL	134	1%	11994
6A	F212-PERSONNEL ON DUTY 12 HOURS	123	1%	11584
6A	F213-CONSULTANT DIETETIC SERVICES PROVIDED	402	5%	31890
6B	MENUS AND NUTRITIONAL ADEQUACY	229	3%	19886
6C	THERAPEUTIC DIETS	490	6%	43555
6C	F223-PHYSICIAN PRESCRIBES THERAPEUTIC DIETS	115	1%	11017
6C	F224-THERAPEUTIC MENUS	590	8%	50870

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
6C	F225-THERAPEUTIC DIET MANUAL	198	2%	17828
6D	FREQUENCY OF MEALS	196	2%	14967
6D	F231-THREE MEALS PER DAY	110	1%	8701
6D	F232-BEDTIME NOURISHMENTS	55		4616
6E	PREPARATION AND SERVICE OF FOOD	196	2%	19393
6E	F238-FOOD PREPARATION METHODS	220	3%	22862
6E	F239-SUBSTITUTE MEALS	123	1%	10164
6F	HYGIENE OF STAFF	159	2%	12332
6F	F241-NO COMMUNICABLE DISEASE AMONG DIETETIC PERSONNEL	95	1%	7013
6F	F242-HYGIENIC FOOD HANDLING	80	1%	6308
6F	F243-OTHER NONFOOD DUTIES	20		1808
6G	SANITARY CONDITIONS	455	6%	38751
6G	F245-SATISFACTORY SOURCES OF FOOD	19		2379
6G	F246-SANITARY STORAGE AND PREPARATION	786	10%	66443
6G	F247-PROPER WASTE DISPOSAL	368	5%	31882
6G	F248-WRITTEN INSPECTION REPORT	96	1%	6514
VII	SPECIALIZED REHABILITATIVE SERVICES	104	1%	6778
7A	ORGANIZATION AND STAFFING	260	3%	18288
7A	F251-REHABILITATIVE STAFF	72		4588
7A	F252-REHABILITATIVE SERVICES OFFERED	53		3933
7A	F253-WRITTEN POLICIES AND PROCEDURES	374	5%	27852
7B	PLAN OF CARE	418	5%	34017
7B	F255-WRITTEN PLAN	283	3%	22603

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

NOT MET

IDENTIFICATION		FACILITIES		BEDS
7B	F256-WRITTEN THERAPY ORDERS	116	1%	9115
7B	F257-PROGRESS REPORT	297	4%	22675
7B	F258-PROGRESS IS REVIEWED	500	6%	40415
7C	DOCUMENTATION OF SERVICES	317	4%	26048
7D	QUALIFYING TO PROVIDE OPT SERVICES	88	1%	6860
VIII	PHARMACEUTICAL SERVICES	105	1%	8057
8A	SUPERVISION OF SERVICES	660	9%	49325
8A	F265-SUPERVISION OF PHARMACIST	66		4336
8A	F266-RESPONSIBILITIES OF PHARMACIST	83	1%	5690
8A	F267-SUFFICIENT HOURS DURING VISITS	606	8%	46830
8A	F268-PHARMACIST REVIEWS DRUG REGIMEN	420	5%	30922
8A	F269-WRITTEN REPORT	402	5%	28377
8B	CONTROL AND ACCOUNTABILITY	298	4%	23536
8B	F273-CONTROL AND ACCOUNTABILITY FOR DRUGS	285	3%	22647
8B	F274-USE OF APPROVED DRUGS	78	1%	5712
8B	F275-DISPENSED IN COMPLIANCE WITH LAW	87	1%	6619
8B	F276-SUFFICIENT RECORDS MAINTAINED	102	1%	8230
8B	F277-PHARMACIST CHECKS RECORDS	177	2%	12952
8C	LABELING OF DRUGS AND BIOLOGICALS	346	4%	25793
8D	PHARMACEUTICAL SERVICES COMMITTEE	749	10%	54764
8D	F280-PHARMACEUTICAL COMMITTEE DEVELOPS POLICIES	581	7%	42578
8D	F281-COMPOSITION OF COMMITTEE	493	6%	34666
8D	F282-COMMITTEE RESPONSIBILITY	592	8%	44095

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

NOT MET

IDENTIFICATION		FACILITIES		BEDS
8D	F283-COMMITTEE MEETS AT LEAST QUARTERLY	387	5%	27958
IX	LABORATORY + RADIOLOGIC SERVICES	16		796
9A	PROVISION FOR SERVICES	78	1%	6370
9A	F288-LAB AND X-RAY SERVICES MEET APPLICABLE CONDITION	63		5471
9A	F289-ARRANGEMENTS FOR OUTSIDE SERVICES	61		4490
9A	F290-PROVIDED ON PHYSICIAN S ORDERS	31		2639
9A	F291-PHYSICIAN NOTIFIED	15		1351
9A	F292-ASSISTS IN ARRANGING TRANSPORTATION	10		682
9A	F293-SIGNED REPORTS	77	1%	4702
9B	BLOOD AND BLOOD PRODUCTS	101	1%	7398
9B	F297-ADEQUATE BLOOD FACILITIES	27		2038
9B	F298-MEETS CERTIFICATION CONDITIONS	30		2225
9B	F299-MEETS TRANSFUSION REQUIREMENTS	35		2694
X	DENTAL SERVICES	61		4556
10A	ADVISORY DENTIST	579	7%	39571
10A	F302-ADVISORY DENTIST	464	6%	32380
10A	F303-ORAL HYGIENE POLICIES	334	4%	23962
10B	ARRANGEMENTS FOR OUTSIDE SERVICES	134	1%	10067
10B	F305-COOPERATIVE AGREEMENT WITH A DENTAL SERVICE	113	1%	7949
10B	F306-MAINTAINS LIST OF DENTISTS	93	1%	7994
10B	F307-ASSISTS PATIENT IN ARRANGING TRANSPORTATION	25		1991
XI	SOCIAL SERVICES	92	1%	6439
11A	SOCIAL SERVICE FUNCTION	253	3%	18856

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
11A	F310-NEEDS IDENTIFIED	150	2%	13174
11A	F311-SERVICES PROVIDED TO MEET NEEDS	145	1%	11730
11A	F312-REFERRED FOR FINANCIAL ASSISTANCE	35		2568
11A	F313-INFORMED OF RIGHTS	144	1%	10172
11B	STAFFING	240	3%	18377
11B	F315-RESPONSIBLE STAFF MEMBERS	51		4657
11B	F316-OUTSIDE AGREEMENT	195	2%	14074
11B	F317-SUFFICIENT SUPPORTIVE PERSONNEL	84	1%	8841
11B	F318-ADEQUATE FACILITIES FOR SOCIAL SERVICE PERSONNEL	29		2693
11C	RECORDS AND CONFIDENTIALITY OF SOCIAL DATA	181	2%	14406
11C	F321-SOCIAL DATA RECORDS MAINTAINED	239	3%	20911
11C	F322-RECORD OF REFERRALS	120	1%	8899
11C	F323-POLICIES FOR CONFIDENTIALITY	109	1%	9335
XII	PATIENT ACTIVITIES	112	1%	7024
12A	RESPONSIBILITY FOR PATIENT ACTIVITIES	338	4%	22803
12A	F326-DESIGNATED STAFF MEMBER	64		3825
12A	F327-CONSULTATION IF NECESSARY	248	3%	16694
12B	PATIENT ACTIVITIES PROGRAM	449	6%	32174
12B	F331-ONGOING PATIENT ACTIVITIES PROGRAM	210	2%	14669
12B	F332-PHYSICIAN APPROVED OF PROGRAM	467	6%	35619
12B	F333-PROMOTES WELL BEING	135	1%	10316
12B	F334-ADEQUATE SPACE AND SUPPLIES	108	1%	9052
XIII	MEDICAL RECORDS	76	1%	5858

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
13A	STAFFING	364	4%	24241
13A	F337-SUPERVISED BY FULL-TIME EMPLOYEE	36		2474
13A	F338-SUPPORTIVE PERSONNEL	51		4118
13A	F339-CONSULTATION IF NECESSARY	234	3%	14935
13B	PROTECTION OF INFORMATION	91	1%	5894
13C	CONTENT	757	10%	57059
13C	F345-SUFFICIENT INFORMATION IN RECORD	125	1%	8995
13C	F346-CONTENTS OF RECORDS	662	9%	50066
13D	PHYSICIAN DOCUMENTATION	69		5195
13D	F351-DOCUMENTATION BY PHYSICIANS	20		1209
13D	F352-PHYSICIAN SIGNS ENTRIES	82	1%	5558
13E	COMPLETION OF RECORDS AND CENTRALIZATION OF REPORTS	283	3%	20322
13E	F354-RECORDS COMPLETED PROMPTLY	246	3%	17753
13E	F355-ALL CLINICAL INFORMATION ENTERED	52		3736
13F	RETENTION AND PRESERVATION	61		5172
13G	INDEXES	636	8%	47276
13H	LOCATION AND FACILITIES	58		4151
XIV	TRANSFER AGREEMENT	15		915
14A	PATIENT TRANSFER	49		3714
14A	F361-WRITTEN AGREEMENT	11		476
14A	F362-TRANSFER OF PATIENTS BETWEEN HOSPITAL AND SNF	17		1088
14A	F363-INTERCHANGE OF INFORMATION	43		3099
14A	F364-SECURITY OF PERSONAL EFFECTS	94	1%	6845

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION XV	PHYSICAL ENVIRONMENT	NOT MET FACILITIES		BEDS
15B	EMERGENCY POWER	93	1%	5827
15B	F368-EMERGENCY POWER SUPPLY	199	2%	13155
15B	F369-POWER REQUIREMENTS	46		2797
15B	F370-EMERGENCY GENERATOR FOR LIFE SUPPORT SYSTEM	96	1%	6159
15C	FACILITIES FOR PHYSICALLY HANDICAPPED	79	1%	4744
15C	F372-ACCESSABILITY OF FACILITY	407	5%	28333
15C	F373-ACCOMMODATIONS FOR HANDICAPPED	40		2797
15C	[4.1] GROUNDS GRADED TO ENTRANCE LEVEL	302	4%	22919
15C	[4.2] WIDTH AND GRADE OF WALKS	50		3193
15C	[4.3] PARKING AREA	15		772
15C	[5.1] RAMPS PROPERLY DESIGNED	476	6%	37655
15C	[5.2] PRIMARY ENTRANCE FOR WHEELCHAIRS	62		3977
15C	[5.3] WIDTH AND WEIGHT OF DOORS	52		4015
15C	[5.4.1] HEIGHT AND DESIGN OF STAIRS	26		1985
15C	[5.4.3] EXTENDED HANDRAILS	56		4274
15C	[5.5] NON-SLIP FLOORS ON COMMON LEVEL	80	1%	6298
15C	[5.6] ACCESSIBLE TOILET ROOMS	5		296
15C	[5.7] ACCESSIBLE WATER FOUNTAINS	144	1%	10562
15C	[5.8] ACCESSIBLE PUBLIC TELEPHONES	221	3%	15184
15C	[5.9] ACCESSIBLE ELEVATORS	142	1%	9737
15C	[5.10] ACCESSIBLE SWITCHES AND CONTROLS	40		2340
15C	[5.11] FACILITIES ARE IDENTIFIABLE BY THE BLIND	16		1206
		616	8%	46861

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
15C	[5.12] AUDIBLE AND VISUAL WARNING SIGNALS	573	7%	43759
15C	[5.13] HAZARDS TO HANDICAPPED ARE ELIMINATED	42		2920
15D	NURSING UNIT	188	2%	15145
15D	F394-NURSING SERVICE AREAS	79	1%	5692
15D	F395-COMMUNICATION SYSTEM	189	2%	14314
15E	PATIENT ROOMS AND TOILET FACILITIES	215	2%	19575
15E	F397-ROOMS DESIGNED FOR ADEQUATE CARE	151	2%	10813
15E	F398-NUMBER OF BEDS	110	1%	9379
15E	F399-SIZE OF SINGLE ROOMS	93	1%	8855
15E	F400-SIZE OF MULTIPATIENT ROOMS	129	1%	9960
15E	F401-ADEQUATE TOILET AND BATHING FACILITIES	74	1%	6512
15E	F402-DIRECT ACCESS TO A CORRIDOR	48		3475
15F	FACILITIES FOR SPECIAL CARE	243	3%	16935
15F	F404-SPECIAL ROOMING PROVISIONS	176	2%	12067
15F	F405-WRITTEN PROCEDURE FOR ISOLATION AND ASEPTIC	235	3%	16638
15F	F406-PRECAUTIONARY SIGNS	40		2833
15G	DINING AND PATIENT ACTIVITIES ROOMS	72		4431
15G	F408-ADEQUATE DINING AREA[S]	83	1%	6123
15G	F409-WELL LIGHTED AND VENTILATED	67		4140
15G	F410-USE OF MULTIPURPOSE ROOM	58		3542
15H	KITCHEN AND DIETETIC SERVICE AREAS	246	3%	19547
15H	F414-ADEQUATE KITCHEN AREAS	46		3030
15H	F415-PROPERLY VENTILATED AND EQUIPPED	242	3%	19838

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
15I	MAINTENANCE OF EQUIPMENT, BUILDING, AND GROUNDS	585	7%	46146
15I	F417-WRITTEN EQUIPMENT MAINTENANCE PROGRAM	287	3%	20497
15I	F418-CLEAN INTERIOR AND EXTERIOR	230	3%	19429
15I	F419-EQUIPMENT MAINTAINED IN SAFE OPERATING CONDITION	193	2%	15324
15J	OTHER ENVIRONMENTAL CONSIDERATIONS	378	5%	28304
15J	F421-FUNCTIONAL, SANITARY ENVIRONMENT	253	3%	20294
15J	F422-ADEQUATE LIGHTING LEVELS	124	1%	9891
15J	F423-COMFORTABLE SOUND LEVEL	34		3179
15J	F424-COMFORTABLE ROOM TEMPERATURES	56		5118
15J	F425-EMERGENCY WATER SUPPLY	370	5%	25487
15J	F426-ADEQUATE VENTILATION	153	2%	13056
15J	F427-HANDRAILS IN CORRIDORS	72		5326
XVI	INFECTION CONTROL	145	1%	11045
16A	INFECTION CONTROL COMMITTEE	694	9%	51401
16A	F430-COMPOSITION OF COMMITTEE	355	4%	25071
16A	F431-ESTABLISHES POLICIES AND PROCEDURES	307	4%	22326
16A	F432-MONITORS STAFF PERFORMANCE	300	4%	21218
16B	ASEPTIC AND ISOLATION TECHNIQUES	381	5%	28473
16B	F436-WRITTEN PROCEDURES	254	3%	19003
16B	F437-PROCEDURES REVIEWED ANNUALLY	200	2%	14469
16C	HOUSEKEEPING	206	2%	16178
16C	F439-SUFFICIENT HOUSEKEEPING PERSONNEL	69		5149
16C	F440-PROVIDES NECESSARY HOUSEKEEPING EQUIPMENT	114	1%	10007

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-75

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
16C	F441-TRAINING OF PERSONNEL	44		3355
16C	F442-NURSING PERSONNEL NOT ASSIGNED HOUSEKEEPING DUTIES	55		3831
16C	F443-OUTSIDE SOURCE OF HOUSEKEEPING	43		3191
16D	LINEN	220	3%	17501
16D	F445-AVAILABLE QUANTITY OF LINEN	75	1%	7003
16D	F446-HANDLING AND PROCESSING OF LINEN	275	3%	21215
16E	PEST CONTROL	89	1%	7420
XVII	DISASTER PREPAREDNESS	75	1%	5266
17A	DISASTER PLAN	249	3%	18599
17A	F450-WRITTEN DISASTER PLAN	152	2%	10836
17A	F451-PLAN DEVELOPED WITH QUALIFIED EXPERTS	118	1%	9368
17A	F452-TRANSFER OF CASUALTIES AND RECORDS	164	2%	13157
17A	F453-INSTRUCTION FOR USE OF ALARM SYSTEM	95	1%	7640
17A	F454-INFORMATION ON CONTAINING FIRE	39		2974
17A	F455-NOTIFICATION PROCEDURES	64		4616
17A	F456-EVACUATION PROCEDURES	91	1%	6384
17B	STAFF TRAINING AND DRILLS	279	3%	20914
17B	F458-EMPLOYEE DISASTER TRAINING	186	2%	14978
17B	F459-ORIENTATION AND TRAINING	265	3%	20347
XVIII	UTILIZATION REVIEW	107	1%	7105
18A	WRITTEN PLAN OF UR ACTIVITY	336	4%	26365
18A	F462-WRITTEN UR PLAN	107	1%	7914
18A	F463-CONTENTS OF PLAN	118	1%	8345

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 9
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
18B	COMPOSITION AND ORGANIZATION OF UR COMMITTEE	77	1%	6088
18B	F465-COMPOSITION OF COMMITTEE	48		4012
18B	F466-MEDICAL DETERMINATIONS	16		787
18B	F467-PHYSICIANS DO NOT REVIEW NEW CASES	56		4460
18C	MEDICAL CARE EVALUATION STUDIES	310	4%	21629
18C	F476-MEDICAL CARE STUDIES	118	1%	7375
18C	F477-EMPHASIS OF STUDIES	139	1%	9958
18C	F478-PURPOSE OF STUDY	142	1%	9856
18C	F479-STUDIES INCLUDE ADMISSIONS	97	1%	5723
18C	F480-ONE STUDY ALWAYS IN PROGRESS	151	2%	9242
18D	REVIEW OF CASES OF EXTENDED DURATION	368	5%	27061
18D	F464-PERIODIC CASE REVIEW	56		3958
18D	F485-REVIEWS CAN INCLUDE NON-BENEFICIARIES	33		1844
18D	F486-REVIEW PERIODS CAN VARY	217	2%	17376
18D	F487-EXCEPTION TO 21-DAY LIMIT	33		2312
18D	F488-ADVANCE PAYMENT APPROVAL	55		3719
18D	F489-THIRTY-NINETY DAY REVIEW LIMITS	68		4680
18D	F490-FINAL DETERMINATION TIME LIMITS	123	1%	8628
18E	ADMISSION OF FURTHER STAY NOT MEDICALLY NECESSARY	78	1%	5628
18E	F496-PHYSICIANS MAKE COMMITTEE DECISION	21		946
18E	F497-CONCURRENCE OBTAINED WITHIN 7 DAYS	34		2162
18E	F498-CONSULTATION WITH ATTENDING PHYSICIAN	24		1278
18E	F499-NOTIFICATION WITHIN 48 HOURS	45		3024

MEDICARE/MEDICAID AUTOMATED CERTIFICATION SYSTEM

TOTAL SKILLED NURSING FACILITIES

NATIONAL DEFICIENCY PATTERNS

TABLE 8
MOST RECENT SURVEYS
FOR ALL FACILITIES
THROUGH 05-12-76

UNITED STATES

IDENTIFICATION		NOT MET FACILITIES		BEDS
18F	ADMINISTRATIVE RESPONSIBILITIES	115	1%	8776
18F	F501-ADMINISTRATIVE STAFF KEPT INFORMED	44		2702
18F	F502-ADMINISTRATOR ACTS UPON RECOMMENDATIONS	105	1%	8788
18G	UTILIZATION REVIEW RECORDS	219	2%	15397
18G	F507-WRITTEN UR COMMITTEE RECORDS KEPT	51		3017
18G	F508-SIGNED REPORTS TO STAFF	107	1%	7405
18G	F509-MINUTES OF COMMITTEE MEETINGS KEPT	267	3%	20022
18H	DISCHARGE PLANNING	419	5%	30082
18H-1	DISCHARGE PLANNING PROGRAM IN OPERATION	418	5%	30027
18H-1	F523-RESULTS AVAILABLE TO UR COMMITTEE	335	4%	23967
18H-2	ADMINISTRATOR DELEGATES RESPONSIBILITY	395	5%	27990
18H-3	WRITTEN DISCHARGE PLANNING PROCEDURES	521	7%	38071
18H-4	APPROPRIATE SUMMARY UPON DISCHARGE	309	4%	20214

LIFE SAFETY CODE DEFICIENCY REPORT

The number of Skilled Nursing Facilities with a reported deficiency have been entered next to the requirement on the attached Fire Safety Survey Report Form SSA-2786. For example: 809 facilities are deficient with respect to 2 - 1 construction type. The total number of SNFs in the Medicare/Medicaid Automated Certification System at the date of report preparation was 7990.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
SOCIAL AND REHABILITATION SERVICE

Form Approved
OMB No. 72-R0973

FIRE SAFETY SURVEY REPORT
Medicare – Medicaid

1 (A) PROVIDER NUMBER	1 (B) MEDICAID I D NO
K1	K2

Part I is a guide to surveying for compliance with the Life Safety Code (21st edition, 1967). Part II contains those Medicare and Medicaid fire safety requirements not otherwise identified in the Life Safety Code. Part III contains a certification form to be completed by the fire authority when waiver of a specific provision of the Life Safety code is recommended. Building sketches can also be included in Part III.

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2 (A) MULTIPLE CONSTRUCTION (BLDGS) K3 A. BUILDING ____ B. WING ____ C. FLOOR ____	2 (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)
3. SURVEY FOR: ☐ MEDICARE ☐ MEDICAID	4 DATE OF SURVEY K4	

5. SURVEY FOR CERTIFICATION OF: (K5)
1. ☐ HOSPITAL 2. ☐ SKILLED NURSING FACILITY 3. ☐ INTERMEDIATE CARE FACILITY

IF "B" OR "C" IS CHECKED, CHECK APPROPRIATE ITEM(S) BELOW:

(1.) ☐ ENTIRE FACILITY (2.) ☐ DISTINCT PART OF: (SPECIFY) _____

(3.) IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED BY JCAH? a. ☐ YES b. ☐ NO

6. BED COMPOSITION:

a. TOTAL NO. OF BEDS IN THE FACILITY.	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE.	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE.	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID.	e. NUMBER OF ICF BEDS CERTIFIED FOR MEDICAID.

7. A. (K6) ☐ THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES):
1. ☐ COMPLIANCE WITH ALL PROVISIONS 2. ☐ ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS

such standards of the NFPA Life Safety Code (21st edition, 1967) as are applicable to hospitals or nursing homes as well as other Medicare and Medicaid requirements as shown in Part II of this form.

B. ☐ THE FACILITY DOES NOT MEET THE STANDARD

SURVEYOR-(SIGNATURE)	TITLE	OFFICE	DATE
8. SURVEYOR I.D. NO. (K7)			
FIRE AUTHORITY OFFICIAL (SIGNATURE)	TITLE	OFFICE	DATE

FORM SSA-2786 (11-74)

I.D. PREFIX	YES	NO	N.A	PART I — Items Identified In LSC	EXPLANATORY REMARKS
K8 809				2-1. **Construction Type** - Building construction complies with Section 10-1321 and 10-1322.	
K9				2-1. Indicate type of construction as defined in NFPA 220 (Standard Types of Building Construction, 1961.) A. 1. ☐ FIRE RESISTIVE 5. ☐ PROTECTED ORDINARY 2. ☐ NON-COMBUSTIBLE 6. ☐ HEAVY TIMBER 3. ☐ PROTECTED NON-COMBUSTIBLE 7. ☐ WOOD FRAME 4. ☐ ORDINARY 8. ☐ PROTECTED WOOD FRAME	
K10				B. _____ Number of stories, not including basement or cellar	
K11				C. _____ Floors on which patient rooms are located if multi-stories	
K12				D. _/_/__ Date original building permit issued or approval given by appropriate authority *(Complete sketch in Part III showing original and subsequent construction dates)*	
K13 497				2-2. **Corridor Walls** - Corridors shall be separated from sleeping rooms and treatment areas by construction having at least a 1-hour fire resistance rating with openings therein, other than doors, limited to 1296 square inches and glazed with wired glass in approved steel frames. 10-1331	
K14 1,073				2-3. **Corridor Doors** - Doors to patient rooms and diagnostic and treatment areas are 1¾" solid wood bonded core doors or the equivalent with any openings limited to 1296 square inches with wired glass in approved steel frames. *(Undercutting of such doors is not permitted).* 10-1332	
K15 398				2-4. **Subdivision of Floor Areas** - Each floor used for sleeping rooms for more than 30 patients, unless provided with a horizontal exit, is divided into at least two sections by a smoke barrier. *(New buildings are required to provide compartmentation on patient floors regardless of the number of patients). (See definition of horizontal exit in 5-5111).* 10-2311	

I.D. PREFIX	YES	NO	N.A		EXPLANATORY REMARKS
K16 433				3-1. **Smoke Barriers** - Smoke barriers or horizontal exits divide corridors into sections of not more than 150 feet in length. 10-2312	
K17 913				3-2. **Smoke Barriers** have at least a ½ hour fire rating and are continuous from exterior wall to exterior wall and floor to floor or roof deck above. *(In new buildings the smoke barrier has a fire-resistance rating of one hour).* 10-2313	
K18 148				3-3. **Common Wall** - If the building shares a common wall with a non-conforming structure, the wall is at least a 2-hour fire rated partition with any openings protected by a self-closing Class B 1½ hour fire door. 10-1131	
K19 385				3-4. **Stairway Enclosures** - Each stairway between stories is enclosed with partitions having at least a 1-hour fire resistance rating to prevent the spread of fire between stories. 10-2321	
K20 97				3-5. **Doors in stairway enclosures** are not equipped with hold-open devices. 10-2246	
K21 402				3-6. **Doors in walls separating hazardous areas** are not equipped with hold-open devices. 10-2246	
K22 137				3-7. **Stairs and smokeproof towers** are Class A or Class B. *(Class B specifications are not acceptable in new construction).* 10-2251, 5-3121	
K23 301				3-8. **Vertical Shafts** - Elevator shafts, light and ventilation shafts, chutes, and other vertical openings between stories are protected as required in item 3-4. 10-2322	
K24 129				3-9. **Fire-Stopping** - Combustible concealed spaces between the basement and the first floor are fire-stopped. *(Fire stopping in new construction shall be in accordance with 6-1311)* 10-2323	
K25 185				3-10. **Linen and Trash Chutes** - Any linen or trash chute which opens directly on to a corridor is sealed by fire-resistive construction to prevent further use or is provided with a door assembly suitable for a Class B location. *(In new construction, chute and incinerator flues do not open directly on to an exit corridor and chutes are sprinklered.)* 10-2324, 7-113	

I.D. PREFIX	YES	NO	N/A		EXPLANATORY REMARKS
K26 243				4-1. **Exits - Number and Type** - At least two exits, remote from each other, are provided for each floor or fire section. At least one of the exits is a door leading directly outside the building or to an interior stairway leading outside the building. 10-2211, 10-2212	
K27 278				4-2. **Access** - Every aisle, passageway, corridor exit discharge, exit location and "access" has a readily available egress leading to the exit. *(In new buildings, corridor dead-ends shall not exceed 30 feet).* 10-2231, 10-1234	
K28 16				4-3. **Capacity** - The capacity of exits providing horizontal travel is 30 persons per exit unit. Where travel is over stairs, the exiting capacity is 22 persons per exit unit. 10-2221	
K29 84				4-4. **Horizontal Exit** - Any horizontal exit is in accordance with section 5-5 and has at least 44 inches in clear width. 10-2261	
K30 155				4-5. **Corridor Width** - Aisles and corridors are a minimum of 48 inches in clear width when serving as a means of egress from institutional sleeping rooms. *(For new construction the corridor is 8 feet in clear width).* 10-2233, 10-1233	
K31 32				4-6. **Room Egress** - All sleeping rooms have a door leading directly to a corridor providing access to an exit, unless there is a door leading directly to grade. See 10-2234 for allowance of one intervening room.	
K32 36				4-7. **Travel distances** to an exit are 100 feet or less from the entrance door and 150 feet from any point in a room. *(In buildings completely protected by an automatic sprinkler system these distances may be increased by 50 feet.)* 10-2232; for new construction: 10-1232	
K33 398				4-8. **Door Width** - Any door to a patient's sleeping room, any door between occupied spaces and the required exits and exit doorways are at least 40 inches in clear width. *(44 inches in new buildings.)* See 10-2242 for allowable exceptions.	
K34 76				4-9. **Doors in Line of Exit Travel** - Every door in the line exit travel from a patient's sleeping room is of the swinging type. 10-2244	

I.D. PREFIX	YES	NO	N.A		EXPLANATORY REMARKS
K35 79				5-1. **Patient Rooms** - Locks installed on patient sleeping room doors other than doors not leading directly to the exterior of the building can be locked only from the corridor side. All sleeping room locks are readily opened by the patient from inside the room without the use of a key. Patient room doors lockable from the inside are permitted provided they can be unlocked from the corridor side and the keys are readily available to attendants. 10-2242	
K36 91				5-2. **Windows** - Every patient's bedroom, unless it has a door leading directly outside of the building, has at least one outside window which can be opened from the inside without the use of tools. 10-2213	
K37 1,440				5-3. **Doors in Fire and Smoke Partitions** - Every door in a fire partition, horizontal exit, and smokestop partition shall be self-closing. Doors may be held open only by electric hold-open devices and are capable of being opened and closed manually. Doors shall be closed upon actuation of the fire alarm system and by one of the approved methods shown as A, B, C in Explanatory Remarks. However, if more than one of the protection systems is installed, each system upon actuation, must close all fire and smoke partition doors. 10-2245, 10-2313	
K38				5-4. **Closing Fire and Smoke Doors** - Indicate which of the following methods will automatically close those fire or smoke doors which are normally held open: 1. ☐ A. Activation of the sprinkler system. 2. ☐ B. Actuation of any detector of a complete smoke or products of combustion detection system. 3. ☐ C. By local detection devices installed to detect smoke or other products of combustion on either side of the door opening.	
K39 654				5-5. **Stairwall doors** bear an appropriate sign indicating that this is a fire exit and must be kept closed. 5-2133	
K40 305				5-6. **Exit Lighting** - Means of egress are illuminated to permit safe evacuation of patients. 10-2272, 5-10113	

I.D. PREFIX	YES	NO	N.A		EXPLANATORY REMARKS
K41 512				6-1. **Exit and Directional Signs** are continuously illuminated with a reliable light source and include the word EXIT in easily visible letters. 10-2271, 5-11121	
K42				6-2. **Hospitals Only:** *(Indicate Not Applicable for Nursing Homes)* **Central electrical systems** are designed, installed, and maintained to assure continuity of electrical power in accordance with NFPA Standard No. 76 *(Essential Electrical Systems for Hospitals, 1967)* 10-1293	
K43 331				6-3. **Emergency lighting** of Type I, II or III is provided in facilities with an inpatient capacity of 30 or more persons. *(In new buildings only types I or II are permitted.)* 10-2273, 5-102, 10-1294	
K44 293				6-4. **Required emergency lighting** is automatic and not manual. 5-10215	
K45 268				6-5. **Interior finish** of walls and ceilings is Class A or Class B. *(In completely sprinklered buildings, Class C interior finish may be continued in use. In newly constructed buildings, means of egress and patient rooms accommodating more than 4 patients have Class A interior finish).* 6-2, 10-1351, 10-2331	
K46 395				6-6. **Floor Covering** has a flame spread rating not in excess of 75 when tested in accordance with NFPA Standard 255, "Flame Spread Tests". *(Flame spread rating of floor covering in completely sprinklered existing buildings is not over 200).*	
K47				B. Indicate floor covering test score: 1. ☐ CONCRETE, MARBLE, TERAZZO, ETC. 2. ☐ RESILIENT 3. ☐ CARPETING	
K48				6-6. A. **Floor Covering** Indicate type of finish floor or floor covering: 1. ☐ 0-75 3. ☐ OVER 200 2. ☐ 76-200 4. ☐ NOT TESTED	
K49				C. Testing Laboratory:	

I.D. PREFIX	YES	NO	N A		EXPLANATORY REMARKS
K50 1,012				7-1. **Sprinkler Coverage** - Automatic Sprinkler protection is provided throughout the facility with adequate water supply and pressure *(15 psi at the most remote sprinkler heads).* Fire resistive buildings or 1-hour protected non-combustible buildings of one story should be marked "Not Applicable." 10-2341, NFPA Std. 13	
K51 456				7-2. **Sprinkler System Maintenance** - Automatic sprinkler systems are maintained, inspected and tested in accordance with NFPA Standard 13A *(Care and Maintenance of Sprinkler Systems)* 6-4131	
K52 →				7-2. A. _____ Date sprinkler system last checked & necessary maintenance last provided.	
				B. Show who provided the service:	
K53 →				C. Note the source of water supply for the sprinkler system:	
K54 1,159				7-3. **Sprinkler Alarm System** - The automatic sprinkler system is electrically inter-connected with the fire alarm system 10-2342	
K55 1,301				7-4. **The main sprinkler control valve** is electrically supervised so that at least a local alarm will sound when the valve is closed. 10-2342	
K56 1,073				7-5. **Manually operated fire alarm system** is provided. In new buildings it is electrically supervised. *(Pre-signal system is not acceptable).* 10-2344, 10-1365	
336 K57				7-6. **The fire alarm system** is tested at least weekly. 17-1412	
K58 277				7-7. **Portable fire extinguishers** are provided in accordance with NFPA Standard 10 *(Installation of Portable Fire Extinguishers).* 10-2345	
K59 335				7-8. **Fire extinguishers** are maintained in accordance with NFPA Standard 10A *(Maintenance and Use of Portable Fire Extinguishers).* 6-4221	
K60 1,014				7-9. **Air Conditioning and ventilating equipment** is maintained in accordance with NFPA 90A *(Installation of Air Conditioning and Ventilating Systems).* 10-2411	
K61 82				7-10. **Fuel-burning space heaters** and portable electric space heaters are not used. 10-2412	
K62 196				7-11. **Combustion and ventilation air** for boiler, incinerator and heater room is taken from and discharged to the outside air. 10-2413	

I.D. PREFIX	YES	NO	N/A		EXPLANATORY REMARKS
K63 1,654				8-1. **Hazardous Areas** - Every hazardous area has automatic fire protection or is separated by construction having at least a 1-hour fire resistance rating. Where a hazard is severe, both automatic fire protection and fire-resistive construction are used. 10-2351	
K64				8-1. A. The following hazardous areas are protected by automatic extinguishing systems and/or fire-separated. AES - Automatic extinguishment system S - Separated N/A - Not Applicable	

	(1) AES	(2) S	(3) N/A	
(a)				boiler, heater rooms
(b)				incinerator
(c)				laundries
(d)				repair shops
(e)				laboratories using hazardous quantities of flammable solvents
(f)				areas storing hazardous quantities of combustibles
(g)				trash collection rooms
(h)				employee locker rooms
(i)				soiled linen rooms
(j)				kitchen
(k)				handicraft shop
(l)				gift shop

K65 191				8-2. **Fire Protection Plan** - The facility has in effect and available to all supervisory personnel written copies of a plan for the protection of all persons in the event of fire and their evacuation to areas of refuge and from the building. 17-4111	

I.D. PREFIX	YES	NO	N/A		EXPLANATORY REMARKS
K66 342				9-1. **Evacuation Plan Posted** - The evacuation plan is posted in prominent locations on all floors. 17-4111	
K67 512				9-2. **Fire Drills** - A minimum of 12 fire drills are conducted annually at irregular intervals to familiarize employees on all shifts with their responsibilities. 17-4113, 17-11	
K68 232				9-3. **Furnishings and Decorations** - Furnishings and decorations do not obstruct exits or the ability to locate exits. 17-1211	
K69 409				9-4. **All combustible draperies and curtains** *(including cubicle curtains)* are rendered and maintained flame-retardant. 17-4151	
K70 568				9-5. **Wastebaskets** are of non-combustible material. 17-1213, 17-4161	
K71 429				9-6. **Smoking** - Regulations to control smoking have been adopted and implemented and are prominently posted throughout the building. 17-4141	

I.D. PREFIX	YES	NO	N/A	PART II — NON-WAIVERABLE Requirements Specified by Federal Regulations 405.1022(b), 405.1134(a)	EXPLANATORY REMARKS
K72 324				10-1. **Nonflammable medical gas systems** such as oxygen and nitrous oxide used for the administration of inhalation therapy and resuscitative purposes comply with NFPA Standard 56B *(Inhalation Therapy, 1968)*	
K73 194				10-2. **Piped-in oxygen systems** shall comply with NFPA Standard 56F *(Nonflammable Medical Gases, 1970)*	
K74				10-3. **Hospitals Only** *(Indicate Not Applicable for nursing homes)* **Anesthetizing areas** and rooms used for the storage of flammable anesthetic agents are designed, operated and maintained in accordance with NFPA standard 56A *(Inhalation Anesthetics, 1971)*	
K75 35				10-4. **Nursing Homes Only** *(Indicate Not Applicable for hospitals)* **Housing of Blind and Non-Ambulatory Patients** - Blind patients and non-ambulatory or physically handicapped patients are not housed above the street level floor unless the facility is of fire resistive construction, 1-hour protected non-combustible construction, or fully sprinklered 1-hour protected ordinary or fully sprinklered protected wood frame constrction.	

I.D. PREFIX	YES	NO	N A	PART III	EXPLANATORY REMARKS
				A. Alternative Provisions for Sprinkler Requirements - If item 5-7 on sprinkler coverage has been answered "NOT MET" and the facility is a one-story protected wood frame facility, answer the next four items.	
K76 519				11-1. **Hazardous Areas**- All hazardous areas are sprinklered.	
K77 347				11-2. **Detection Systems** - Automatic fire detection devices are installed in all areas required by the Life Safety Code to be protected by an automatic sprinkler system. The detection system is currently listed with UL's Fire Protection List. The system is arranged to close all fire doors in barrier partitions and, where possible, shall be hooked into the local fire department or central control. At a minimum, the detection system must activate an alarm system inside and outside the building.	
K78 21C				11-3. **Compartmentation** - Patient rooms are separated from each other and all other areas by construction having at least a 1-hour fire resistance rating.	
K79 126				11-4. **Fire Department Response** - The response time and capability of the local fire department is adequate, in the judgment of the State fire authority official, to provide an acceptable level of protection for an unsprinklered facility.	

B. RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code (21st edition, 1967) recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. (If additional space is required, use reverse side.)

PROVISION NUMBER(S)	JUSTIFICATION
K80	

SURVEYOR (SIGNATURE)	TITLE	OFFICE	DATE

FIRE AUTHORITY OFFICIAL (SIGNATURE)	TITLE	OFFICE	DATE

FORM SSA-2786 (11-74)

INVENTORY OF HEALTH CARE FACILITY SURVEYORS UNITED STATES-1974

DHEW Publication No. (HSA) 75-6503

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Services Administration
Bureau of Quality Assurance
Division of Provider Standards and Certification

CONTENTS

INVENTORY OF HEALTH CARE FACILITY SURVEYORS

INTRODUCTION

During the months November, 1974 through January, 1975, a nation-wide survey of health facility surveyors for Medicare-Medicaid was conducted by CPI Associates, Inc., under a contract to the Division of Provider Standards and Certification (DPSC). This report contains a compilation of data derived from that survey.

A questionnaire was developed for the survey and is included in the Appendix. The questionnaire sought information concerning age, sex, professional discipline, education, work experience, work status and activities, surveyor training, survey structure, program responsibility, kinds of facilities surveyed, and survey functions. The purpose of the questionnaire was to obtain information on all State and county employees, including life safety code surveyors, who as part of their normal duties conduct on-site surveys and complete at least a portion of the survey report form for facilities covered under Title XVIII (Medicare and Title XIX (Medicaid).

BACKGROUND

The 1974 national inventory of health facility surveyors constitutes the second of its kind. The first was conducted in 1972 by the Community Health Service through the Community Profile Data Center and the Division of Medical Care Standards. In the 1972 Surveyor Inventory, questionnaires were sent to 2,061 individuals, 1,886 of whom were later determined to be employed in survey-related activities. Fifteen-hundred fifty-one persons responded after three mailings and one phone call was made in an attempt to elicit response. The findings of the inventory are included in "Inventory of Health Care Facilities Surveyors; United States—1972" (DHEW Publication No. HSM 73-6503).

The 1974 inventory of surveyors was quite similar in format to that of 1972. There were, however, differences in definitions of health facility surveyor, and in methodology, as will be delineated below. Thus, comparability of the two studies is somewhat limited.

PURPOSE OF SURVEY

The Division of Provider Standards and Certification, of the Bureau of Quality Assurance, Health Services Administration, in cooperation with the Social Security Administration, Social Rehabilitation Administration, and the Office of Nursing Home Affairs, is responsible for operation of a continuing program designed to improve the effectiveness of State health certification procedures. A major part of this mandate is the training of State and Federal personnel engaged in survey activities. Such training is the responsibility of the Bureau of Quality Assurance, Division of Provider Standards and Certification.

In 1971, the President stated that there would be 2,000 surveyors trained by 1973 for the survey of health facilities. According to the Under-Secretary of Health, Education, and Welfare, in a speech to a conference of State long-term care facility surveyors in St. Petersburg, Florida in June of 1974, that goal has been reached.

Over the period that training has been conducted, there have been six university-based training programs involving one or more of three courses. First, there has been a basic training course for surveyors with emphasis in four major areas: (1) techniques of surveying health facilities, (2) techniques of proper documentation, (3) techniques of consultation, and (4) techniques of programming for improvement. Second, there has been an advanced course for surveyors that emphasizes the four areas covered in the basic course, but which offered an opportunity for surveyors with one to two years of experience to refine their skills. Surveyors in the advanced course have been given greater instruction on the technical and professional aspects of their jobs and have taken optional training in such topical areas as investigation of complaints, comprehensive health planning, and quality of life. The third course offered has been the supervisor training institute. The institute has been directed towards improvement of the certification process in general and has involved basic training in management by objective theory.

The information in this inventory is provided as a basis for planning and development of any future training activities for surveyors. The report contains data concerning the characteristics of surveyors, their responsibilities and activities, the kind of training received by surveyors, and areas where training could be improved.

METHOD

When the 1972 surveyor inventory was conducted, 335 nonsurveyors—Director, Supervisors, or consultants—were included in the population analyzed in the inventory. To achieve a more "pure" analysis of surveyors per se, a formal definition of surveyor was composed for the 1974 inventory. The definition was as follows:

> Any individual who as part of his/her normal duties makes on-site inspection visits to facilities which, under law (Medicare-Medicaid), require certification and is responsible for completing at least a portion of a survey report form documenting information derived from observations made during on-site visits.

In September, 1973, the ten HFSIP Regional Coordinators provided the Division of Provider Standards and Certification with the names of surveyors that they had obtained from the directors of the State survey agency in their respective regions. During August of 1974, the heads of the Regional Offices were asked to obtain an update of the lists that took into account the above definition of health facility surveyor. The lists of surveyors' names were transmitted to CPI Associates and they served as the basis for the inventory. The lists and the time at which they were submitted may have affected the quality of the inventory. First, some States provided more comprehensive lists than others. For instance, some States sent names not only of surveyors but also of all individuals employed in the licensure and certification program. And some States neglected to include the life safety code surveyors in their lists. Second, the lists were not completely current because of an OMB clearance delay that precluded mailing the questionnaires before November.

The questionnaire itself was based upon the 1972 questionnaire in format. Changes were made, however, to accommodate alterations in regulations made since 1972. For instance, in 1972 surveyors had the Federal survey functions for only the Medicare program—hospitals, nursing homes, and home health agencies. By 1974 functions had been expanded to include the Medicaid Program—hospitals, skilled nursing facilities, intermediate care facilities, institutions for the mentally retarded and other related conditions, home health agencies, independent laboratories, outpatient/physical therapy services, domiciliary facilities, and portable x-ray facilities. Questions were added in the 1974 questionnaire to elicit information about these additional facilities.

The 1974 questionnaire also varied from the 1972 instrument in that more elaborate information was requested in some areas. For example, the 1974 questionnaire included questions on survey structure (single surveyor vs. team survey construction) whereas the 1972 questionnaire did not. Also, the 1972 questionnaire did not include questions on the number of facilities surveyed and the number of hours spent in survey. The 1974 questionnaire included such questions.

Given that the basic questions were the same in both the 1972 and 1974 questionnaires, an extensive pre-test was not conducted. The "pre-test" for the 1972 questionnaire was considered by the Division of Provider Standards and Certification to have been the 1972 inventory. New questions were perused extensively by personnel in the DPSC and tested on a selected number of surveyors.

On November 14, 1974, the first mailing of the questionnaire occurred; the total number of questionnaires mailed was 2,118. There were two follow-up mailings, the last of which brought the overall response rate of 88.5 percent (cf. Table 1). Eleven States had response rates of 100.0 percent—Alaska, Arizona, Delaware, Hawaii, Nevada, New Hampshire, North Carolina, South Carolina, South Dakota, Vermont, and Wyoming. Detracting from the overall rate were States which had relatively low response rates, e.g., five States had less than 70.0 percent return—the District of Columbia, Iowa, Puerto Rico, Virgin Islands, and West Virginia.

The method used differs from that used in 1972 in that in the 1972 inventory non-respondents were contacted by phone in an attempt to obtain the information asked for in the questionniare. Such a procedure was not followed in the 1974 inventory. Phone calls were made only to ascertain whether or not individuals were surveyors. Through these phone calls it was determined that 86.4 percent of the persons who actually survey facilities responded. The difference in information gathering techniques between 1972 and 1974 may account for the difference in response rate to the two instruments. Moreover, because it has been found that information elicited in telephone interviews differs from that which would be elicited through questionnaires, the comparability of the two sets of data is limited.

The number of persons included in the analysis and who met the definition of surveyor was 1,541 of the 1,875 who returned their questionnaires. Three hundred and thirty-four respondents were deleted from the analysis because: (1) they were no longer employed by the agency, (2) they had clerical or other duties not related to surveying, (3) they functioned as supervisors of surveyors per se, (4) they served only as consultants and performed no direct survey functions, or (5) they functioned as administrators and/or directors and conducted no on-site surveys. This deletion represents a variation from the approach used in 1972, as noted above, since in 1972, directors, consultants, and supervisors were included. The variation further limits comparability.

In the following sections information about health facility surveyors based on the responding population of 1,541 will be provided. The results should be interpreted in light of the fact, as in any mail survey, the validity of response may have been affected by the construction of questions in the questionnaire, the accuracy and completeness of the listing of the surveyors' names submitted by the State Survey Agency to the DHEW Regional offices, and/or by the respondent's views and manner of reporting.

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TABLE 1

NUMBER OF QUESTIONNAIRES AND RESPONSE RATE, BY STATE, 1974

State	Number of Questionnaires Mailed	Number of Questionnaires Returned	Response Rate to General Mailing	Number of Applicable Questionnaires Mailed	Number of Applicable Responses	Response Rate on Applicable Questionnaires
Alabama	33	31	93.9	26	24	92.3
Alaska	8	8	100.0	6	6	100.0
Arizona	12	12	100.0	12	12	100.0
Arkansas	19	17	89.5	17	15	88.2
California	156	147	94.2	120	111	92.5
Colorado	25	22	88.0	24	21	87.5
Connecticut	46	37	80.4	41	32	78.0
Delaware	10	10	100.0	9	9	100.0
District of Columbia	23	14	60.9	22	13	59.1
Florida	55	52	94.5	48	45	93.8
Georgia	26	24	92.3	19	17	89.5
Hawaii	10	10	100.0	9	9	100.0
Idaho	14	13	92.9	13	12	92.3
Illinois	120	101	84.2	107	88	82.2
Indiana	46	45	97.8	39	38	97.4
Iowa	70	53	75.7	53	36	67.9
Kansas	32	29	90.6	27	24	88.9
Kentucky	33	29	87.9	22	18	81.8
Louisiana	13	11	84.6	13	11	84.6
Maine	40	32	80.0	34	26	76.5
Maryland	50	47	94.0	35	32	91.4
Massachusetts	68	62	91.2	53	47	88.7
Michigan	49	44	89.8	48	43	89.6
Minnesota	59	54	91.5	41	36	87.8
Mississippi	10	8	80.0	9	7	77.8
Missouri	43	41	95.3	37	35	94.6
Montana	13	12	92.3	9	8	88.9
Nebraska	28	25	89.3	25	22	88.0
Nevada	11	11	100.0	10	10	100.0
New Hampshire	21	21	100.0	17	17	100.0
New Jersey	44	35	79.5	41	32	78.0
New Mexico	3	3	100.0	2	2	100.0
New York	189	165	87.3	169	145	85.8
North Carolina	27	27	100.0	24	24	100.0
North Dakota	15	12	80.0	12	9	75.0
Ohio	69	58	84.1	61	50	82.0
Oklahoma	24	22	91.7	21	19	90.5
Oregon	22	21	95.5	18	17	94.4
Pennsylvania	163	128	78.5	127	92	72.4
Puerto Rico	17	11	64.7	17	11	64.7
Rhode Island	27	25	92.6	22	20	90.9
South Carolina	15	15	100.0	13	13	100.0
South Dakota	24	24	100.0	18	18	100.0
Tennessee	15	14	93.3	15	14	93.3
Texas	113	102	90.3	100	89	89.0
Utah	18	17	94.4	17	16	94.1
Vermont	13	13	100.0	9	9	100.0
Virginia	27	26	96.3	26	25	96.2
Virgin Islands	1	0	0.0	1	0	0.0
Washington	65	62	95.4	45	42	93.3
West Virginia	15	10	66.7	14	9	64.3
Wisconsin	63	57	90.5	61	55	90.2
Wyoming	6	6	100.0	6	6	100.0
Total	2,118	1,875	88.5	1,784	1,541	86.4

SECTION A. CHARACTERISTICS OF SURVEYORS

This portion of the report is concerned with basic information about the 1,541 surveyors who responded to the questionnaire. The fifteen tables presented in this section include demographic data, information concerning educational attainment, and data concerning surveyors' professional disciplines.

Some summary information may be presented:

(1) The mean age for those who answered the question concerning age was 46 years. The median age was 47 years.

(2) Approximately 50 percent were male and 50 percent were female.

(3) The average number of years employed as a surveyor was four years. Ninety-seven percent of the surveyors served in a health field prior to becoming surveyors, spending on the average of 16 years in such employment. Twenty-eight percent of the surveyors had been employed in a non-health field that has aided them in the survey activities. The average number of years spent in such a non-health field was ten years.

(4) Ninety-eight percent were employed by the State.

(5) Thirty-eight percent of the respondents were nurses; 13 percent, sanitarians; and seven percent, hospital administrators. Seventy-one percent of all respondents were certified or registered in their professional disciplines.

(6) As might be expected given the number of nurses in the surveyor population, 33 percent of the respondents held nursing diplomas. Sixty-six percent of all respondents held baccalaureate degrees. Approximately 45 percent of the surveyors had completed at least some graduate work, 27 percent receiving graduate degrees. Thirty-eight percent of those receiving technical school certificates received them in health-related fields. The vast majority of respondents attending universities at any level obtained their training in health-related fields.

TABLE 2

LOCATION OF RESPONDENTS, BY DISCIPLINE, 1974

Professional Discipline	Health, Education, and Welfare Region										
	I	II	III	IV	V	VI	VII	VIII	IX	X	Total
Hospital Administrator	2	11	0	34	9	19	8	5	17	0	105
Health Administrator	3	6	8	10	10	4	2	2	10	1	56
Medical Records Administrator	1	1	1	7	1	3	1	3	3	4	25
Medical Technologist	6	9	3	8	2	3	4	3	11	2	51
Nurse, RN	94	73	87	34	128	29	54	24	35	31	589
Nurse, LPN or LVN	1	0	0	4	2	1	1	1	1	0	11
Nutritionist	0	12	2	6	3	4	0	1	3	0	31
Dietitian	5	7	6	6	7	9	1	3	3	3	50
Occupational Therapist	1	0	0	2	0	0	0	0	1	0	4
Pharmacist	0	2	4	7	0	2	1	3	4	1	24
Physical Therapist	2	0	8	0	2	0	0	2	4	0	18
Physician, DO	0	1	0	0	0	0	0	0	0	0	1
Physician, MD	5	13	1	5	11	1	1	4	4	1	46
Sanitarian	4	24	12	2	56	35	18	10	25	20	206
Social Worker	1	8	0	0	1	1	0	0	3	1	15
Architect	1	5	1	2	3	0	1	2	2	0	17
Engineer	2	4	4	5	19	0	2	4	0	0	40
Speech or Audiologist Therapist	0	2	0	0	4	2	1	0	0	0	9
Recreational Therapist	2	0	1	3	2	0	0	0	0	0	8
Laboratory Technician	0	0	0	0	3	0	4	1	5	2	15
Fire Marshal, Life Safety Code Surveyor, Health Inspector	8	3	21	2	17	1	11	6	2	9	80
Counselor	0	0	0	0	1	0	0	0	0	0	1
Educator	1	0	1	0	1	1	1	0	0	0	5
Nursing Home Administrator	1	0	0	1	0	3	0	1	0	0	6
Surveyor [1]	11	7	20	24	28	18	6	3	9	2	128
Total	151	188	180	162	310	136	117	78	142	77	1,541

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding disciplines blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 3

EDUCATIONAL ATTAINMENT OF SURVEYORS, BY REGION, 1974

Region	Level of Educational Attainment[1]									
	Some High School Only	High School Diploma Only	Some College	Technical School Certificate	Associate Degree	Diploma in Nursing	Baccalaureate Degree	Some Graduate Work	Graduate Degree	Not Ascertained
Region I	0	7	6	12	7	85	80	30	30	0
Region II	0	4	0	8	5	49	171	24	119	0
Region III	3	20	5	8	5	78	90	33	29	1
Region IV	0	6	2	11	10	29	126	39	42	0
Region V	2	31	9	27	13	115	174	51	72	3
Region VI	0	4	3	5	3	22	111	40	22	0
Region VII	1	15	7	14	4	53	44	19	15	1
Region VIII	0	2	0	6	3	20	55	13	23	1
Region IX	1	8	6	14	17	34	97	32	41	0
Region X	1	5	0	6	5	21	64	16	22	0
Total	8	102	38	111	72	506	1,012	297	415	6

[1]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions. (1) People who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the category "some graduate work" unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

TABLE 4

REGIONAL LOCATION OF SURVEYORS, BY AGE, 1974

Age	Region										
	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Region VIII	Region IX	Region X	Total
Under 25 years	1	3	3	1	5	3	0	0	0	0	16
25 - 34 years	20	31	43	30	55	30	12	16	22	12	271
35 - 44 years	25	43	42	35	65	30	24	13	29	17	323
45 - 54 years	61	65	50	63	85	29	44	28	52	29	506
55 - 64 years	30	35	33	24	75	37	31	19	34	17	335
65 years and over	6	4	3	2	13	3	4	0	4	0	39
Unknown	8	7	6	7	12	4	2	2	1	2	51
Total	151	188	180	162	310	136	117	78	142	77	1,541

TABLE 5

NUMBER OF SURVEYORS, BY SEX AND REGION

Sex of Respondent	Health, Education and Welfare Region										
	I	II	III	IV	V	VI	VII	VIII	IX	X	Total
Male	43	75	78	99	160	87	62	41	86	36	767
Female	108	113	102	63	150	49	55	37	56	41	774
Total	151	188	180	162	310	136	117	78	142	77	1,541

FIGURE 1

PERCENT DISTRIBUTION OF SURVEYORS, BY AGE AND SEX - 1974

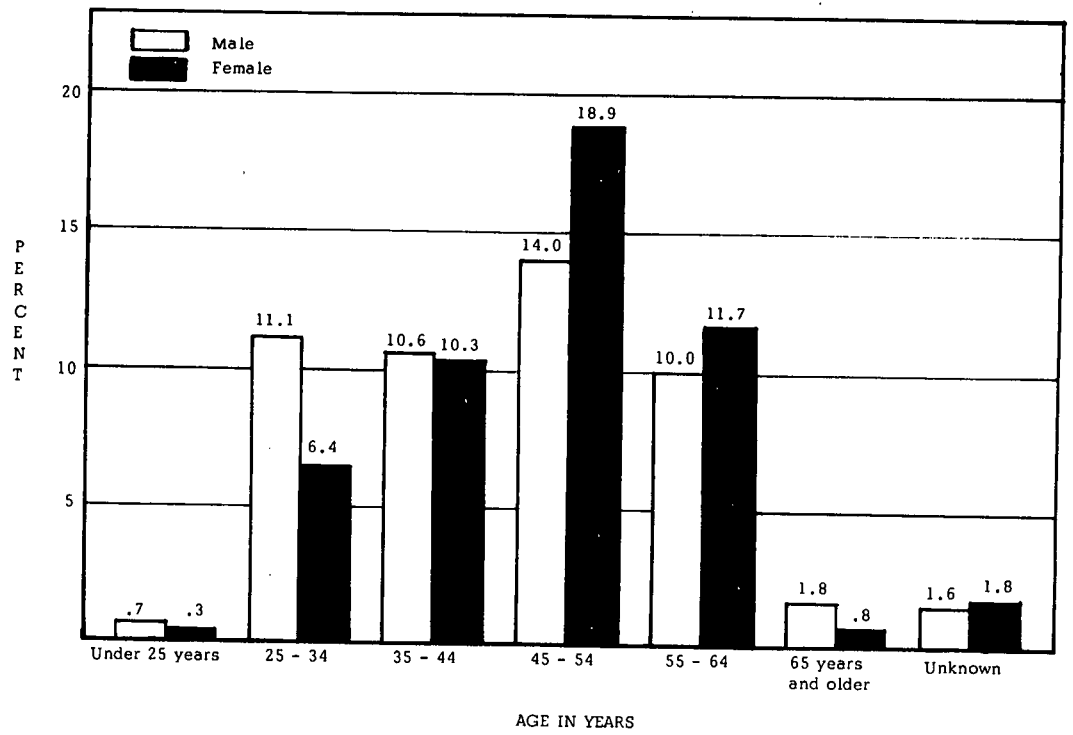

TABLE 6

AGE AND SEX OF SURVEYORS, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Under 25 Yrs.		25-34 Yrs.		35-44 Yrs.		45-54 Yrs.		55-64 Yrs.		65 Yrs. & Over		Unknown		Total		Total Per Discipline
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Hospital Administrator	0	0	5	0	16	0	43	3	33	1	2	0	2	0	101	4	105
Health Administrator	1	0	8	0	8	2	19	4	10	0	2	0	2	0	50	6	56
Medical Records Administrator	0	0	0	6	0	4	1	6	0	5	0	2	0	1	1	24	25
Medical Technologist	0	0	6	5	10	5	9	6	2	4	0	2	0	2	27	24	51
Nurse, RN	1	1	7	52	7	122	8	229	1	134	1	4	2	20	27	562	589
Nurse, LPN or LVN	0	0	0	1	3	3	0	2	1	1	0	0	0	0	4	7	11
Nutritionist	0	2	1	9	0	5	1	5	0	7	0	0	0	1	2	29	31
Dietitian	0	1	0	9	0	7	0	12	0	17	0	3	0	1	0	50	50
Occupational Therapist	0	0	0	0	0	1	0	3	0	0	0	0	0	0	0	4	4
Pharmacist	0	0	3	0	5	1	4	1	7	0	1	0	2	0	22	2	24
Physical Therapist	0	0	3	2	1	3	5	4	0	0	0	0	0	0	9	9	18
Physician, DO	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1
Physician, MD	0	0	0	0	8	0	8	2	15	2	9	0	1	1	41	5	46
Sanitarian	6	1	69	8	49	0	40	2	24	1	1	1	4	0	193	13	206
Social Worker	0	0	0	2	0	1	1	5	1	3	0	0	1	1	3	12	15
Architect	0	0	2	0	7	0	4	1	2	0	1	0	0	0	16	1	17
Engineer	0	0	12	0	12	0	9	0	7	0	0	0	0	0	40	0	40
Speech or Audiological Therapist	1	0	2	0	1	1	2	0	0	1	0	0	1	0	7	2	9
Recreational Therapist	0	0	4	1	0	0	1	1	0	1	0	0	0	0	5	3	8
Laboratory Technician	0	0	4	0	2	0	5	1	2	1	0	0	0	0	13	2	15
Fire Marshal ; Life Safety Code Surveyor; Health Inspector	1	0	12	0	13	0	28	1	17	0	5	0	3	0	79	1	80
Counselor	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1
Educator	0	0	0	1	0	1	0	0	3	0	0	0	0	0	3	2	5
Nursing Home Administrator	0	0	0	0	1	0	2	0	3	0	0	0	0	0	6	0	6
Surveyor[1]	1	0	33	4	20	3	25	2	26	3	5	0	6	0	116	12	128
Total	11	5	171	100	164	159	216	290	154	181	27	12	24	27	767	774	1,541

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 7

NUMBER OF SURVEYORS BY DISCIPLINE
WHO ARE REGISTERED OR CERTIFIED, 1974

Professional Discipline	Registered or Certified	Not Registered or Certified	Not Ascertained or Not Applicable	Total
Hospital Administrator	18	14	73	105
Health Administrator	16	9	31	56
Medical Records Administrator	22	1	2	25
Medical Technologist	36	6	9	51
Nurse, RN	575	2	12	589
Nurse, LPN or LVN	10	1	0	11
Nutritionist	23	2	6	31
Dietitian	49	0	1	50
Occupational Therapist	4	0	0	4
Pharmacist	23	0	1	24
Physical Therapist	17	0	1	18
Physician, DO	1	0	0	1
Physician, MD	41	3	2	46
Sanitarian	145	32	29	206
Social Worker	10	2	3	15
Architect	12	0	5	17
Engineer	27	7	6	40
Speech or Audiological Therapist	5	1	3	9
Recreational Therapist	3	0	5	8
Laboratory Technician	8	1	6	15
Fire Marshal; Life Safety Code Surveyor or Health Inspector	18	3	59	80
Counselor	0	0	1	1
Educator	3	0	2	5
Nursing Home Administrator	3	0	3	6
Surveyor[1]	20	7	101	128
Total	1,089	91	361	1,541

[1] This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 8

NUMBER OF PHYSICIAN/SURVEYORS
PER MEDICAL SPECIALITY, 1974

Physician's Medical Specialty	Number of Physician/Surveyors
Anesthesiology	5
Geriatrics	2
Internal Medicine	4
Pediatrics	1
Public Health	10
Psychiatry	8
Pathology	3
Preventive Medicine	6
Obstetrics/Gynecology	1
Not Ascertained	6
Total	46

TABLE 9

NUMBER OF SOCIAL WORKER/SURVEYORS
PER SOCIAL WORK SPECIALTY, 1974

Social Work Specialty	Number of Social Work/Surveyors
Medical Social Work	6
Psychiatric Social Work	1
Public Health Social Work	1
Community Organization/Community Mental Health	1
Not Ascertained	6
Total	15

TABLE 10

TYPE OF AGENCY EMPLOYING SURVEYORS,
BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	State	County
Hospital Administrator	104	1
Health Administrator	56	0
Medical Records Administrator	25	0
Medical Technologist	51	0
Nurse, RN	579	10
Nurse, LPN or LVN	11	0
Nutritionist	31	0
Dietitian	48	2
Occupational Therapist	4	0
Pharmacist	23	1
Physical Therapist	17	1
Physician, DO	1	0
Physician, MD	46	0
Sanitarian	184	22
Social Worker	15	0
Architect	17	0
Engineer	40	0
Speech or Audiological Therapist	9	0
Recreational Therapist	8	0
Laboratory Technician	15	0
Fire Marshal; Life Safety Code Inspector; Health Inspector	80	0
Counselor	1	0
Educator	5	0
Nursing Home Administrator	6	0
Surveyor[1]	127	1
Total	1,503	38

[1]This category includes: people who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 11

WORK EXPERIENCE OF SURVEYORS, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Years of Survey Experience					Years Experience in the Health Field								Years Experience in Non-Health Field							
	1 year or less	2-4 years	5-7 years	8 or more years	Not Ascertained	1 year or less	2-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25 years or more	0 years or not Ascertained	1 year or less	2-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25 years or more	0 years or not Ascertained
Hospital	13	45	23	22	2	2	8	8	10	7	30	34	6	1	14	4	4	2	1	3	76
Hospital Administrator	9	21	17	9	0	3	12	6	4	5	9	10	7	2	8	6	3	1	1	2	33
Health Administrator	8	11	1	4	1	3	2	1	3	6	4	4	2	1	5	1	3	0	0	0	15
Medical Records Administrator	7	20	15	9	0	0	3	8	10	9	8	11	2	1	4	3	0	0	0	0	43
Medical Technologist	156	233	99	90	11	2	22	72	98	85	118	179	13	10	21	10	12	0	0	1	535
Nurse, RN	4	2	3	2	0	0	0	3	1	0	4	3	0	0	0	0	1	0	0	0	10
Nurse, LPN or LVN	11	5	12	1	2	1	6	8	5	3	1	0	7	4	2	1	1	1	0	2	20
Nutritionist	14	15	11	10	0	1	7	13	4	7	5	13	0	4	5	5	2	2	0	0	32
Dietitian	1	3	0	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	0	4
Occupational Therapist	4	9	7	3	1	0	0	3	3	6	4	7	1	0	0	1	1	0	0	0	22
Pharmacist	3	8	4	3	0	0	0	5	5	3	1	3	1	0	3	1	0	0	0	0	14
Physical Therapist	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Physician, DO	5	20	13	8	0	0	0	5	5	3	7	23	3	0	1	1	0	0	0	0	44
Physician, MD	45	77	47	34	3	17	48	49	18	11	15	12	36	5	24	22	7	9	5	2	132
Sanitarian	3	4	8	0	0	0	3	2	1	2	3	1	3	1	1	3	2	1	0	0	7
Social Worker	0	7	4	3	3	2	2	2	0	0	0	0	11	0	1	2	2	5	3	0	4
Architect	5	19	8	7	1	1	7	5	1	1	0	0	25	0	6	9	3	2	7	3	10
Engineer	2	4	2	1	0	0	1	1	1	2	0	0	4	0	2	0	1	0	1	0	5
Speech or Audiological Therapist	3	2	2	0	1	0	2	2	0	0	0	0	4	0	1	2	0	1	0	0	4
Recreational Technician	1	6	5	2	1	0	2	2	1	4	0	4	2	1	1	0	1	0	0	0	12
Fire Marshal; Life Safety Code Surveyor; Health Inspector	17	45	7	2	9	4	7	6	4	1	1	1	56	2	10	7	7	5	15	17	17
Counselor	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
Educator	3	0	0	2	0	0	0	1	1	0	0	1	2	0	1	2	0	1	0	0	1
Nursing Home Administrator	0	2	1	3	0	0	1	2	0	0	3	0	0	0	0	0	2	0	0	0	4
Surveyor[1]	36	62	10	17	3	12	21	14	14	6	8	9	44	7	13	7	10	7	8	16	60
Total	351	620	299	233	38	48	154	220	189	162	223	316	229	39	123	88	62	37	41	46	1,105

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories

TABLE 12

NUMBER OF RESPONDENTS PER HEALTH FIELD
PRIOR TO EMPLOYMENT AS SURVEYOR, 1974

Health Fields In Which Respondents Worked Prior to Becoming Surveyors	Number of Respondents[1]
Hospital Administration	110
Health Administration	50
Medical Records Administration	25
Medical Technology	34
Nursing, Administration	116
Nursing	465
Nursing Home Administration	46
Dietetics	60
Nutrition	17
Occupational Therapy	5
Physical Therapy	15
Recreational Therapy	6
Physician (M.D.)	39
Physician (D.O.)	1
Dentistry	5
Pharmacy	30
Sanitation	85
Environmental Health	36
Health and Safety Inspection	60
Biological Science/Laboratory Work	77
Food/Dairy Processing	12
Social Work, Health-Related	14
Architecture, Health-Related	7
Education, Health-Related	95
Public Health	116
Hospital Work, Unspecified	74
Other	73

[1]Total does not equal 1,497 as some of the 1,497 respondents for whom the question was applicable or from whom an answer was ascertained served in more than one field prior to becoming surveyors.

TABLE 13

EDUCATIONAL ATTAINMENT OF SURVEYORS, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Level of Educational Attainment[2]									
	Some High School Only	High School Diploma Only	Some College	Technical School Certificate	Associate Degree	Diploma in Nursing	Baccalaureate Degree	Some Graduate Work	Graduate School	Not Ascertained
Hospital Administrator	0	6	1	11	7	3	86	25	42	0
Health Administrator	0	3	2	5	7	4	41	15	15	1
Medical Records Administrator	0	1	3	7	6	1	14	8	1	0
Medical Technologist	0	0	0	5	2	0	49	9	15	0
Nurse, RN	1	0	20	8	18	485	293	111	149	1
Nurse, LPN or LVN	0	0	0	4	1	6	3	2	0	0
Nutritionist	0	0	0	0	0	0	31	7	18	0
Dietitian	0	0	0	1	0	0	49	12	28	0
Occupational Therapist	0	0	0	0	0	0	4	4	0	0
Pharmacist	0	0	0	1	1	0	22	6	3	1
Physical Therapist	0	0	0	2	0	1	18	4	7	0
Physician, DO	0	0	0	0	0	0	1	0	1	0
Physician, MD	0	0	0	1	0	1	45	1	43	0
Sanitarian	1	16	1	22	14	1	172	52	34	0
Social Worker	0	0	0	0	1	1	14	1	12	0
Architect	0	5	0	0	1	0	10	1	1	1
Engineer	0	0	1	2	0	0	39	10	11	0
Speech or Audiological Therapist	0	3	0	0	0	0	6	3	0	0
Recreational Therapist	0	0	0	1	2	0	6	0	5	0
Laboratory Technician	0	0	0	4	1	0	12	3	7	0
Fire Marshal; Life Safety Code Surveyor; Health Inspector	1	35	6	19	6	0	15	3	1	1
Counselor	0	0	0	0	0	0	1	0	1	0
Educator	0	1	0	1	0	0	5	1	3	0
Nursing Home Administrator	0	0	1	0	0	0	4	1	1	0
Surveyor[1]	5	32	3	17	5	3	72	18	17	1
Total	8	102	38	111	72	506	1,012	297	415	6

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

[2]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions. (1) People who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the category "some graduate work" unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

TABLE 14

FIELD OF STUDY FOR 111 SURVEYORS
WHO ATTENDED TECHNICAL SCHOOL, 1974

Field of Study	Number of Surveyors
Business	12
Trade	33
Sanitation	8
Medical Training	42
Fire and Safety	6
Not Ascertained	10

76-611 O - 76 - 17

TABLE 15

SURVEYORS' FIELDS OF STUDY BY EDUCATIONAL ATTAINMENT, 1974

Level of Educational Attainment[1]	Field of Study																																Total
	Liberal Arts	Social Science	Life Science	Business	Natural Science	Engineering	Home Economics	Environmental Health	Architecture	Agriculture	Education	Law	Nursing	Physical or Occupational Therapy	Pharmacy	Pre-Med	Public Administration	Medical Records Administration	Sanitation	Medical School: Dental School	Public Health Administration	Surveyor Training Course	Nursing Home Administration	Recreational Therapy	Nursing Education	Hospital Administration	Fire Safety	General, Non-Major	Other	Not Ascertained	
Some College	0	1	0	4	0	0	0	0	0	0	1	0	9	0	0	1	0	0	0	0	0	0	0	0	2	0	0	2	18	38
Associate Degree	9	7	5	11	3	1	0	1	1	0	4	0	10	1	2	1	0	0	2	0	1	1	0	0	0	0	2	2	3	5	72
Baccalaureate Degree	31	56	147	73	26	47	64	19	11	17	18	0	164	12	23	16	0	5	3	0	19	0	0	8	37	5	4	1	10	196	1,012
Some Graduate Work	7	31	22	22	5	5	14	4	1	3	22	3	37	2	0	1	5	4	2	6	39	1	7	2	6	20	2	0	2	22	297
Graduate Degree	4	24	29	13	1	4	36	10	2	0	25	1	70	3	2	0	8	0	1	41	55	0	5	2	25	33	0	0	7	14	415

[1] If respondents had credentials in more than one area, they were coded in all areas that applied, with two exceptions, (1) people who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the category "some graduate work" unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

TABLE 16

EDUCATIONAL ATTAINMENT OF SURVEYORS,
BY NUMBER OF YEARS EMPLOYED AS SURVEYOR, 1974

Number of Years of Survey Experience	Level of Educational Attainment[1]									
	Some High School Only	High School Diploma Only	Some College	Technical School Certificate	Associate Degree	Diploma in Nursing	Baccalaureate Degree	Some Graduate Work	Graduate Degree	Not Ascertained
1 year or less	1	19	7	1	20	128	220	62	82	0
2 - 4 years	7	51	15	33	36	201	385	127	144	3
5 - 7 years	0	11	8	45	9	90	222	58	98	0
8 or more years	0	15	7	24	7	78	165	44	83	0
Not Ascertained	0	6	1	8	0	9	20	6	8	3
Total	8	102	38	111	72	506	1,012	297	415	6

[1]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions, (1) people who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the category "some graduate work" unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

SECTION B. TRAINING OF SURVEYORS

In this section of the report there are seven tables describing the kinds of training that surveyors have had. As in Section A, several general points may be derived from these tables and from additional information found in the questionnaire:

(1) Sixty percent of the surveyors responding to the questionnaire have attended one or more of the DHEW-sponsored university-based courses. Fifty-nine percent had attended the basic course; 9 percent, the advanced course; and 4 percent, the supervisor training institute. By region, Regions VI and IX had the highest percentage attendance at the DHEW-sponsored courses.

(2) Not included in the tables is information pertaining to the location and date of attendance at the university-based courses. The data reveal that 45% of the 861 persons who reported the university they attended for the basic course had received training from Tulane. Twenty-one percent received their training from the University of California at Los Angeles; 13 percent, the University of Colorado; 13 percent, the University of Maryland; and 8 percent; the University of New Hampshire. Most had taken the basic course during 1972 or 1973.

(3) The likelihood of attendance at a university-based course increased with the number of years that a surveyor had been employed. Only 30 percent of those employed one year or less had attended any of the courses. Sixty percent of those employed two or four years had attended a course. And 73 percent of those employed five to seven years or 8 or more years had attended.

(4) Percentagewise, the professional discipline most likely to be in attendance at any university-based course were hospital administrators, health administrators, registered nurses, social workers, speech or audiological therapists, and nursing home

administrators. Nurses, who represented 38 percent of the total population of surveyors, had 71 percent attendance for at least one course.

(5) Fifty-four percent of the respondents reported having professional disciplines that required continuing education. Of these individuals, 62 percent stated that the DHEW-sponsored university-based courses met the discipline's requirements. Courses most likely to meet requirements were the basic and advanced courses.

(6) Those most likely to have attended a university-based course were those who had received at least one higher-educational credential. Those least likely to have attended were those who had attended high school only or received a high school diploma only.

(7) Aside from the university-based courses, respondents had opportunities to attend other continuing education conferences. Approximately 70 percent availed themselves of that opportunity since 1972.

TABLE 17

ATTENDANCE AT DHEW-SPONSORED COURSES,
BY REGION, 1974

Region	Attendance at any DHEW Course			Number Who Attended [1]		
	Attended	Did Not Attend	Not Ascertained	Basic Course	Advanced Course	Supervisor Training Institute
Region I	83	68	0	81	15	5
Region II	110	77	1	109	2	3
Region III	86	92	2	82	15	7
Region IV	105	57	0	105	22	12
Region V	161	147	2	156	29	10
Region VI	102	33	1	102	27	7
Region VII	75	41	1	74	9	4
Region VIII	48	30	0	47	0	3
Region IX	103	36	3	102	22	11
Region X	49	28	0	49	2	1
Total	922	609	10	907	143	63

[1] Persons who attended more than one course were included in all categories that applied.

TABLE 18

ATTENDANCE AT DHEW-SPONSORED COURSES, BY STATE, 1974

State	Attendance at any DHEW Courses			Number Who Attended [1]		
	Attended	Did Not Attend	Not Ascertained	Basic Course	Advanced Course	Supervisor Training Institute
Alabama	22	2	0	22	6	1
Alaska	2	4	0	2	1	1
Arizona	7	4	1	7	4	0
Arkansas	7	8	0	7	0	0
California	86	23	2	86	14	10
Colorado	11	10	0	11	0	0
Connecticut	20	12	0	20	6	1
Delaware	5	4	0	5	1	0
District of Columbia	8	5	0	8	2	0
Florida	25	20	0	25	11	3
Georgia	13	4	0	13	0	0
Hawaii	6	3	0	5	2	0
Idaho	6	6	0	6	1	0
Illinois	45	42	1	43	5	2
Indiana	14	23	1	13	2	1
Iowa	19	17	0	19	2	0
Kansas	10	14	0	9	3	1
Kentucky	11	7	0	11	0	1
Louisiana	11	0	0	11	6	0
Maine	11	15	0	10	0	0
Maryland	21	11	0	21	5	1
Massachusetts	29	18	0	28	2	0
Michigan	18	25	0	16	0	2
Minnesota	27	9	0	27	9	3
Mississippi	6	1	0	6	0	0
Missouri	32	3	0	32	0	1
Montana	5	3	0	5	0	1
Nebraska	14	7	1	14	4	1
Nevada	4	6	0	4	2	0
New Hampshire	6	11	0	6	1	1
New Jersey	2	29	1	2	0	0
New Mexico	1	1	0	1	1	0
New York	102	43	0	101	1	3
North Carolina	10	14	0	10	0	0
North Dakota	8	1	0	8	0	1
Ohio	32	18	0	32	13	2
Oklahoma	16	3	0	16	1	6
Oregon	12	5	0	12	0	0
Pennsylvania	40	52	0	37	7	5
Puerto Rico	6	5	0	6	1	0
Rhode Island	13	7	0	13	6	3
South Carolina	9	4	0	9	3	5
South Dakota	14	4	0	14	0	0
Tennessee	9	5	0	9	2	2
Texas	67	21	1	67	19	1
Utah	9	7	0	9	0	0
Vermont	4	5	0	4	0	0
Virginia	10	15	0	9	0	1
Washington	29	13	0	29	0	0
West Virginia	2	5	2	2	0	1
Wisconsin	25	30	0	25	0	0
Wyoming	1	5	0	0	0	1
Total	922	609	10	907	143	63

[1] Persons who attended more than one course were included in all categories that applied.

TABLE 19

ATTENDANCE AT DHEW-SPONSORED COURSES,
BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Attendance at DHEW Courses			Number Who Attended [2]		
	Attended	Did Not Attend	Not Ascertained	Basic Course	Advanced Course	Supervisor Training Institute
Hospital Administrator	85	20	0	85	29	17
Health Administrator	43	13	0	41	9	8
Medical Records Administrator	9	16	0	9	1	0
Medical Technologist	9	39	3	9	0	1
Nurse, RN	420	166	3	415	57	21
Nurse, LPN or LVN	10	1	0	10	0	1
Nutritionist	14	17	0	14	2	0
Dietitian	26	24	0	25	1	1
Occupational Therapist	1	3	0	1	0	0
Pharmacist	15	9	0	14	1	1
Physical Therapist	7	10	1	8	1	0
Physician (D.O.)	1	0	0	0	0	1
Physician (M.D.)	4	42	0	3	1	0
Sanitarian	151	55	0	151	24	5
Social Worker	12	3	0	12	1	0
Architect	2	15	0	1	0	0
Engineer	6	34	0	6	0	0
Speech or Audiological Therapist	7	2	0	5	1	0
Recreational Therapist	5	3	0	5	1	0
Laboratory Technician	2	13	0	2	2	0
Fire Marshal; Life Safety Code Surveyor; Health Inspector	12	65	3	11	0	0
Counselor	0	1	0	0	0	0
Educator	3	2	0	3	1	0
Nursing Home Administrator Surveyor	5	1	0	5	1	1
	73	55	0	72	10	6
Total	922	609	10	907	143	63

[1]This category includes: persons who called themselves surveyors, persons who left the question blank, and persons whose professional disciplines could not be coded in the above categories.

[2]Persons who attended more than one course were included in all categories that applied.

TABLE 20

ROLE OF DHEW-SPONSORED COURSES
IN MEETING PROFESSIONAL DISCIPLINE'S REQUIREMENTS
FOR CONTINUING EDUCATION, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Number of Surveyors Whose Professional Disciplines Require Continuing Education	Number of Surveyors Whose Professional Disciplines Require Continuing Education			Courses that Meet Discipline's Requirements:							
		DHEW-Sponsored Courses Meet Discipline's Requirements	DHEW-Sponsored Courses Do Not Meet Discipline's Requirements	Not Ascertained	Basic Course	Advanced Course	Supervisor Training Institute	Basic and Advanced Courses	Basic and Supervisor Training Institute	Advanced and Supervisor Training Institute	Basic, Advanced and Supervisor Training Institute	Not Ascertained
Hospital Administrator	57	44	13	0	7	2	3	17	1	6	8	0
Health Administrator	33	28	5	0	10	2	2	6	1	1	6	0
Medical Records Administrator	25	11	6	8	2	0	0	1	0	0	6	2
Medical Technologist	26	8	18	0	3	2	1	1	0	0	1	0
Nurse, RN	285	187	85	13	93	20	6	50	0	0	18	0
Nurse, LPN or LVN	7	7	0	0	4	1	0	1	0	0	1	0
Nutritionist	30	9	16	5	4	1	0	1	0	0	2	1
Dietitian	50	14	29	7	4	1	1	3	0	0	5	0
Occupational Therapist	3	2	1	0	0	1	0	0	0	0	0	1
Pharmacist	14	5	9	0	1	1	0	0	0	0	2	1
Physical Therapist	2	1	1	0	1	0	0	0	0	0	0	0
Physician, DO	0	0	0	0	0	0	0	0	0	0	0	0
Physician, MD	27	4	19	4	1	1	0	0	0	0	0	2
Sanitarian	112	92	16	4	40	6	3	29	1	0	13	0
Social Worker	4	3	1	0	0	0	0	1	0	0	2	0
Architect	3	2	1	0	0	1	0	1	0	0	0	0
Engineer	19	8	11	0	1	2	1	1	0	0	2	1
Speech or Audiological Therapist	6	6	0	0	3	3	0	0	0	0	0	0
Recreational Therapist	3	1	2	0	0	1	0	0	0	0	0	0
Laboratory Technician	6	1	5	0	0	0	1	0	0	0	0	0
Fire Marshal; Life Safety Code Surveyor; Health Inspector	51	28	18	5	7	10	0	8	0	1	2	0
Counselor	0	0	0	0	0	0	0	0	0	0	0	0
Educator	3	3	0	0	2	0	1	0	0	0	0	0
Nursing Home Administrator	6	5	0	1	0	0	1	4	0	0	0	0
Surveyor[1]	60	48	12	0	11	13	0	11	0	4	9	0
Total	832	517	268	47	194	68	20	135	3	12	77	1

[1] This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 21

ATTENDANCE AT DHEW-SPONSORED COURSES,
BY EDUCATIONAL ATTAINMENT, 1974

Level of Educational Attainment[1]	Attendance at any DHEW Course			Number Who Attended:[2]		
	Attended	Did Not Attend	Not Ascertained	Basic Course	Advanced Course	Supervisor Training Course
Some High School Only	2	6	0	2	0	0
High School Diploma Only	38	63	1	34	7	5
Some College	25	12	1	25	8	0
Technical School Certificate	57	52	2	57	7	7
Associate Degree	42	28	2	42	7	3
Diploma in Nursing	360	144	2	357	48	17
Baccalaureate Degree	620	387	5	613	101	45
Some Graduate School	202	92	3	202	38	18
Graduate Degree	239	176	0	233	24	21
Not Ascertained	3	2	1	3	1	0

[1]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions, (1) people who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the category "some graduate work" unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

[2]Persons who attended more than one course were included in all categories that applied.

TABLE 22

ATTENDANCE AT DHEW-SPONSORED COURSES,
BY NUMBER OF YEARS OF SURVEY EXPERIENCE, 1974

Number of Years of Survey Experience	Attendance at DHEW Courses			Number Who Attended [1]		
	Attended	Did Not Attend	Not Ascertained	Basic Course	Advanced Course	Supervisor Training Institute
1 year or less	105	242	4	105	2	2
2 - 4 years	411	208	1	402	62	24
5 - 7 years	218	78	3	217	43	19
8 or more years	171	62	0	166	32	17
Not Ascertained	17	19	2	17	4	1
Total	922	609	10	907	143	63

[1]Persons who attended more than one course were included in all categories that applied.

TABLE 23

REGIONAL LOCATION OF SURVEYORS,
BY CONTINUING EDUCATION CONFERENCES,
COMPLETED SINCE 1972

Continuing Education Conferences	Health, Education, and Welfare Region										
	I	II	III	IV	V	VI	VII	VIII	IX	X	Total
Number of respondents who have attended continuing education courses	104	140	129	118	195	79	79	57	107	64	1,072
Number of Respondents who have not attended	39	45	41	40	105	54	34	19	30	12	419
Not ascertained	8	3	10	4	10	3	4	2	5	1	50
Subjects of Conferences											
Administration	3	17	7	8	13	10	4	5	7	2	76
Care of Aging	4	20	10	7	21	5	4	5	14	3	93
Dietetic Services	10	14	3	9	15	12	2	1	8	5	79
Environmental Health	1	2	2	0	9	2	3	2	3	2	26
Life Safety	6	27	30	6	32	6	16	9	10	6	148
Home Health Agencies	2	1	1	0	1	3	1	2	1	1	13
Infection Control	6	20	7	3	11	1	3	5	7	4	67
Laboratory Procedures	2	3	2	6	0	2	1	1	8	5	30
Hospital Services	1	0	0	1	1	1	0	2	0	0	6
Legal Aspects	1	2	0	1	0	1	0	0	7	2	14
Medical Records	12	7	9	12	15	6	3	6	16	2	88
Mental Health	4	2	0	0	3	0	2	1	4	0	16
Mental Retardation	5	2	2	5	4	6	0	0	8	3	35
Intermediate Care Facilities	5	5	7	4	4	8	3	1	3	5	45
Skilled Nursing Facilities	5	1	6	6	3	7	1	2	1	4	36
Nursing Services	14	17	4	12	24	7	6	8	13	4	109
Patient Activities	3	1	1	5	7	0	0	4	5	2	28
Pharmacy Services	13	3	7	11	9	4	12	1	5	2	67
Radiation Hazards	1	0	0	0	1	0	2	0	0	0	4
Rehabilitation	9	1	2	1	10	1	2	1	4	1	32
Social Services	2	5	1	4	3	0	2	1	1	1	20
Survey Process	12	5	27	16	29	21	11	7	10	9	147
Title VI	0	0	0	1	0	0	0	0	0	0	1
Title XVIII & XIX (Regulations)	13	17	15	15	17	13	5	7	15	16	133
Utilization Review	1	7	7	3	7	2	5	1	5	10	48
Government-conducted Workshops, Seminars, Staff Meetings (topic unspecified)	24	10	34	29	26	12	13	9	21	12	190
Conferences conducted by Associations in Respondent's Discipline	15	21	14	16	27	8	7	9	11	13	141
Conferences dealing with Specific Diseases	3	3	4	3	8	1	1	3	4	2	32
Other	20	23	15	21	32	2	14	11	24	8	170

SECTION C. SURVEY RESPONSIBILITIES AND ACTIVITIES

This section of the report deals with surveyors' activities and responsibilities. There are 22 tables in this section which describe program responsibility, functional responsibility, survey structure, kinds of facilities surveyed, conditions of participation and standards surveyed, estimated number of facilities surveyed per year, and estimated number of hours spent surveying particular kinds of facilities.

General points that may be drawn from these tables include:

(1) Seventy percent of the surveyors are responsible for Title XVIII, Title XIX, and Licensure.

(2) Twelve percent of those reporting that have survey activities spent one to 25 percent of their time as surveyors. Nineteen percent spent 26 to 50 percent; 16 percent, 51 to 75 percent; and 43 percent, 76 to 100 percent. The estimates of 10 percent were not ascertained. (Not included in the tables is information about the number of hours spent in survey-related activities. These may be summarized as follows. Reporting surveyors spent an average of four hours per week in pre-survey file review. They spent an average of 16 hours per week in actual surveying. An average of nine hours per week is spent in report writing and other survey-related activities, while an average of eight hours is spent in travel. An average of seven hours is spent in consultation and/or follow-up. Seven hours are spent in other activities. This brings the average work week for surveyors to approximately 51 hours. This average may be somewhat inflated, but some surveyors reported that travel was on the "surveyor's own time" and others reported that they normally worked a longer than 40 hour week.)

(3) In addition to their survey activities, one percent of the surveyors spent their time in director positions. Eight percent reported that they spent a portion of their time in administrative duties in offices. Twelve percent acted in supervisory capacities. Sixty-two percent functioned as consultants.

(4) Those most likely to hold administrative duties are those who hold higher-educational credentials.

(5) The likelihood of holding administrative positions is directly associated with the number of years of survey experience.

(6) Males are significantly more likely than females to hold administrative positions.

(7) Seventeen percent always work as single surveyors. Fifty-one percent sometimes as single surveyors and sometimes as part of a team. Thirty-one percent always work as part of a team.

(8) Facilities for which a team is most likely to be used include general hospitals, psychiatric and TB hospitals, skilled nursing facilities, intermediate care facilities, institutions for the mentally retarded and other related conditions, outpatient/physical therapy services, and domiciliary facilities. Facilities for which a surveyor is likely to be solely responsible include home health agencies, independent laboratories, and portable x-ray facilities.

(9) Persons in almost all disciplines were likely to survey other conditions of participation or standards as well as their own areas of expertise.

TABLE 24

PROGRAM RESPONSIBILITY OF SURVEYORS,
BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Kind of Program Responsibility							
	Title XVIII	Title XIX	Licensure Only	Title XVIII & Title XIX	Title XIX and Licensure	Title XVIII and Licensure	All Programs	Not Ascertained
Hospital Administrator	13	2	0	16	1	4	68	1
Health Administrator	0	0	2	4	5	1	41	3
Medical Records Administrator	1	0	0	8	1	1	13	1
Medical Technologist	13	1	1	6	1	9	19	1
Nurse, RN	28	21	6	39	19	29	440	7
Nurse, LPN or LVN	0	0	0	1	3	0	6	1
Nutritionist	1	1	0	2	1	2	24	0
Dietitian	2	0	0	5	4	3	34	2
Occupational Therapist	0	0	0	1	0	0	3	0
Pharmacist	3	1	0	2	1	1	14	2
Physical Therapist	5	1	0	4	0	0	8	0
Physician, DO	0	0	0	0	0	0	1	0
Physician, MD	5	0	1	6	3	3	26	2
Sanitarian	1	0	6	5	8	4	181	1
Social Worker	1	0	0	2	0	1	11	0
Architect	0	0	2	3	0	2	10	0
Engineer	1	0	0	1	1	0	36	1
Speech or Audiological Therapist	0	0	0	1	2	0	6	0
Recreational Therapist	0	0	0	3	0	0	5	0
Laboratory Technician	5	0	1	1	0	1	6	1
Fire Marshal; Life Safety Code Surveyor, Health Inspector	0	1	4	23	1	1	46	4
Counselor	0	0	0	1	0	0	0	0
Educator	1	2	0	1	0	0	1	0
Nursing Home Administrator	0	1	0	1	0	1	3	0
Surveyor [1]	7	6	1	16	10	4	77	7
Total	87	37	24	152	61	67	1,079	34

[1] This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 25

PROGRAM RESPONSIBILITY, BY PERCENTAGE OF TIME SPENT AS SURVEYOR, 1974

Percentage of Time Spent As Surveyor	Program Responsibility								
	Title XVIII Certification Only	Title XIX Certification Only	Licensure Only	Title XVIII and XIX Certification	Title XIX Certification & Licensure	Title XVIII Certification & Licensure	Title XVIII and XIX Certification & Licensure	Not Ascertained	Total
1 - 25	14	1	4	17	4	7	127	5	179
26 - 50	25	1	1	20	17	13	196	5	278
51 - 75	10	4	3	18	5	12	184	2	238
76 - 100	25	24	13	57	26	25	444	6	620
Not ascertained	10	6	2	7	28	7	70	11	141
Total	84	36	23	119	80	64	1,021	29	1,456[1]

[1]Total does not equal 1,541 because 85 individuals did not list "surveyor" as a functional responsibility even though they answered later questions concerning survey activities.

TABLE 26

FUNCTIONAL RESPONSIBILITY, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Number of Surveyors Who Hold Functional Responsibility as:[1]						
	Director	Administrator (in office)	Supervisor (of field operations)	Surveyor	Consultant	Other	Not Ascertained
Hospital Administrator	3	21	27	101	66	16	1
Health Administrator	4	18	17	52	26	8	4
Medical Records Administrator	1	0	1	23	24	0	0
Medical Technologist	0	11	9	50	35	11	0
Nurse, RN	7	21	40	564	386	97	16
Nurse, LPN or LVN	0	0	1	11	4	0	0
Nutritionist	0	1	4	31	25	6	0
Dietitian	0	3	5	44	40	16	4
Occupational Therapist	0	0	0	3	3	1	1
Pharmacist	1	2	1	23	21	5	1
Physical Therapist	0	2	1	15	14	1	2
Physician, DO	0	0	0	0	0	0	1
Physician, MD	4	6	10	38	31	6	6
Sanitarian	1	15	22	201	133	26	2
Social Worker	0	1	0	15	13	4	0
Architect	0	3	2	15	12	0	2
Engineer	0	3	8	37	29	12	2
Speech or Audiological Therapist	0	0	0	9	9	0	0
Recreational Therapist	0	1	1	8	5	2	0
Laboratory Technician	0	3	2	15	8	0	1
Fire Marshal; Life Safety Code Surveyor; Health Inspector	1	1	6	70	24	10	2
Counselor	0	0	0	1	1	0	0
Educator	0	0	1	5	1	0	0
Nursing Home Administrator	0	1	1	6	2	0	0
Surveyor[2]	1	13	20	119	46	10	3
Total	23	126	179	1,456	958	231	48

[1]Respondents were coded in all categories that applied.

[2]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

76-611 O - 76 - 18

TABLE 27

FUNCTIONAL RESPONSIBILITY OF SURVEYORS,
BY EDUCATIONAL ATTAINMENT, 1974

Level of Educational Attainment[1]	Number of Surveyors Who Hold Functional Responsibilities as:[2]						
	Director	Administrator (in office)	Supervisor (of field operations)	Surveyor	Consultant	Other	Not Ascertained
Some High School Only	0	0	2	7	2	1	0
High School Diploma Only	1	3	10	92	28	9	6
Some College	1	4	3	37	20	7	0
Technical School Certificate	0	10	12	105	63	15	2
Associate Degree	0	4	5	68	35	7	3
Diploma in Nursing	4	15	36	487	320	90	12
Baccalaureate Degree	18	110	146	957	693	145	30
Some Graduate School	7	31	50	286	209	39	5
Graduate Degree	12	51	63	388	299	65	15
Not Ascertained	1	1	0	5	3	0	1

[1]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions, (1) people who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the "some graduate work" category unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

[2]Respondents were coded in all categories that applied.

TABLE 28

FUNCTIONAL RESPONSIBILITY OF SURVEYORS,
BY NUMBER OF YEARS OF SURVEY EXPERIENCE

Number of Years of Survey Experience	Number of Surveyors Who Hold Functional Responsibilities as :[1]						
	Director	Administrator (in office)	Supervisor (of field operations)	Surveyor	Consultant	Other	Not Ascertained
1 year or less	2	10	16	336	212	53	7
2 - 4 years	8	48	72	591	366	85	16
5 - 7 years	7	27	43	273	202	56	18
8 or more years	6	38	44	222	162	32	5
Not Ascertained	0	3	4	35	17	5	2
Total	23	126	179	1,457	959	231	48

[1]Respondents were coded in all categories that applied.

TABLE 29

FUNCTIONAL RESPONSIBILITY, BY SEX OF SURVEYOR, 1974

Sex	Number of Surveyors Who Hold Functional Responsibility as:[1]						
	Director	Administrator (in office)	Supervisor (of field operations)	Surveyor	Consultant	Other	Not Ascertained
Male	16	97	122	720	437	97	23
Female	7	29	57	736	521	134	25
Total	23	126	179	1,456	958	231	48

[1]Respondents were coded in all categories that applied.

TABLE 30

NUMBER OF SURVEYORS WHO WORK AS SINGLE SURVEYORS SOMETIMES AS PART OF A TEAM, OR ALWAYS AS PART OF A TEAM, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Survey Structure				Total
	Always Work As Single Surveyor	Sometimes Work As Part of a Team[1]	Always Work As Part of a Team	Not Ascertained	
Hospital Administrator	5	76	22	2	105
Health Administrator	7	35	11	3	56
Medical Records Administrator	0	4	20	1	25
Medical Technologist	12	35	3	1	51
Nurse, RN	116	280	188	5	589
Nurse, LPN or LVN	0	7	2	2	11
Nutritionist	1	8	22	0	31
Dietitian	1	13	36	0	50
Occupational Therapist	0	1	3	0	4
Pharmacist	1	12	11	0	24
Physical Therapist	4	7	7	0	18
Physician, DO	0	1	0	0	1
Physician, MD	7	29	9	1	46
Sanitarian	16	113	76	1	206
Social Worker	0	5	10	0	15
Architect	8	8	1	0	17
Engineer	11	20	9	0	40
Speech or Audiological Therap.	1	5	3	0	9
Recreational Therapist	1	4	3	0	8
Laboratory Technician	8	6	1	0	15
Fire Marshal; Life Safety Code Surveyor; Health Inspector	38	34	7	1	80
Counselor	1	0	0	0	1
Educator	2	2	1	0	5
Nursing Home Administrator	0	5	1	0	6
Surveyor[2]	24	78	26	0	128
Total	264	788	472	17	1,541

[1]Of those respondents who sometimes work as single surveyors or always work as single surveyors, 770 use consultant support back-up, 146 do not, and the answers of 136 were not ascertained.

[2]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 31

NUMBER OF SURVEYORS WHO WORK AS SINGLE SURVEYORS, SOMETIMES AS PART OF A TEAM, OR ALWAYS AS PART OF A TEAM, BY EDUCATIONAL LEVEL, 1974

Level Of Educational Attainment[1]	Survey Structure				Total
	Always Work As Single Surveyor	Sometimes Work as Part of a Team[2]	Always Work As Part of a Team	Not Ascertained	
Some High School Only	0	7	1	0	8
High School Diploma Only	32	53	15	2	102
Some College	9	22	7	0	38
Technical School Certificate	23	55	30	3	111
Associate Degree	10	42	18	2	72
Diploma in Nursing	103	242	156	5	506
Baccalaureate Degree	148	509	346	9	1,012
Some Graduate School	36	166	93	2	297
Graduate Degree	58	194	157	6	415
Not Ascertained	1	5	0	0	6

[1]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions, (1) people who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the "some graduate work" category unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

[2]Of those respondents who sometimes work as single surveyors or always work as single surveyors, 770 use consultant support back-up, 146 do not, and the answers of 136 were not ascertained.

TABLE 32

NUMBER OF SURVEYORS SURVEYING PARTICULAR KINDS OF FACILITIES, BY SURVEY STRUCTURE[1]

Survey Structure[2]	Kind of Facilities[3]											
	General Hospitals	Psychiatric and/or Tuberculosis Hospitals	Skilled Nursing Facilities	Intermediate Care Facilities	Institutions for the Mentally Retarded and other Related Conditions	Home Health Agencies	Independent Laboratories	Outpatient/Physical Therapy Services	Domiciliary Facilities	Portable X-Ray Facilities	Whether or not team is used depends on whether surveyors can get together as a team	Whether or not team is used depends on size of facility
Work as Single Surveyor	469	257	585	522	189	126	65	44	87	14	6	5
Work as Part of a Team	758	361	910	769	322	91	32	77	104	12	6	5

[1] The kinds of facilities surveyed with a particular structure could not be ascertained for 73 of the 1,541 respondents.

[2] Respondents who "sometimes work as part of a team" were divided and coded into the other two categories, "work as single surveyors" and "work as part of a team." See question G. 1 in questionnaire.

[3] Respondents who survey more than one kind of facility were included in all categories that applied.

TABLE 33

NUMBER OF SURVEYORS SURVEYING PARTICULAR KINDS OF FACILITIES, BY REGION, 1974

Region	Number of Surveyors Who Survey [1]								
	Hospitals	Skilled Nursing Facilities	Intermediate Care Facilities	Institutions for the Mentally Retarded and Other Related Conditions	Home Health Agencies	Independent Laboratories	Outpatient/Physical Therapy Services	Domiciliary Facilities	Portable X-Ray Facilities
Region I	65	100	97	29	22	10	16	33	4
Region II	163	159	139	77	12	13	28	7	1
Region III	103	150	141	99	26	9	19	49	4
Region IV	150	144	133	86	48	13	23	27	6
Region V	165	249	243	158	17	9	21	34	5
Region VI	63	106	103	38	17	5	16	5	3
Region VII	72	87	84	36	6	3	8	31	3
Region VIII	61	66	57	41	17	7	16	13	3
Region IX	130	124	76	82	53	16	26	4	3
Region X	70	67	61	27	7	8	3	29	1
Total	1,042	1,252	1,134	673	225	93	176	232	33

[1]Respondents who survey more than one kind of facility were included in all categories that applied.

TABLE 34

NUMBER OF SURVEYORS SURVEYING PARTICULAR KINDS OF FACILITIES, BY STATE, 1974[1]

State	Hospitals	Skilled Nursing Facilities	Intermediate Care Facilities	Institutions for the Mentally Retarded and Other Related Conditions	Home Health Agencies	Independent Laboratories	Outpatient/Physical Therapy Services	Domiciliary Facilities	Portable X-Ray Facilities
Alabama	21	22	20	3	14	2	3	10	0
Alaska	6	6	4	3	2	1	2	0	0
Arizona	8	10	2	2	2	1	5	0	2
Arkansas	7	9	7	7	1	2	1	1	0
California	105	98	63	71	45	12	18	1	0
Colorado	19	17	17	17	4	1	5	4	0
Connecticut	9	20	19	4	7	5	8	10	2
Delaware	3	8	7	6	2	1	2	1	0
District of Columbia	10	10	9	7	5	2	2	5	1
Florida	41	34	32	29	5	4	6	5	2
Georgia	17	17	16	13	3	1	2	0	1
Hawaii	8	7	6	3	3	2	1	1	0
Idaho	12	10	9	6	1	1	0	2	0
Illinois	43	61	58	42	9	8	5	7	5
Indiana	15	17	24	8	0	0	0	1	0
Iowa	25	23	27	13	3	0	6	8	0
Kansas	18	12	12	9	1	1	0	1	2
Kentucky	17	17	16	8	8	2	5	4	2
Louisiana	11	11	11	6	5	0	2	0	0
Maine	19	20	22	10	3	0	2	10	1
Maryland	24	28	31	12	1	1	1	22	0
Massachusetts	11	32	26	6	4	2	1	12	0
Michigan	42	43	35	35	0	0	4	9	0
Minnesota	31	34	35	18	1	0	1	4	0
Mississippi	6	6	4	3	0	1	0	0	0
Missouri	7	31	25	5	1	1	2	19	1
Montana	8	8	8	7	4	2	4	0	0
Nebraska	22	21	20	9	1	1	0	3	0
Nevada	9	9	5	6	3	1	2	2	1
New Hampshire	12	13	12	3	4	1	3	0	0
New Jersey	20	22	21	9	2	5	6	4	0
New Mexico	2	2	2	2	1	0	0	0	0
New York	132	127	117	66	7	7	22	3	1
North Carolina	24	23	22	16	12	2	6	7	1
North Dakota	6	6	2	1	1	0	0	0	0
Ohio	19	39	37	23	5	1	8	5	0
Oklahoma	19	19	18	12	5	3	5	0	0
Oregon	15	13	13	7	2	3	0	7	0
Pennsylvania	38	77	68	58	8	1	9	15	3
Puerto Rico	11	10	1	2	3	1	0	0	0
Rhode Island	7	9	13	2	2	1	0	0	1
South Carolina	11	12	12	7	3	1	0	1	0
South Dakota	12	14	13	4	1	1	0	6	0
Tennessee	13	13	11	7	3	0	1	0	0
Texas	24	65	65	11	5	0	8	4	3
Utah	10	15	11	10	5	3	3	2	2
Vermont	7	6	5	4	2	1	2	1	0
Virginia	19	20	20	12	6	3	3	5	0
Washington	37	38	35	11	2	3	1	20	1
West Virginia	9	7	6	4	4	1	2	1	0
Wisconsin	15	55	54	32	2	0	3	8	0
Wyoming	6	6	6	2	2	0	4	1	1
Total	1,042	1,252	1,134	673	225	93	176	232	33

[1]Respondents who survey more than one kind of facility were included in all categories who applied.

TABLE 35

KINDS OF FACILITIES SURVEYED, BY PROFESSIONAL DISCIPLINE, 1974

Professional Discipline	Kinds of Facilities[2]																
	Hospitals																
	Hospitals, -- General Psychiatric, and/or Tuberculosis	General	Psychiatric	Tuberculosis	General and Psychiatric	Psychiatric and Tuberculosis	General and Tuberculosis	General, Psychiatric and Tuberculosis	Particular Kind of Hospital Surveyed Not Ascertained	Skilled Nursing Facilities	Intermediate Care Facilities	Institutions for Mentally Retarded and Other Related Conditions	Home Health Agencies	Independent Laboratories	Outpatient/Physical Therapy Services	Domiciliary Facilities	Portable X-Ray Facilities
Hospital Administrator	103	36	1	0	26	0	0	39	1	78	60	47	16	4	25	6	7
Health Administrator	43	18	1	0	10	1	3	10	0	43	41	30	13	5	5	8	2
Medical Records Administrator	20	8	0	0	4	0	2	5	1	23	12	9	3	0	1	2	0
Medical Technologist	46	25	0	0	11	0	1	5	4	7	5	12	1	45	3	0	1
Nurse, RN	304	153	6	0	86	0	9	39	11	474	449	209	122	6	55	110	6
Nurse, LPN or LVN	7	2	0	0	4	0	0	1	0	8	8	7	1	0	0	0	0
Nutritionist	24	15	0	0	4	0	1	2	2	31	27	20	1	0	0	3	1
Dietitian	38	22	1	0	8	0	0	5	2	44	41	31	3	1	0	5	0
Occupational Therapist	3	1	1	0	1	0	0	0	0	4	4	2	1	0	0	0	0
Pharmacist	20	8	0	0	7	0	1	4	0	20	19	11	4	1	1	2	0
Physical Therapist	6	2	2	0	2	0	0	0	0	15	11	3	6	0	11	1	0
Physician, DO	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0
Physician, MD	41	10	6	0	10	0	1	9	5	24	10	10	2	5	8	2	1
Sanitarian	137	57	0	1	38	0	1	38	2	198	183	107	10	2	32	42	2
Social Worker	12	7	2	0	1	0	0	2	0	15	13	7	4	1	2	1	1
Architect	15	5	0	0	5	0	1	4	0	17	17	9	2	1	6	2	0
Engineer	38	14	0	0	10	0	0	14	0	38	36	29	3	1	4	9	1
Speech or Audiological Therapist	3	12	0	0	1	0	0	0	0	9	8	7	0	0	1	1	0
Recreational Therapist	2	2	0	0	0	0	0	0	0	8	7	1	1	0	0	1	0
Laboratory Technician	12	6	0	0	1	0	1	2	2	4	0	2	1	11	0	0	0
Fire Marshal; Life Safety Code Surveyor; Health Inspector	67	25	0	0	23	0	1	18	0	79	77	61	5	2	8	5	0
Counselor	1	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
Educator	3	2	0	0	1	0	0	0	0	2	4	1	1	0	1	1	0
Nursing Home Administrator	5	3	0	0	0	0	1	1	0	4	4	4	2	1	1	1	0
Surveyor[1]	91	34	2	2	32	0	3	16	3	105	97	53	23	7	12	30	11
Total	1,042	468	22	3	286	1	26	204	33	1,252	1,134	673	225	93	176	232	33

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories

[2]Respondents who survey more than one kind of facility were included in all categories that applied.

TABLE 36

KINDS OF FACILITIES SURVEYED,
BY EDUCATIONAL LEVEL, 1974

Level of Educational Attainment[1]	Kinds of Facilities[2]								
	Hospitals	Skilled Nursing Facilities	Intermediate Care Facilities	Institutions for the Mentally Retarded and Other Retarded Conditions	Home Health Agencies	Independent Laboratories	Outpatient/Physical Therapy Services	Domiciliary Facilities	Portable X-Ray Facilities
Some High School Only	8	8	7	6	2	0	1	1	0
High School Diploma Only	72	94	91	67	12	2	8	13	2
Some College	19	36	31	18	3	1	2	9	1
Technical School Certificate	87	96	83	59	14	7	6	14	8
Associate Degree	50	59	54	34	13	5	12	8	1
Diploma in Nursing	241	409	387	177	97	4	43	92	6
Baccalaureate Degree	768	791	699	423	155	82	134	146	22
Some Graduate School	211	250	221	132	53	16	47	47	8
Graduate Degree	328	309	251	172	62	38	51	46	9
Not Ascertained	4	5	5	2	1	0	1	1	0

[1]Persons who attended high school or received a high school diploma and went no further were included in the categories referring to high school. Persons who went further than high school were coded in other categories. If they had credentials in more than one area, they were coded in all areas that applied, with two exceptions, (1) people who received baccalaureate or associate degrees were not included in the "some college" category, and (2) persons who received graduate degrees were not included in the category "some graduate work" unless the field of study listed by the respondent under "some graduate work" differed from that in which the respondent received a graduate degree.

[2]Respondents who survey more than one kind of facility were included in all categories that applied.

TABLE 37. PROFESSIONAL DISCIPLINE OF SURVEYORS, BY HOSPITAL CONDITIONS OF PARTICIPATION, 1974

Conditions of Participation	Professional Discipline																										
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal; Life Safety Code Surveyor; Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[1]	Total
Compliance with State and Local Laws	92	41	5	23	185	4	9	9	2	14	2	1	13	112	5	11	26	2	1	7	53	0	2	4	69	692
Governing Body	90	34	4	5	134	5	0	3	1	7	2	0	12	54	2	1	3	0	2	2	4	0	3	3	43	414
Physical Environment	80	32	1	8	103	4	2	8	0	4	2	0	7	127	1	9	25	2	2	1	11	0	3	4	47	483
Medical Staff	82	32	9	4	141	5	0	3	1	5	2	1	31	46	1	0	0	0	2	2	2	0	3	4	42	418
Nursing Department	45	23	2	2	279	5	1	1	0	7	1	0	11	32	0	2	0	0	1	2	1	0	2	2	31	450
Dietary Department	59	27	1	4	106	4	22	35	2	4	0	0	5	104	1	2	2	2	2	1	3	0	3	3	34	426
Medical Records Department	77	25	19	5	173	5	1	5	1	6	3	1	27	32	1	2	0	0	2	2	2	0	3	3	36	431
Pharmacy or Drug Room	81	28	2	6	191	5	0	1	0	20	1	0	8	43	1	2	0	0	2	3	3	0	3	2	32	434
Laboratories	41	17	4	45	83	0	0	0	0	2	0	0	17	51	1	3	1	2	0	6	7	0	2	1	30	313
Radiology Department	67	21	3	9	93	4	0	1	0	6	2	0	12	59	1	4	3	1	0	5	6	0	2	2	35	337
Medical Library	79	26	11	4	132	5	0	3	0	7	2	0	12	27	1	0	0	0	2	2	3	0	3	3	33	355
Complementary Department	60	20	4	3	189	6	0	2	1	5	4	0	8	46	0	1	2	0	1	2	2	0	3	3	37	399
Outpatient Department	60	22	8	3	195	5	0	1	0	5	2	1	14	42	0	4	0	1	1	1	3	0	3	3	35	409
Emergency Services Department	60	23	8	4	228	6	0	1	0	8	1	1	14	61	1	3	0	1	1	2	5	0	3	3	36	470
Social Work Department	66	25	2	3	145	3	0	3	1	5	2	0	10	29	12	0	0	0	2	1	1	0	2	1	33	346
Utilization Review Plan	88	31	13	5	96	4	0	4	1	4	1	1	36	51	3	0	1	0	2	2	1	1	3	4	46	398
Life Safety Code	9	7	0	0	4	0	0	0	0	1	0	0	3	41	0	15	30	3	0	0	59	0	0	0	33	205

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

[2]Respondents who survey more than one condition of participation were coded in all categories that applied.

TABLE 38. PROFESSIONAL DISCIPLINE OF SURVEYOR, BY SKILLED NURSING FACILITY CONDITIONS OF PARTICIPATION, 1974

Conditions of Participation[1]	Professional Discipline																									
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal; Life Safety Code Surveyor; Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[2]	Total
Compliance with Federal, State and Local Laws	74	42	9	5	367	7	15	18	3	14	8	0	7	180	6	14	29	8	3	2	60	0	2	4	93	970
Governing Body and Management	72	38	4	3	322	6	6	10	1	8	5	0	5	108	5	0	7	5	3	2	3	0	2	3	58	676
Patient Care Policies	64	30	6	3	447	7	9	11	2	11	8	0	10	73	8	1	2	4	4	2	3	0	2	4	54	765
Physician Services	51	27	12	3	416	7	1	2	1	6	5	1	17	59	4	0	2	1	1	2	1	0	2	3	47	671
Nursing Services	30	25	2	3	463	6	2	6	0	13	3	0	5	58	4	1	1	1	2	2	1	0	1	1	41	671
Dietetic Services	50	30	2	4	257	5	31	43	2	5	0	0	3	150	4	1	2	6	4	1	2	0	2	3	49	656
Special Rehabilitative Services	50	25	2	3	407	5	0	1	3	2	14	0	6	69	5	1	0	1	3	2	4	0	2	1	42	648
Pharmaceutical Services	65	30	2	3	408	6	0	1	0	19	1	0	6	68	3	1	1	1	3	2	0	0	2	1	44	668
Laboratory and Radiologic Services	52	25	3	6	298	5	2	3	0	6	2	0	10	85	3	2	0	3	4	3	3	0	2	2	49	568
Dental Services	64	28	4	3	352	5	4	5	1	8	3	0	5	72	3	0	0	2	5	2	1	0	2	2	51	622
Social Services	62	25	3	4	348	5	1	4	1	7	3	0	4	72	15	0	1	3	5	1	2	0	2	1	48	617
Patient Activities	61	29	3	4	399	6	5	6	3	6	6	0	2	92	10	0	1	4	7	2	4	0	2	2	55	709
Medical Records	57	30	23	4	410	7	2	7	1	8	5	0	16	61	4	0	0	1	5	2	1	0	2	2	51	699
Transfer Agreement	68	37	7	4	317	6	1	5	1	5	3	0	7	88	4	0	1	4	3	2	3	1	2	4	58	631
Physical Environment	63	30	2	4	192	5	4	8	0	4	5	0	3	186	3	9	22	8	3	1	17	0	2	4	61	636
Infection Control	57	28	2	4	329	8	9	11	0	7	2	0	10	173	3	0	7	6	3	2	2	0	2	2	56	723
Disaster Preparedness	63	31	2	3	192	5	5	9	0	2	2	0	3	163	3	3	6	8	3	2	15	0	2	4	57	583
Utilization Review	72	33	14	3	228	6	0	3	1	3	4	0	20	86	3	0	0	3	3	2	1	1	2	3	53	544
Life Safety Code	13	8	1	0	23	0	0	0	0	0	1	0	3	63	0	15	30	5	0	0	72	0	0	0	46	280

[1]Respondents who survey more than one condition of participation were included in all categories that applied.

[2]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 39. PROFESSIONAL DISCIPLINE OF SURVEYOR BY INTERMEDIATE CARE FACILITY CONDITIONS OF PARTICIPATION, 1974

Conditions of Participation	Professional Discipline																									
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal Life Safety Code Surveyor; Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[2]	Total
State Licensure	58	39	5	5	380	8	14	24	3	12	6	0	5	161	7	12	28	8	2	0	50	0	3	4	77	911
Conformity with Federal, State and Local Laws	59	39	6	4	374	8	11	21	3	12	7	0	6	154	7	11	22	8	2	0	52	0	2	4	75	887
Administrative Management	57	37	2	3	345	7	6	7	1	7	6	0	4	92	4	0	2	5	2	0	2	0	3	4	54	650
Transfer Agreement	56	34	5	4	324	7	1	3	1	5	3	0	3	74	4	0	1	4	2	0	3	0	3	4	53	594
Arrangements for Services	54	32	3	4	353	7	2	7	1	5	5	0	4	66	5	0	0	4	2	0	2	0	3	3	53	615
Resident Record System	43	29	12	4	407	8	2	6	1	4	4	0	3	64	6	0	1	3	3	0	3	0	3	3	50	659
Life Safety Code	15	13	0	1	36	1	0	1	0	1	1	0	1	72	0	15	28	4	0	0	73	0	0	0	46	308
Environment and Sanitation	52	30	1	3	158	6	7	12	0	2	4	0	3	179	2	8	23	7	2	0	12	0	3	4	57	575
Dietetic Services	44	29	3	4	272	7	25	41	1	5	0	0	2	139	3	2	2	6	3	0	2	0	3	3	45	641
Drugs and Biologicals	46	30	3	4	423	8	0	2	1	17	1	0	6	52	3	1	1	1	1	0	1	0	3	2	42	648
Health Services	40	26	2	3	436	8	2	4	1	7	5	0	9	52	3	0	1	1	2	0	2	0	3	1	43	651
Disclosure of Ownership	54	34	2	3	298	7	1	3	1	4	4	0	1	83	4	0	1	4	2	0	2	0	3	4	51	566
Administrator	55	35	3	3	324	7	2	2	1	6	4	0	1	96	4	1	1	6	2	0	4	0	3	4	51	615
Resident Services Director	46	28	3	3	360	7	0	2	1	3	4	0	3	67	4	0	1	2	2	0	2	0	3	2	47	590
Rehabilitation Services	43	25	3	3	407	8	0	2	3	2	11	0	7	62	3	0	1	1	3	0	3	0	3	1	42	633
Social Services	49	26	4	4	348	7	1	3	2	5	4	0	3	59	13	0	1	2	4	0	2	0	3	1	46	587
Activities Program	50	28	3	4	378	8	4	6	3	4	5	0	4	84	9	0	1	4	7	0	4	0	3	2	48	659
Physician Services	41	27	8	3	416	8	1	2	1	6	6	1	11	50	3	2	1	1	1	0	2	0	3	2	44	640

[1] Respondents who survey more than one standard were included in all categories that applied.

[2] This categories includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 40. PROFESSIONAL DISCIPLINE OF SURVEYOR, BY CONDITIONS OF PARTICIPATION FOR INSTITUTIONS FOR THE MENTALLY RETARDED AND OTHER RELATED CONDITIONS, 1974

Conditions of Participation	Professional Discipline																									
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal Life Safety Code Surveyor; Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[2]	Total
State Licensure	42	26	4	7	148	7	5	9	2	8	2	0	3	84	2	7	20	5	1	0	36	0	1	4	33	456
Conformity with Federal, State and Local Laws	39	28	4	3	152	6	7	10	1	9	1	0	2	86	3	7	17	7	1	1	35	0	0	4	38	461
Disclosure of Ownership	36	23	2	0	110	5	0	1	0	2	1	0	0	45	0	0	0	3	1	0	1	0	1	4	13	248
Transfer Agreement	38	23	4	0	124	4	0	1	0	2	1	0	0	34	0	0	0	3	1	0	0	1	1	3	15	255
Admission of Residents	33	20	4	1	157	5	1	0	0	2	1	0	1	21	3	0	0	0	1	0	0	0	1	3	10	264
Active Treatment	24	16	3	1	170	4	2	0	1	2	1	0	4	17	0	0	0	1	1	0	1	0	1	2	9	260
Administrative Management	38	22	2	0	136	5	1	0	0	2	1	0	1	41	0	0	0	2	1	0	0	0	1	3	15	271
Administrator	36	23	2	0	140	5	0	0	0	2	1	0	1	44	0	0	0	4	1	0	1	0	1	3	15	279
Qualified Mental Retardation Professional	21	20	2	1	144	3	0	0	1	0	1	0	2	18	3	0	0	0	1	0	0	0	1	4	7	229
Arrangements for Services	29	22	2	1	155	5	1	2	1	3	1	0	2	25	3	0	0	3	1	0	0	0	1	3	7	267
Services as Needed	24	17	3	1	165	4	1	0	1	1	3	0	2	20	5	0	0	0	1	0	0	0	1	2	13	264
Direct Care Staff	21	16	2	1	181	4	3	0	0	1	1	0	2	17	1	0	0	0	1	0	0	0	1	2	8	262
Health Services	21	18	2	6	190	5	3	3	0	1	3	0	5	20	0	0	0	1	1	0	0	0	1	2	9	291
Dietetic Services	28	19	1	1	112	4	20	29	1	1	1	0	1	63	0	0	1	4	1	0	0	0	1	2	10	301
Drugs & Biologicals	29	20	2	1	176	5	0	0	0	11	1	0	3	24	0	0	0	1	1	0	0	0	1	3	11	289
Resident Record System	30	19	9	1	177	5	3	1	0	1	1	0	1	20	1	0	0	1	1	0	1	0	1	3	11	287
Life Safety Code	8	7	0	0	12	0	0	0	0	0	0	0	0	38	0	8	22	4	0	0	54	0	0	0	33	186
Environment and Sanitation	32	21	1	0	65	5	3	7	1	1	1	0	1	97	0	4	15	6	1	0	6	0	1	4	17	289
Relationship to 249.13	16	14	0	0	60	0	0	1	0	0	1	0	0	16	0	0	1	2	1	0	0	0	0	3	3	118

[1]Respondents who survey more than one standard were included in all categories that applied.

[2]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

TABLE 41. PROFESSIONAL DISCIPLINE OF SURVEYOR, BY HOME HEALTH AGENCY CONDITIONS OF PARTICIPATION, 1974

Conditions of Participation[1]	Professional Discipline																										
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal Life Safety Code Surveyor, Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[2]	Total
Compliance with Federal, State, and Local Laws	14	11	2	0	115	1	0	1	0	2	1	0	1	7	0	1	3	0	1	1	5	0	1	1	23	191
Organization, Services, Administration	13	11	1	0	111	1	0	1	0	2	1	0	1	4	1	0	0	0	1	1	1	0	1	2	14	167
Group of Professional Personnel	12	10	1	0	115	1	0	1	0	2	1	0	1	3	2	0	0	0	1	1	1	0	1	1	14	168
Acceptance of Patients, Plan Of Treatment, and Medical Supervision	11	10	2	0	115	1	0	1	0	2	1	0	1	2	1	0	0	0	1	1	1	0	1	1	14	166
Skilled Nursing Service	11	10	0	0	117	1	0	1	0	2	1	0	1	3	0	0	0	0	0	1	1	0	1	0	16	166
Therapy Services	12	10	1	0	114	1	0	1	1	2	6	0	1	2	0	0	0	0	1	1	1	0	1	1	14	170
Medical Social Services	10	10	1	0	110	1	0	1	0	2	1	0	1	2	4	0	0	0	1	1	1	0	1	0	13	160
Home Health Aide Services	11	10	1	1	115	1	0	1	0	2	1	0	1	2	0	0	0	0	0	1	1	0	1	0	14	163
Clinical Records	11	10	3	0	115	1	1	1	0	3	2	0	1	2	1	0	0	0	1	1	1	0	1	1	14	170
Evaluation	11	10	1	0	112	1	0	1	0	3	1	0	1	3	2	0	0	0	0	1	2	0	1	1	14	165
Qualifying to Provide Outpatient Physical Therapy Services	12	9	1	0	74	1	0	0	0	2	6	0	1	3	0	0	0	0	1	1	1	0	1	1	13	127

[1]Respondents who survey more than one condition of participation were included in all categories that apply.

[2]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional discipline could not be coded in the above categories.

TABLE 42. DISCIPLINE OF SURVEYOR, BY INDEPENDENT LABORATORY CONDITIONS OF PARTICIPATION, 1974

Conditions of Participation[2]	Professional Discipline																									Total
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal Life Safety Code Surveyor; Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[1]	
Compliance with State and Local Laws	4	3	0	44	4	0	0	1	0	1	0	0	4	1	0	1	1	0	0	11	2	0	0	0	5	82
Clinical Laboratory; Laboratory Director	4	3	0	44	4	0	0	1	0	1	0	0	4	1	0	0	0	0	0	9	0	0	0	1	4	76
Clinical Laboratory; Supervision	4	3	0	44	4	0	0	1	0	1	0	0	4	1	0	0	0	0	0	9	0	0	0	1	4	76
Clinical Laboratory; Tests Performance	4	3	0	44	3	0	0	1	0	1	0	0	4	1	0	0	0	0	0	9	0	0	0	1	4	75
Clinical Laboratory; Technical Personnel	4	3	0	43	4	0	0	1	0	1	0	0	4	1	0	0	0	0	0	9	0	0	0	1	4	75
Clinical Laboratory; Records, Equipment, and Facilities	4	3	0	44	3	0	0	1	0	1	0	0	4	1	0	0	0	0	0	9	0	0	0	1	4	75

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

[2]Respondents who survey more than one condition of participation were included in all categories that applied.

76-811 O - 76 - 19

TABLE 43. DISCIPLINE OF SURVEYOR, BY CONDITIONS OF PARTICIPATION FOR OUTPATIENT/PHYSICAL THERAPY SERVICES

Conditions of Participation[2]	Professional Discipline																									Total
	Hospital Administrator	Health Administrator	Medical Records Administrator	Medical Technologist	Nurse, RN	Nurse, LPN or LVN	Nutritionist	Dietitian	Occupational Therapist	Pharmacist	Physical Therapist	Physician, DO	Physician, MD	Sanitarian	Social Worker	Architect	Engineer	Speech or Audiological Therapist	Recreational Therapist	Laboratory Technician	Fire Marshal Life Safety Code Surveyor; Health Inspector	Counselor	Educator	Nursing Home Administrator	Surveyor[1]	
Compliance with State and Local Laws	23	5	0	3	43	0	0	0	0	1	10	0	3	25	0	5	3	0	0	0	5	0	1	0	9	135
Administrative Management	22	5	0	3	42	0	0	0	0	1	10	0	1	11	0	0	0	0	0	0	0	0	1	1	5	102
Patient Care Policies	21	5	0	2	50	0	0	0	0	1	11	0	5	9	1	0	0	0	0	0	0	0	1	1	4	111
Program Evaluation	20	5	0	2	43	0	0	0	0	1	11	0	2	9	0	0	0	0	0	0	0	0	1	0	5	99
Physician Service and Plan of Care	18	5	0	3	43	0	0	0	0	1	11	0	7	8	0	0	0	0	0	0	0	0	1	0	5	102
Physical Therapy Services	18	5	0	2	52	0	0	0	0	1	11	0	4	9	0	0	0	0	0	0	0	0	1	1	5	109
Rehabilitation Program	18	5	0	3	47	0	0	0	0	1	11	0	5	8	1	0	0	0	0	0	0	0	1	1	5	106
Arrangements for Physical Therapy Services to be Performed by Other than Salaried Clinic or Agency Personnel	18	5	0	3	41	0	0	0	0	1	10	0	0	7	0	0	0	0	0	0	0	0	1	0	4	90
Clinical Records	19	5	1	2	45	0	0	0	0	1	11	0	5	9	0	0	0	0	0	0	0	0	1	1	5	106
Emergency Procedures	20	5	0	2	45	0	0	0	0	1	11	0	6	12	0	1	1	0	0	0	1	0	1	0	5	111
Physical Environment	22	5	0	3	33	0	0	0	0	1	11	0	1	31	0	5	3	1	0	0	5	0	1	1	6	129

[1]This category includes: persons who called themselves surveyors, persons who left the question regarding discipline blank, and persons whose professional disciplines could not be coded in the above categories.

[2]Respondents who survey more than one condition of participation were included in all categories that applied.

TABLE 44

ESTIMATED NUMBER OF FACILITIES SURVEYED YEARLY, BY NUMBER OF SURVEYORS SURVEYING PARTICULAR KINDS OF FACILITIES

Kinds of Facilities[2]	Number of Surveyors Estimating They Survey:										Total Number of Surveyor	Average Number of Facilities Surveyed[1]
	1 - 5 Facilities	6 - 10 Facilities	11 - 15 Facilities	16 - 20 Facilities	21 - 25 Facilities	26 - 35 Facilities	36 - 50 Facilities	51 - 64 Facilities	65 or more Facilities	Not Ascertained		
Hospitals	164	337	140	173	61	37	11	5	4	110	1,042	12.5
Skilled Nursing Facilities	153	186	145	152	108	138	148	33	55	134	1,252	23.6
Intermediate Care Facilities	233	214	119	92	76	85	100	20	55	140	1,134	20.3
Institutions for the Mentally Retarded and Other Related Conditions	469	62	17	16	8	1	4	0	1	95	673	4.5
Home Health Agencies	92	33	18	15	6	17	9	5	3	27	225	13.2
Independent Laboratories	22	5	8	12	3	4	10	3	6	20	93	22.9
Outpatient/Physical Therapy Services	107	24	10	4	1	0	0	0	1	29	176	4.8
Domiciliary Facilities	85	62	23	15	7	5	9	1	1	24	232	10.8
Portable X-Ray Facilities	18	1	2	3	1	0	0	0	2	6	33	11.8

[1]Average is based on number of surveyors whose estimates were ascertained.

[2]Respondents who survey more than one kind of facility were included in all categories that applied.

TABLE 45

ESTIMATED NUMBER OF HOURS SPENT SURVEYING,
BY NUMBER OF SURVEYORS SURVEYING PARTICULAR KINDS OF FACILITIES

Kinds of Facilities[1]	Number of Surveyors Estimating They Spend:										Total Number of Surveyors	Average Number of Hours
	1 - 4 Hours	5 - 8 Hours	9 - 12 Hours	13 - 16 Hours	17 -20 Hours	21 - 24 Hours	25 - 36 Hours	37 - 48 Hours	49 or more Hours	Not Ascertained		
Hospitals	96	347	137	154	80	53	47	9	9	110	1,042	12.5
Skilled Nursing Facilities	132	370	155	222	97	81	63	8	12	94	1,252	12.9
Intermediate Care Facilities	146	442	147	137	57	35	29	2	10	130	1,134	10.7
Institutions for the Mentally Retarded & Other Related Conditions	80	170	72	85	44	45	32	14	9	122	673	13.8
Home Health Agencies	40	103	28	18	7	2	0	2	1	24	225	8.7
Independent Laboratories	31	40	2	4	0	0	0	0	0	16	93	5.5
Outpatient/Physical Therapy Services	55	63	8	9	1	0	0	1	0	39	176	6.5
Domiciliary Facilities	73	90	10	9	4	1	1	0	1	34	232	6.6
Portable X-Ray Facilities	16	6	2	0	0	0	0	0	0	9	33	3.9

[1]Respondents who survey more than one kind of facility were included in all categories that applied.

CONCLUSIONS

Summary characteristics have been presented at the beginnings of Sections A, B, and C and need not be presented here. But some general conclusions may be derived from the data.

The majority of the surveyors have received training. However, due to turnover and expanding State survey staffs necessary to meet Medicare/Medicaid demands, there is a continuing need for entry-level training. Likewise, there is need for training staff who survey in specialty areas such as fire safety and laboratory services.

The focus of future training must be sensitive to special needs of States, regions, disciplines, and years of survey experience so that basic as well as specialized training requirements are met in the most effective manner.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BUREAU OF QUALITY ASSURANCE
DIVISION OF PROVIDER STANDARDS AND CERTIFICATION

APPENDIX

CONFIDENTIAL: *All information which permits the identification of the individual will be held strictly confidential, will be used by personnel engaged in and only for the purposes of the survey.*

Dear Health Facility Surveyor:

The Division of Provider Standards and Certification has been periodically conducting a national inventory of surveyors to update our census on surveyors to assist in the development and projection of plans for the surveyor training programs. We have contracted with CPI Associates, Inc. to perform and to prepare a report on this inventory study. However, we do need your assistance in completing the enclosed questionnaire.

The purpose of the questionnaire is to obtain information on all State and local employees who survey health care facilities and home health agencies. This includes surveys conducted for State licensure programs, Title XVIII (Medicare) and Title XIX (Medicaid) certification, Life Safety Code, and inspections for compliance with local health facility ordinances. For purposes of this inventory, the term "Surveyor" includes any individual who, as part of his normal duties, makes on-site visits to facilities, which, under law (Medicare/Medicaid), require certification, and is responsible for completing and documenting at least a portion of a survey report form. No individual respondent will be identified in the final report since it consists of a summary of all questionnaires. Confidentiality measures will be in effect throughout the study and a copy of the final report will be sent to each respondent.

Please complete all questions on this form and return it within five days in the enclosed self-addressed envelope.

Thank you for your interest and support.

Sincerely yours,

Michael J. Spodnik, Jr.
Acting Director
Division of Provider Standards
and Certification

Enclosures

OMB #68-R1289
Expires June 30, 1977

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BUREAU OF QUALITY ASSURANCE
DIVISION OF PROVIDER STANDARDS AND CERTIFICATION

CONFIDENTIAL: *All information which permits the identification of the individual will be held strictly confidential, will be used solely by personnel engaged in and only for the purposes of the Survey.*

HEALTH FACILITY SURVEYOR INVENTORY

A. BIOGRAPHICAL DATA

1. Year of Birth _____ 2. Sex 1 ☐ Male 2 ☐ Female

B. EDUCATIONAL ATTAINMENT (Check **ALL** categories that apply)

1 ☐ Less than High School
2 ☐ High School Diploma
3 ☐ Technical School Certificate; Specify major field: _____
4 ☐ Associate Degree; Specify major field: _____
5 ☐ Diploma in Nursing; Specify number of years spent in training: _____
6 ☐ Baccalaureate Degree; Specify major field: _____
7 ☐ Some Graduate Work; Specify major field: _____
8 ☐ Graduate Degree; Specify major field: _____

C. PROFESSIONAL DISCIPLINE (Check **ONLY** one and indicate whether you are **registered or certified** to fulfill your discipline's requirements)

Discipline	Registered/Certified Yes	No	Not Applicable
01 ☐ Hospital Administrator	☐	☐	☐
02 ☐ Health Administrator	☐	☐	☐
03 ☐ Medical Records Administrator	☐	☐	☐
04 ☐ Medical Technologist	☐	☐	☐
05 ☐ Nurse, RN	☐	☐	☐
06 ☐ Nurse, LPN or LVN	☐	☐	☐
07 ☐ Nutritionist	☐	☐	☐
08 ☐ Dietitian	☐	☐	☐
09 ☐ Occupational Therapist	☐	☐	☐
10 ☐ Pharmacist	☐	☐	☐
11 ☐ Physical Therapist	☐	☐	☐
12 ☐ Physician, DO; Specify specialty: _____	☐	☐	☐
13 ☐ Physician, MD; Specify specialty: _____	☐	☐	☐
14 ☐ Sanitarian	☐	☐	☐
15 ☐ Social Worker; Specify field: _____	☐	☐	☐
16 ☐ Other; Specify: _____	☐	☐	☐

D. EXPERIENCE

1. How many years since 1966 have you worked as a health-related facility surveyor under the Medicare-Medicaid programs? _____
2. How many years did you work in the health field prior to becoming a Medicare-Medicaid surveyor? _____
   Specify field(s): _____
3. How many years did you work in a non-health field that has aided you in your job as surveyor? _____
   Specify field(s): _____

E. 1. Do you, as part of your normal duties, make on-site inspection visits to facilities which, under law (Medicare-Medicaid), require certification?

1 ☐ Yes 2 ☐ No

2. Are you responsible for completing at least a portion of a survey report form, documenting information derived from observations made during these on-site visits?

1 ☐ Yes 2 ☐ No

3. Type of agency in which employed for surveying activities (Check appropriate box)

1 ☐ State (Specify State: _____)

2 ☐ County/Parish (Specify County/Parish and State: _____)

3 ☐ City (Specify City and State: _____)

4 ☐ Other (Specify location: _____)

4. Official name of agency: _____

5. Address of agency: _____

_____

_____

6. How many hours per week are you employed in:

Pre-Survey File Review _____ Travel _____

Actual Surveying _____ Consultation and/or Follow-up _____

Report Writing and Other Survey-Related Activities _____ Other _____

7. What responsibilities do you have in the Licensure/Certification Program?
(Check ALL that apply and estimate the percentage of time you spend in fulfilling that responsibility; percentages should not exceed a total of 100%)

Responsibilities	Percentage of Time
1 ☐ Director	_____
2 ☐ Administrator (in office)	_____
3 ☐ Supervisor (of field operations)	_____
4 ☐ Surveyor	_____
5 ☐ Consultant	_____
6 ☐ Other Specify: _____	_____

F. SURVEYOR-RELATED TRAINING

1. Have you attended and completed any of the DHEW-sponsored university-based health facility surveyor training courses?

1 ☐ Yes 2 ☐ No

IF **YES** is checked, which one(s)?

1 ☐ Basic course (Specify university and date: _____)

2 ☐ Advanced course (Specify university and date: _____)

3 ☐ Supervisor training institute (Specify university and date: _____)

2. Does your professional discipline require continuing education?

1 ☐ Yes 2 ☐ No

IF **YES** is checked, do any of the courses mentioned in question 1 of this section meet your discipline's requirements?

1 ☐ Yes 2 ☐ No

IF **YES** is checked, which one(s)?

1 ☐ Basic course

2 ☐ Advanced course

3 ☐ Supervisor training institute

3. Since 1972 have you attended other continuing education conferences that have helped you in your survey functions and responsibilities?

1 ☐ Yes 2 ☐ No

IF **YES** is checked, specify subject area(s): _____

OMB# 68-R1289
Expires June 30, 1977

G. TYPE, AREA AND FUNCTIONAL RESPONSIBILITY

1. Do you work as:

1 ☐ a single surveyor

2 ☐ sometimes as a single surveyor, sometimes as part of a team

3 ☐ part of a team (two or more persons, excluding life safety code surveyors, who are responsible for surveying the same facility)

If you work **at least sometimes** as a single surveyor, do you utilize consultant support back-up?

1 ☐ Yes 2 ☐ No

If you work sometimes as a single surveyor and sometimes as part of a team, for what kinds of facilities do you function as a single surveyor? _____ For what kinds of facilities do you function as part of a team? _____ .

If you work **at least sometimes** as part of a team, please answer the following questions:

What is the average size of the teams on which you worked during past year _____ .

Specify the professional disciplines represented on the teams with which you worked during the past year (Check **ALL** that apply)

01 ☐ Hospital Administrator

02 ☐ Health Administrator

03 ☐ Medical Records Administrator

04 ☐ Medical Technologist

05 ☐ Nurse, RN

06 ☐ Nurse, LPN or LVN

07 ☐ Nutritionist

08 ☐ Dietitian

09 ☐ Occupational Therapist

10 ☐ Pharmacist

11 ☐ Physical Therapist

12 ☐ Physician, DO

13 ☐ Physician, MD; Specify specialty(s): _____

14 ☐ Sanitarian

15 ☐ Social Worker; Specify field(s): _____

16 ☐ Other; Specify _____

Do you survey facilities together as a team or do you conduct individual visits on separate days?

1 ☐ Survey facilities together as a team

2 ☐ Conduct individual visits on separate days

2. Program Responsibility (Check **ALL** that apply)

1 ☐ Title XVIII Certification

2 ☐ Title XIX Certification

3 ☐ Licensure

3. Survey Functions

1. Do you survey **hospitals**?

1 ☐ Yes 2 ☐ No

If **YES** is checked, please answer the following questions:

Please estimate the average number of hospital facilities you survey yearly _____

Please estimate the average number of hours spent in facility for survey _____

What kind of hospital facilities do you survey? (Check **ALL** that apply)

1 ☐ General

2 ☐ Psychiatric

3 ☐ TB

OMB#68-R1289
Expires June 30, 1977

What condition(s) of participation do you survey in hospitals? (Check ALL that apply)

01 ☐ Compliance with State and Local laws
02 ☐ Governing Body
03 ☐ Physical Environment
04 ☐ Medical Staff
05 ☐ Nursing Department
06 ☐ Dietary Department
07 ☐ Medical Records Department
08 ☐ Pharmacy or Drug Room
09 ☐ Laboratories
10 ☐ Radiology Department
11 ☐ Medical Library
12 ☐ Complementary Department
13 ☐ Outpatient Department
14 ☐ Emergency Service or Department
15 ☐ Social Work Department
16 ☐ Utilization Review Plan
17 ☐ Life Safety Code

2. Do you survey **skilled nursing facilities?**

1 ☐ Yes 2 ☐ No

If YES is checked, please answer the following questions:

Please estimate the average number of skilled nursing facilities you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

What condition(s) of participation do you survey in skilled nursing facilities? (Check ALL that apply)

01 ☐ Compliance with Federal, State, and Local laws
02 ☐ Governing Body and Management
03 ☐ Patient Care Policies
04 ☐ Physician Services
05 ☐ Nursing Services
06 ☐ Dietetic Services
07 ☐ Specialized Rehabilitative Services
08 ☐ Pharmaceutical Services
09 ☐ Laboratory and Radiologic Services
10 ☐ Dental Services
11 ☐ Social Services
12 ☐ Patient Activities
13 ☐ Medical Records
14 ☐ Transfer Agreement
15 ☐ Physical Environment
16 ☐ Infection Control
17 ☐ Disaster Preparedness
18 ☐ Utilization Review
19 ☐ Life Safety Code

3. Do you survey **intermediate care facilities?**

1 ☐ Yes 2 ☐ No

If YES is checked, please answer the following questions:

Please estimate the average number of intermediate care facilities you survey yearly _____

Please estimate the average number of hours you spend in facility survey _____

What standards do you survey in intermediate care facilities? (Check ALL that apply)

01 ☐ State Licensure
02 ☐ Conformity with Federal, State, and Local laws
03 ☐ Administrative Management
04 ☐ Transfer Agreement
05 ☐ Arrangements for Services
06 ☐ Resident Record System
07 ☐ Life Safety Code
08 ☐ Environment and Sanitation
09 ☐ Dietetic Services
10 ☐ Drugs and Biologicals
11 ☐ Health Services
12 ☐ Disclosure of Ownership
13 ☐ Administrator
14 ☐ Resident Services Director
15 ☐ Rehabilitation Services
16 ☐ Social Services
17 ☐ Activities Program
18 ☐ Physician Services

OMB #68-R1289
Expires June 30, 1977

4. Do you survey institutions for the mentally retarded and other related conditions?

1 ☐ Yes 2 ☐ No

If YES is checked, please answer the following questions:

Please estimate the average number of mental retardation facilities you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

What standards do you survey in institutions for the mentally retarded and other related conditions? (Check ALL that apply)

01 ☐ State Licensure
02 ☐ Conformity with Federal, State, and Local laws
03 ☐ Disclosure of Ownership
04 ☐ Transfer Agreement
05 ☐ Admission of Residents
06 ☐ Active Treatment
07 ☐ Administrative Management
08 ☐ Administrator
09 ☐ Qualified Mental Retardation Professional
10 ☐ Arrangements for Services
11 ☐ Services as Needed
12 ☐ Direct Care Staff
13 ☐ Health Services
14 ☐ Dietetic Services
15 ☐ Drugs and Biologicals
16 ☐ Resident Record System
17 ☐ Life Safety Code
18 ☐ Environment and Sanitation
19 ☐ Relationship to 249.13

5. Do you survey home health agencies?

1 ☐ Yes 2 ☐ No

If YES is checked, please answer the following questions:

Please estimate the average number of home health agencies you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

What condition(s) of participation do you survey in home health agencies? (Check ALL that apply)

01 ☐ Compliance with Federal, State, and Local law
02 ☐ Organization, Services, Administration
03 ☐ Group of Professional Personnel
04 ☐ Acceptance of Patients, Plan of Treatment and Medical Supervision
05 ☐ Skilled Nursing Service
06 ☐ Therapy Services
07 ☐ Medical Social Services
08 ☐ Home Health Aide Services
09 ☐ Clinical Records
10 ☐ Evaluation
11 ☐ Qualifying to Provide Outpatient Physical Therapy Services

6. Do you survey independent laboratories?

1 ☐ Yes 2 ☐ No

If YES is checked, please answer the following questions:

Please estimate the average number of independent laboratories you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

What condition(s) of participation do you survey in independent laboratories? (Check ALL that apply)

1 ☐ Compliance with State and Local laws
2 ☐ Clinical Laboratory; Laboratory Director
3 ☐ Clinical Laboratory; Supervision
4 ☐ Clinical Laboratory; Tests Performance
5 ☐ Clinical Laboratory; Technical Personnel
6 ☐ Clinical Laboratory; Records, Equipment, and Facilities

OMB#68-R1289
Expires June 30, 1977

7. Do you survey **outpatient/physical therapy services?**

1 ☐ Yes 2 ☐ No

If **YES** is checked, please answer the following questions:

Please estimate the average number of outpatient/physical therapy services you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

What condition(s) of participation do you survey in outpatient/physical therapy services? (Check **ALL** that apply)

01 ☐ Compliance with State and Local laws

02 ☐ Administrative Management

03 ☐ Patient Care Policies

04 ☐ Program Evaluation

05 ☐ Physician Service and Plan of Care

06 ☐ Physical Therapy Services

07 ☐ Rehabilitation Program

08 ☐ Arrangements for Physical Therapy Services to be Performed by Other than Salaried Clinic or Agency Personnel

09 ☐ Clinical Records

10 ☐ Emergency Procedures

11 ☐ Physical Environment

8. Do you survey **domiciliary facilities?**

1 ☐ Yes 2 ☐ No

If **YES** is checked, please answer the following questions:

Please estimate the average number of domiciliary facilities you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

9. Do you survey **portable x-ray facilities?**

1 ☐ Yes 2 ☐ No

If **YES** is checked, please answer the following questions:

Please estimate the average number of portable x-ray facilities you survey yearly _____

Please estimate the average number of hours you spend in facility for survey _____

OMB#68-R1289
Expires June 30, 1977

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE 65

BUREAU OF QUALITY ASSURANCE
DIVISION OF PROVIDER STANDARDS AND CERTIFICATION

Dear Surveyor:

Approximately two weeks ago, you were sent a questionnaire concerning your duties as a surveyor of facilities participating in the Medicare and Medicaid programs. This questionnaire was to be returned within five days after receipt, and your questionnaire has not yet been received.

The Division of Provider Standards and Certification has been periodically conducting a national inventory of surveyors to update our census on surveyors and to assist in the development and projection of plans for the surveyor training programs. To make a more reliable assessment of training needs and the nature of the surveyor population, a high rate of response by surveyors is needed. Therefore, we would like your questionnaire as soon as possible.

We have enclosed a copy of the questionnaire, which also includes a letter giving a more detailed explanation of the survey. As we note in the letter and on the questionnaire, all answers will be kept confidential.

Thank you for your cooperation.

Sincerely,

Michael J. Spodnik, Jr.
Acting Director
Division of Provider Standards
and Certification

Enclosures

MANUAL.....
PART ..

CHAPTER 8-40

Safety Standard for Flammability of Floor Coverings

DRAFT

8-40-00 Purpose

To establish a Department of Health, Education, and Welfare safety standard on the flammability of floor coverings.

8-40-10 Policy

It is the policy of the Department of Health, Education, and Welfare to assure a safe and healthful environment insofar as practicable, for its employees in the performance of their assigned responsibilities and to those members of the public whose environments may be affected by activities or programs of the Department, through the establishment of appropriate Departmental safety and health standards, criteria, policy and guidance for uniform and consistent use on a Department-wide basis.

8-40-20 Applicability

This standard is applicable to all types of floor coverings and surfacings used in all facilities owned or operated by the Department of Health, Education, and Welfare and to all program areas of the Department including Federally aided and grant programs.

8-40-30 Effective Date

This standard is effective on January 1, 1977; floor coverings installed prior to the effective date of this standard may be continued in use. In those cases where a purchase contract or similar commitment to install floor coverings was entered into prior to January 1, 1977, but for installation to commence after that date, the policy standards in this chapter should be adhered to if it is feasible to renegotiate the contract or

8-40-30 (continued)

similar commitment.

8-40-40 Standard for Flammability

A. Floor coverings used in corridors and means of egress in health care facilities shall have a minimum critical radiant flux of 0.45 watts per square centimeter as determined by the Flooring Radiant Panel Test (FRPT). See Exhibit X-25.

B. Floor coverings used in corridors and means of egress in facilities other than health care shall have a minimum critical radiant flux of 0.22 watts per square centimeter as determined by the Flooring Radiant Panel Test (FRPT). See Exhibit X-25.

C. Carpets and rugs used in spaces other than corridors and means of egress of all facilities (including health care) are required by Federal Law to meet "Standard for the surface Flammability of Carpets and Rugs" DOC FF-1-70 (Pill Test).

See Federal Register, April 10, 1970. Only those floor coverings installed after April 10, 1970 are required to meet DOC FF-1-70. Floor coverings of other materials used in spaces other than corridors and means of egress of all facilities may be required to meet the interior finish requirements of the "Life Safety Code," 1973 edition as published by the National Fire Protection Association as determined by the authority having jurisdiction.

D. When floor coverings are composed of multi-layered materials, such as a carpet over a separate pad, the minimum criteria above shall apply to the entire assembly.

E. When an additive or process has been applied to either the basic material or to the final floor covering material which significantly decreases the flammability of the floor covering and enables it to meet the acceptance criterion of this standard, the test method calls for a washing or other determination that such treatment or process is not easily removed by normal maintenance procedures.

F. Special treatments, such as carpet shampoo which may render a floor covering less flammable, shall not be used to comply with above criteria. The use of such treatments requires judgment on the part of the enforcing official as to the acceptability of such treatments for previously installed floor coverings.

8-40-50 Standard for Smoke Developed

Floor coverings, installed throughout any facility, after the effective date of this standard shall possess a "smoke developed" rating of 450 or less as determined by the standard "Smoke Generated by Solid Materials".
(Note: This standard is currently National Fire Protection Association's No. 258T and was developed as National Bureau of Standards Technical Note No. 708. The smoke developed rating is intended to permit hardwood floors and most resilient (vinyl, asbestos, etc.) floor coverings).

8-40-60 Standard for Static Build-up

Floor coverings, unless in conflict with another safety or medical standard, installed after the effective date of this standard, shall not build-up a static level exceeding 3.5 kV when tested by the AATCC Test Method 134-1969. In locations where flammable liquids, vapors, gases, and highly combustible solids are present, there should be no measurable build-up of static electricity charges.

8-40-70 Standard for General Safety

Floor coverings, installed throughout any facility after the effective date of this standard, shall be of types which do not present an unusual slipping or tripping hazard to those persons traveling over them.

8-40-80 Standard for Use by Handicapped

All carpeting in areas subject to use by handicapped individuals shall, in addition to meeting other requirements of these standards, be specified as high density, low uncut pile, and non-absorbent. Underlayments are permissible provided they are specified as firm or hard and do not exceed 3/8 inches in depth. Carpets,and underlayments if used, shall be installed stretched taut and securely anchored at all edges to the floor. Edging strips shall not project higher than 3/8 inches above the floor line.

8-40-90 Previous Standards for Departmental Facilities

Floor coverings in use in Department owned or operated health care facilities prior to the effective date of this standard and installed after May 17, 1973 are required to have a flame spread rating of 75 or less as determined by ASTM E-84 test method (Steiner Tunnel).

(Note: This ASTM E-84 standard will no longer apply to floor coverings installed after the effective date of this standard.

8-40-100 Previous Standards for Program Facilities

Floor coverings in use in facilities under a Department funded or grant program were required to meet various standards according to the particular program. These floor coverings may be continued in use, provided they met the applicable standards of the specific program (Hill-Burton, Medicare, Medicaid, etc.) at the time of installation.

(Note: These program standards will no longer apply to floor coverings installed after the effective date of this standard.)

8-40-110 Exceptions

When deviations from the basic intent of this standard are required to meet specific conditions or problems, justifications supporting such determinations may be submitted to the official possessing waiver authority for the specific program or facility involved. In the case of Departmental owned or operated facilities justifications shall be submitted via appropriate organizational channels to the Director, Office of Safety Management, in accordance with 8-00-40 of the Safety Management Manual, DHEW.

76-611 O - 76 - 20

FLOORING RADIANT PANEL TEST (FRPT) EXHIBIT X-25

1. Scope

1.1 This method of test describes a procedure for measuring the critical radiant flux of horizontally mounted floor covering systems exposed to a flaming ignition source in a graded radiant heat energy environment, in a test chamber. The specimen can be mounted over underlayment, a simulated concrete structural floor, bonded to a simulated structural floor or otherwise mounted in a typical and representative way.

1.2 This method measures the critical radiant flux at flame out. It provides a basis for estimating one aspect of flame spread behavior for floor covering systems in corridors or exitways of buildings. The imposed radiant flux simulates the thermal radiation levels likely to impinge on the floor of a corridor whose upper surfaces are heated by flames and/or hot gases from a fully developed fire in an adjacent room or compartment.

2. Summary of Method

2.1 The basic elements of the test chamber, Figure 1, are: 1) an air gas fueled radiant heat energy panel inclined at 30° to and directed at 2) a horizontally mounted floor covering system specimen, Figure 2. The radiant panel generates a radiant energy flux distribution ranging along the 100 cm length of the test specimen from a nominal maximum of 1.0 watts/cm^2 to a minimum of 0.1 watt/cm^2. The test is initiated by open flame ignition from a pilot burner. The distance burned to flame out is converted to watts/cm^2 from the flux profile graph, Figure 6, and reported as critical radiant flux, watts/cm^2.

3. Significance

3.1 This method of test is designed to provide a basis for estimating one aspect of the flame spread behavior of a floor covering system installed in a building corridor. The test environment is intended to simulate conditions that have been observed and defined in full scale corridor experiments.

3.2 The test is intended to be suitable for regulatory statutes, specification acceptance, design purposes, or development and research.

3.3 The fundamental assumption inherent in the test is that "critical radiant flux" is one measure of the sensitivity to flame spread of floor covering systems in a building corridor.

3.4 The test is applicable to floor covering system specimens which follow or simulate accepted installation practice. Tests on the individual elements of a floor system are of limited value and not valid for evaluation of the flooring system.

4. Definitions of Terms

4.1 Critical Radiant Flux is the level of incident radiant heat energy on the floor covering system at the most distant flame out point. It is reported as watts/cm^2 (Btu/ft^2 sec).

4.2 Flux Profile is the curve relating incident radiant heat energy on the specimen plane to distance from the initiation of flaming ignition point, i.e. 0 cm.

4.3 Total Flux Meter is the instrument used to measure the level of radiant heat energy incident on the specimen plane at any point.

4.4 Black Body Temperature is the temperature of a perfect radiator--a surface with an absorptivity of unity and, therefore, a reflectivity of zero.

5. Flooring Radiant Panel Test Chamber -- Construction and Instrumentation

5.1 The flooring radiant panel test chamber employed for this test shall be located in a draft protected laboratory.

5.1.1 The flooring radiant panel test chamber, Figures 3 and 4, shall consist of an enclosure 140 cm [55 in] long by 50 cm [19-1/2 in] deep by 71 cm [28 in] above the test specimen. The sides, ends and top shall be of 1.3 cm [1/2 in] calcium silicate-asbestos fibre, 0.58 g/cm^3 [36 lbs/ft^3] nominal density, insulating material with a thermal conductivity @ 200 F of 0.96 cal (gm)/hr cm^2 deg C per cm [0.77 Btu/(hr) (ft^2) (deg F per in)]. One side shall be provided with a draft tight fire resistant glass window so that the entire length of the test specimen may be observed from outside the fire test chamber. On the same side and below the observation window is a door which when open allows the specimen platform to be moved out for mounting or removal of test specimens.

5.1.2 The bottom of the test chamber shall consist of a sliding steel platform which has provisions for rigidly securing the test specimen holder in a fixed and level position.

The free, or air access, area around the platform shall be in the range of 1950-3550 cm^2 [300-500 square inches].

5.1.3 The top of the chamber shall have an exhaust stack with interior dimensions of 12.5 cm [5 in] wide by 38 cm [15 in] deep by 30 cm [12 in] high at the opposite end of the chamber from the radiant panel.

5.2 The radiant heat energy source shall be a panel of porous refractory material mounted in a cast iron frame, with a radiation surface of 30.5 x 45.7 cm [12 by 18 in]. It shall be capable of operating at temperatures up to 816 C [1500 F]. The panel fuel system shall consist of an aspirator for mixing gas and air at approximately atmospheric pressure, a clean dry air supply capable of providing 28.3 NTP m^3 per hr [1000 Standard Cubic Feet per Hour] at 7.6 cm [3.0 in] of water, and suitable instrumentation for monitoring and controlling the flow of fuel to the panel.

5.2.1 The radiant heat energy panel is mounted in the chamber at 30° to the horizontal specimen plane. The horizontal distance from the 0 mark on the specimen fixture to the bottom edge (projected) of the radiating surface of the panel is 8.9 cm [3-1/2 in]. The panel to specimen vertical distance is 14 cm [5-1/2 in] (see Figure 3).

5.2.2 The radiation pyrometer for standardizing the thermal output of the panel shall be suitable for viewing a circular area 25.4 cm [10 in] in diameter at a range of about 1.37 m [54 in]. It shall be calibrated over the 490-510 C (914-950 F) operating black body temperature range in accordance with the procedure described in Appendix A.

5.2.3 A high impedance potentiometer voltmeter with a suitable millivolt range shall be used to monitor the output of the radiation pyrometer described in 5.2.2.

5.3 The specimen holder (see Figure 5), is constructed from heat resistant stainless steel[1] having overall dimensions of 115 cm [45 in] by 32 cm [12-3/4 in] with a specimen opening of 20 cm [7.9 in] x 100 cm [40 in]. Six slots are cut in the flange on either side of the holder to reduce warping. The holder is fastened to the platform with two stud bolts at each end.

5.4 The pilot burner used to ignite the specimen is a commerical propane venturi torch[2] with an axially symmetric burner tip having a propane supply tube with an orifice diameter of 0.0076 cm [0.003 in]. In operation, the propane flow is adjusted to give a pencil flame blue inner cone length of 1.3 cm [1/2 in]. The pilot burner is positioned so that the flame generated will impinge on the center line of the specimen at the 0 distance burned point at right angles to the specimen length (see Figures 3 and 4). The burner shall be capable of being swung out of the ignition position so that the flame is horizontal and at least 5 cm [2 in] above the specimen plane.

5.5 Two 0.32 cm [1/8 in] stainless steel sheathed grounded junction chromel alumel thermocouples[3] are located in the Flooring Radiant Panel Test Chamber (see Figures 3 and 4).

5.5.1 An indicating potentiometer with a range of 100-500 C (212-932 F) may be used to determine the chamber temperatures prior to a test.

5.6 An exhaust duct with a capacity of 28.3-85 NTP m^3 per minute (1000-3000 SCFM) decoupled from the chamber stack by at least 7.6 cm [3 in] on all sides and with an effective area of the canopy slightly larger than plane area of the chamber with the specimen platform in the out position is used to remove combustion products from the chamber.

5.7 The dummy specimen which is used in the flux profile determination shall be made of 1.9 cm [3/4 in] inorganic 0.58 g/cm^3 [36 lbs/ft^3] nominal density calcium silicate asbestos fibre board (see Figure 5). It is 25 cm [10 in] wide by 107 cm [42 in] long with 2.7 cm [1-1/16 in] diameter holes centered on and along the center line at the 10, 20, 30 ---- 90 cm locations, measured from the maximum flux end of the specimen.

5.7.1 The total heat flux transducer used to determine the flux profile of the chamber in conjunction with the dummy specimen should be of the Schmidt-Boelter[4] type, have a range of 0-1.5 watts/cm^2 (0-1.32 Btu/ft^2 sec), and shall be calibrated over the operating flux level range of 0.10 to 1.5 watts/cm^2 in accordance with the procedure outlined in Appendix A. A source of 15-25 C cooling water shall be provided for this instrument.

5.7.2 A high impedance or potentiometric voltmeter with a range of 0-10 m.v. and reading to 0.01 m.v. shall be used to measure the output of the total heat flux transducer during the flux profile determination.

5.8 A timer shall be conveniently mounted on the chamber for measuring preheat and pilot contact time.

6. Safety Precautions

6.1 The possibility of a gas-air fuel explosion in the test chamber should be recognized. Suitable safeguards consistent with sound engineering practice should be installed in the panel fuel supply system. These may include one or more of the following: 1) a gas feed cut off activated when the air supply fails, 2) a fire sensor directed at the panel surface that stops fuel flow when the panel flame goes out, 3) a commerical gas water heater or gas fired furnace pilot burner control thermostatic shut off which is activated when the gas supply fails or other suitable and approved device. Manual reset is a requirement of any safeguard system used.

6.2 In view of the potential hazard from products of combustion, the exhaust system must be so designed and operated that the laboratory environment is protected from smoke and gas. The operator should be instructed to minimize his exposure to combustion products by following sound safety practice, e.g. insure exhaust system is working properly, wear appropriate clothing including gloves, et al.

7. Sampling

7.1 The samples selected for testing shall be representative of the product.

7.2 Standard ASTM sampling practice shall be followed where applicable, see ASTM Method E-122.

8. Washing of Textile Floor Coverings

8.1 If the carpet has had a treatment, or is made of fibers which have had a treatment as the term "treatment" is defined in 8.2, the selected sample shall be washed as prescribed in Appendix C, unless this method can be proven to be unsuitable for the particular fabric involved. In this case, such other method as the manufacturer determines is likely to be used on the carpet in service and which is agreed to by the purchaser, may be used. Alternatively, the carpet may be washed and dried as many times under such other washing and drying procedures as shall have been demonstrated to be the equivalent of ten washings under the washing procedure described herein.

8.2 "Treatment" as that term is used in this standard shall mean any process, such as spraying, padding, dipping, brushing, or otherwise applying a material onto the pile or primary backing of a carpet at any stage of manufacture, which has the effect of reducing flammability.[5]

8.3 This washing requirement may be modified or waived by the purchaser if the manufacturer will certify that washing does not affect the permanence of the fire-retardancy resulting from the treatment.

9. Test Specimens

9.1 The test specimen shall be a floor covering system sized to provide for adequate clamping in the mounting frame. Its minimum dimensions shall exceed the frame width [20 cm (7.9 in) nominal] and length [100 cm (39.4 in) nominal] by about 5 cm (2 in). It may be necessary to notch or punch holes in the specimen to accommodate the mounting frame bolts (see Figure 5).

9.2 Insofar as possible, the floor covering system specimen should simulate actual installation practice. Typical examples follow:

9.2.1 A carpet mounted over the standard[6] cushion or the standard simulated concrete subfloor[7] (see Appendix B2.1).

9.2.2 A carpet with or without integral cushion pad bonded to a high density inorganic sheet simulating a concrete subfloor (see Appendix B2.2).

9.2.3 A resilient floor bonded to a high density inorganic sheet simulating a concrete subfloor (see Appendix B3.1).

9.2.4 A hardwood floor nailed to a plywood subfloor, then sanded and finished according to standard practice (see Appendix B4.1).

9.3 A minimum of three specimens per sample shall be tested.

10. Radiant Heat Energy Flux Profile Standardization

10.1 In a continuing program of tests, the flux profile shall be determined not less than once a week. Where the time interval between tests is greater than one week, the flux profile shall be determined at the start of the test series.

10.2 Mount the dummy specimen in the mounting frame and attach the assembly to the sliding platform.

10.3 With the sliding platform out of the chamber, ignite the radiant panel. Allow the unit to heat for one hour. The pilot burner is off during this determination. Adjust the fuel mixture to give an air-rich flame. Make fuel flow settings to bring the panel black body temperature to about 500 C (932 F), and the chamber temperature to about 180 C (356 F). When equilibrium has been established, move the specimen platform in the chamber.

10.4 Allow 0.5 hours for the closed chamber to equilibrate.

10.5 Measure the radiant heat energy flux level at the 40 cm point with the total flux meter instrumentation. This is done by inserting the flux meter in the opening so that its detecting plane is 0.16-0.32 cm (1/16-1/8 in) above and parallel to the plane of the dummy specimen and reading its output after 30 ± 10 seconds. If the level is within the limits specified in 10.6 the flux profile determination is started. If it is not, make the necessary adjustments in panel fuel flow. A suggested flux profile data log format is shown in Figure 7.

10.6 The test shall be run under chamber operating conditions which give a flux profile of the form shown in Figure 6. The radiant heat energy incident on the dummy specimen at the 40 cm point shall be 0.5 ± 0.02 watts/cm^2 (0.44 ± 0.017 Btu/ft^2 sec).

10.7 Insert the flux meter in the 10 cm opening following the procedure given in 10.5 above. Read the m.v. output at 30 ± 10 seconds and proceed to the 20 cm point. Repeat the 10 cm procedure. The 30 - 90 cm flux levels are determined in the same manner. Following the 90 cm measurement, make a check reading at 40 cm. If this is within the limits set forth in 10.6. the test chamber is in calibration and the profile determination is completed. If not, carefully adjust fuel flow, allow 0.5 hours for equilibrium and repeat the procedure.

10.8 Plot the radiant heat energy flux data as a function of distance along the specimen plane on rectangular coordinate graph paper. Carefully draw the best smooth curve through the data points. This curve will hereafter be referred to as the flux profile curve.

10.9 Determine the open chamber black body and chamber temperatures that are identified with the standard flux profile by opening the door and moving the specimen platform out. Allow 0.5 hours for the chamber to equilibrate. Read optical pyrometer output and record black body temperature in C. This is the temperature setting that can be used in subsequent test work in lieu of measuring the radiant flux at 40 cm using the dummy specimen. The chamber temperature also should be determined again after 0.5 hours and is an added check on operating conditions.

11. Conditioning

11.1 Specimens shall be conditioned according to standard practice for the floor covering being tested unless otherwise specified; see ASTM E-171-63.

12. Test Procedure

12.1 With the sliding platform out of the chamber, ignite the radiant panel. Allow the unit to heat for one hour. Read the panel black body temperature and the chamber temperature. If these temperatures are in agreement to within ±5 C with those determined in accordance with 10.9 above, the chamber is ready for use.

12.2 Invert the sample holder on a workbench and insert the flooring system. Place the steel bar clamps across the back of the assembly and tighten nuts firmly. Return the sample holder to its upright position, clean the test surface with a vacuum and mount on the specimen platform.

12.3 Ignite the pilot burner, move the specimen into the chamber and close the door. Start the timer. After 2 minutes preheat, with the pilot burner on and set so that the flame is horizontal and 5 cm above the specimen, bring the pilot burner flame into contact with the center of the specimen at the 0 cm mark. Leave the pilot burner flame in contact with the specimen for 10 minutes, then remove to a position 5 cm above the specimen. If the specimen does not ignite within 10 minutes following pilot burner flame application, the test is terminated by extinguishing the pilot burner flame.

12.4 For specimens that do ignite, the test is continued until the flame goes out. Observe and record significant phenomena such as melting, blistering, penetration of flame to the substrate, etc.

12.5 When the test is completed, the door is opened, the specimen platform is pulled out.

12.6 Measure the distance burned i.e. the point of farthest advance of the flame front, to the nearest 0.1 cm. From the flux profile curve, convert the distance to watts/cm^2 critical radiant heat flux at flame out. Read to two significant figures. A suggested data log format is shown in Figure 8.

12.7 Remove the specimen and its mounting frame from the moveable platform.

12.8 The succeeding test can begin as soon as the panel black body temperature is verified (see 12.1). The test assembly should be at room temperature prior to start up.

13. Calculations

13.1 The mean and standard deviation of the critical radiant flux test data on the three specimens are calculated in accordance with ASTM standard practice (ASTM Manual on Quality Control of Materials 1951 Edition STP 15C).

$$S = \sqrt{\frac{(\Sigma X^2 - n \bar{X}^2)}{n - 1}}$$

where S = estimated standard deviation

X = value of single observation

n = number of observations, and

$\bar{X}$ = arithmetic mean of the set of observations.

14. Report

14.1 The report shall include the following:

14.1.1 Description of the flooring system tested including its elements.

14.1.1.1 If a textile floor covering is tested, indicate whether it has been washed in accordance with 8.1.

14.1.2 Description of the procedure used to assemble the flooring system specimen.

14.1.3 Number of specimens tested.

14.1.4 Average critical radiant flux and standard deviation.

14.1.5 Observations of the burning characteristics of the specimen during the testing exposure, such as delamination, melting, sagging, shrinking, etc.

15. Precision[8]

Defining a test result as the average of 3 replicate determinations, the repeatability (within laboratory variability) is about 20 per cent of the measured value[9] and the reproducibility (among laboratory variability) is of the order of 35 per cent of the measured value.[10]

APPENDIX A

Procedure for Calibration of Radiation Instrumentation

A1 Radiation Pyrometer

A1.1 Calibrate the radiation pyrometer by means of a conventional black body enclosure placed within a furnace and maintained at uniform temperatures of 490, 500, and 510 C (914, 932, 950 F). The black body enclosure may consist of a closed chromel metal cylinder with a small sight hole in one end. Sight the radiation pyrometer upon the opposite end of the cylinder where a thermocouple indicates the black body temperature. Place the thermocouple within a drilled hole and in good thermal contact with the black body. When the black body enclosure has reached the appropriate temperature equilibrium, read the output of the radiation pyrometer. Repeat for each temperature.

A2 Total Heat Flux Meter

A2.1 Calibrate the total flux meter against a standard quartz lamp source having a radiant energy output of approximately 0.15 watts/cm^2 in accordance with the procedure [NBS Report of Calibration, Test No.: 221.12/ 1B/74 Interdivision Work Order No. 490-2220, dated 10/17/74] developed by the NBS optical radiation group. The precision (3 sigma limits) of the calibration based on 25 measurements at the above single point is of the order of ±1%. For a calibration across the operating range of the instrument, the manufacturer of the transducer should be contacted. This calibration can be good to ±5%.

APPENDIX B

Guide to Mounting Methods

B1 Introduction

B1.1 This guide has been compiled as an aid in selecting a method for mounting various flooring materials in the fire test chember. These mountings are suggested for test method uniformity and convenience.

B2 Mounting Procedures

B2.1 Carpet and Cushion Pad Over Concrete, Simulated -- Carpet specimens should be cut in the machine direction. To mount a specimen, invert the holder on a clean, flat surface. Insert the test specimen in the holder. Then insert the cushion pad with the waffle side facing the carpet followed by a 0.64 cm [1/4 in] thick cement asbestos board* and a 1.2 cm [1/2 in] 0.58 gms/cm^2 [36 lbs/ft^3] inorganic millboard. Finally, place the steel bar clamps across the assembly and tighten firmly. Turn the specimen upright and vacuum to remove any foreign particles. Brush the surface to raise the pile to its normal position. Mount the test assembly on the specimen transport frame so that the pile lay faces the panel.

B2.2 Carpet with or without Integral Cushion Pad Bonded to Concrete, Simulated -- carpet specimens should be cut in the machine direction. The adhesive shall be that recommended by the carpet manufacturer (see note B5.1). Apply the adhesive to the smooth side of the cement asbestos board according to the directions provided by the adhesive manufacturer. Mount the specimen in testing frame as described in B2.1 and test according to standard procedure.

*The cement asbestos board may spall during a test. This can be avoided by heating for 12 hours at 325°F.

B2.3 Carpet, Other -- The actual sub-floor may be substituted for the standard cement asbestos board substrate.

B3 Resilient Flooring

B3.1 Follow and/or simulate commerical installation practice. This will in most instances mean bonding to the standard cement asbestos substrate.

B4 Hardwood Flooring

B4.1 Follow and/or simulate commerical installation practice. In a typical system, the substrate would be a 5/8" plywood sheet covered with building paper. The oak flooring strips would be nailed to the plywood then sanded, sealed, and waxed. The assembly should be treated with the moisture content of the oak at 7-8%.

B5 Notes

B5.1 Taylor's Multi-purpose Latex Base #260 or equivalent.

APPENDIX C

Method for Washing Textile Floor Coverings

C1 Purpose and Scope

C1.1 This laboratory procedure is designed to produce results comparable to the "Rotary Brush" and the "Roll-A-Jet" methods customarily used for textile floor coverings in service. The method is suitable whenever cleaning procedures, in which a textile floor covering is wetted-down, scrubbed, rinsed, and dried, are to be simulated.

C1.2 This method is applicable to either soiled or unsoiled textile floor coverings.

C1.3 This method is applicable for evaluating the permanence of fire-retardant treatments for textile floor coverings.

C2 Principle

C2.1 The test is performed by wetting the textile floor covering with water, applying a solution of a sodium alkylsulfate surfactant, hand scrubbing with a nylon bristle brush, rinsing, extracting excess water, and then drying in a vented oven.

C3 Apparatus and Materials

C3.1 Cleaning agent--a 1%, by volume, solution of a sodium alkylsulfate (see note C5.1).

C3.2 A brush having nylon bristles 0.056 to 0.066 cm (0.022 to 0.026 in) in diameter and a bristle height of 2.2 to 2.9 cm (0.88 to 1.13 in). Width of the brush should be approximately 5 cm (2 in). A desirable length of the brush should be approximately one dimensional width of the test specimen (see note C5.2).

C3.3 A hydro extractor (see note C5.3).

C3.4 Laboratory oven, a vented circulating air type, capable of removing the moisture from the specimens when maintained at 105 C (221 F) for 2 hours (see note C5.4).

C4 Procedure

C4.1 Cut three test specimens, 110 x 30 cm (41 x 11 in) in size from the sample free from defects or creases. The perimeter shall be stitched, if necessary, to prevent delamination, distortion, or other degradation.

C4.2 Immerse the test specimen to be washed in a container of water at 18 to 30 C (65 to 85 F) until it appears to be uniformly wet. Remove specimen, drain until excess water runs off, and then position on a flat working surface with traffic surface up.

C4.3 Apply 250 ml. of the surfactant solution at a temperature of 18 to 30 C (65 to 85 F) distributed uniformly over the traffic surface of the test specimen. Hand scrub, with minimum pressure, the traffic surface with the nylon bristle brush for 10 strokes in the long direction, lifting the brush between strokes. Attempt to keep the brush centered on the specimen during each stroke. Rotate the specimen a half-turn and repeat the brush strokes, doing this until the specimen has been stroked 10 times in each long direction for a total of 20 strokes.

C4.4 Thoroughly rinse the specimen on both sides by spraying forcibly with water at 46 to 52 C (115 to 125 F) until foaming ceases.

C4.5 Position the washed and rinsed test specimen in the hydro-extractor to extract excess water so there is no over-lapping and spin-dry for approximately 3 minutes.

C4.6 Place the damp-dry specimen in the oven at 104 to 110 C (220 to 230 F) for 30 minutes and then remove for additional washing.

C4.7 Repeat steps C4.2 to C4.6 nine times until the specimen has been washed a total of 10 times.

C4.8 On the 10th and final cycle, keep the specimen in the oven until dry, or for not less than 2 hours. Remove the specimen from the oven and allow to stand at least 8 hours in order to come to equilibrium conditions with the laboratory environment.

C4.9 Cut the three specimens to 105 x 25 cm (40 x 10 in) in size, condition as prescribed in paragraph 11.1 of the test method, and test.

C5 Notes

C5.1 Orvus WA Paste has been found to be suitable. Available from Procter and Gamble Company, Textile Specialities Section, P.O. Box 599, Cincinnati, Ohio 45201.

C5.2 A suitable brush may be obtained from the Atlanta Brush Company, 19 Hilliard Street, Atlanta, Georgia 30312 (stock number 1-4638).

C5.3 A satisfactory means of extracting excess water from specimens is the use of the spin-dry cycle only in a home laundry type of washing machine. Care must be used in setting the machine or closing the water valves so that no rinse water is admitted during this spin-dry cycle.

C5.4 Procedure 2 of ASTM D 2654-71, "Moisture Content and Moisture Regain of Textile Material," without the predrying feature for the incoming air describes a satisfactory oven.

Figure 1. Flooring Radiant Panel Tester Apparatus

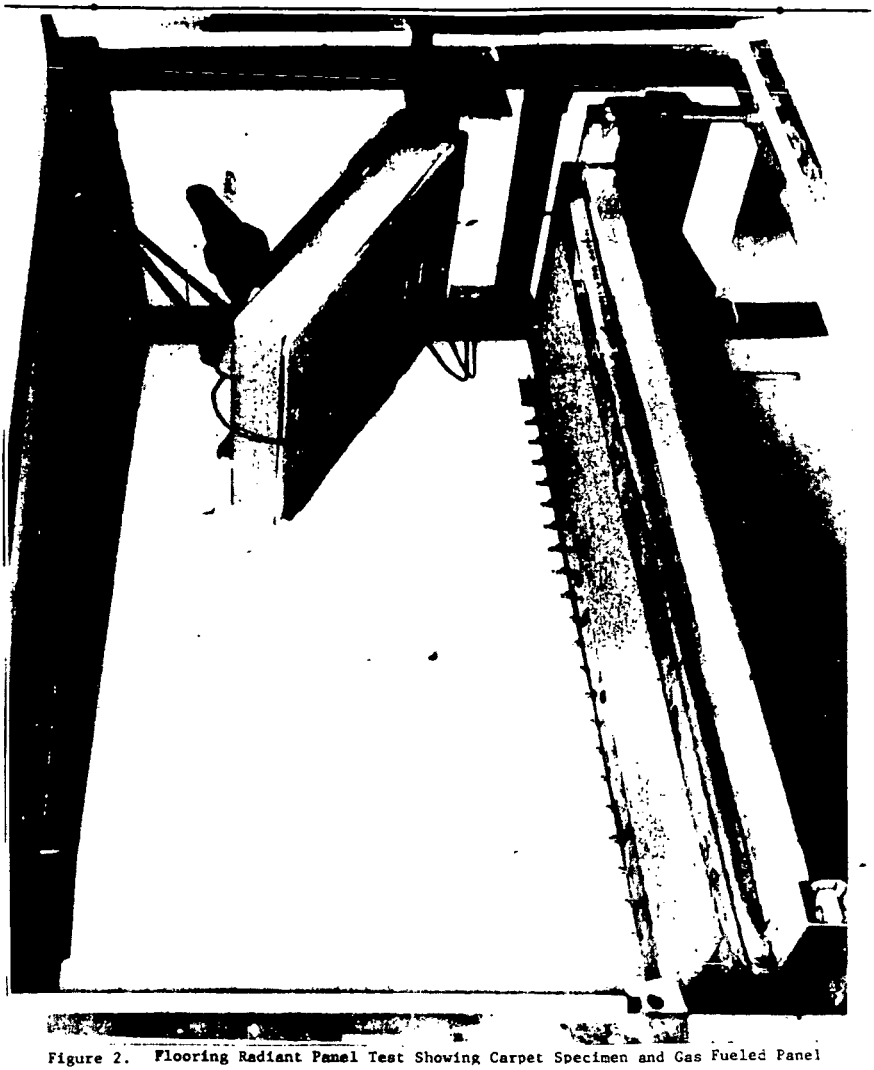

Figure 2. Flooring Radiant Panel Test Showing Carpet Specimen and Gas Fueled Panel

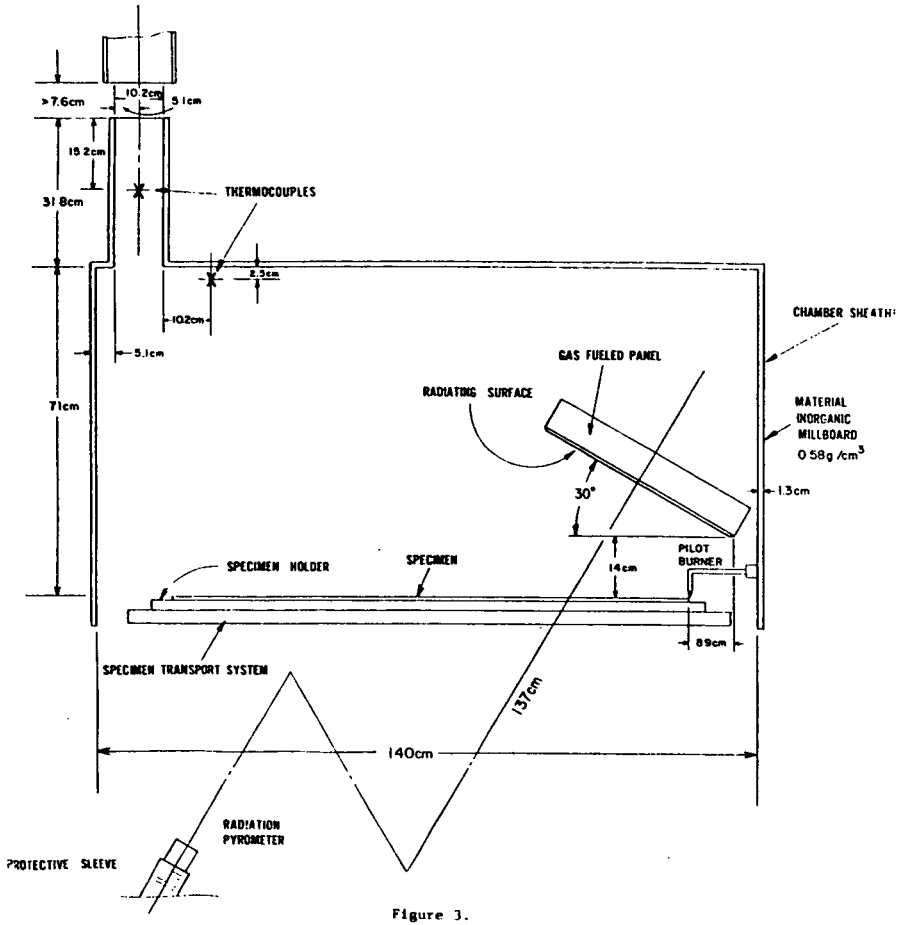

Figure 3.

FLOORING RADIANT PANEL TESTER SCHEMATIC
SIDE ELEVATION

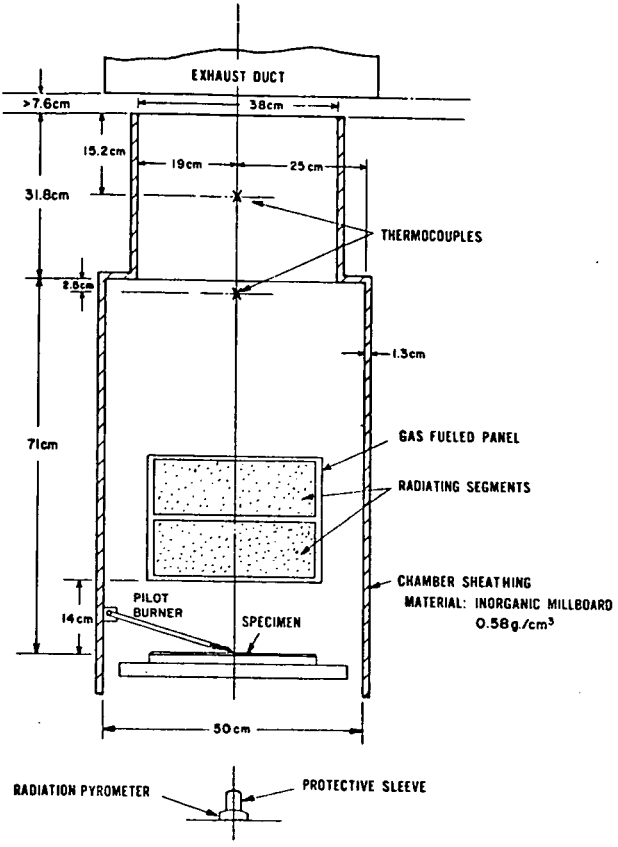

Figure 4.
FLOORING RADIANT PANEL TESTER SCHEMATIC
LOW FLUX END, ELEVATION

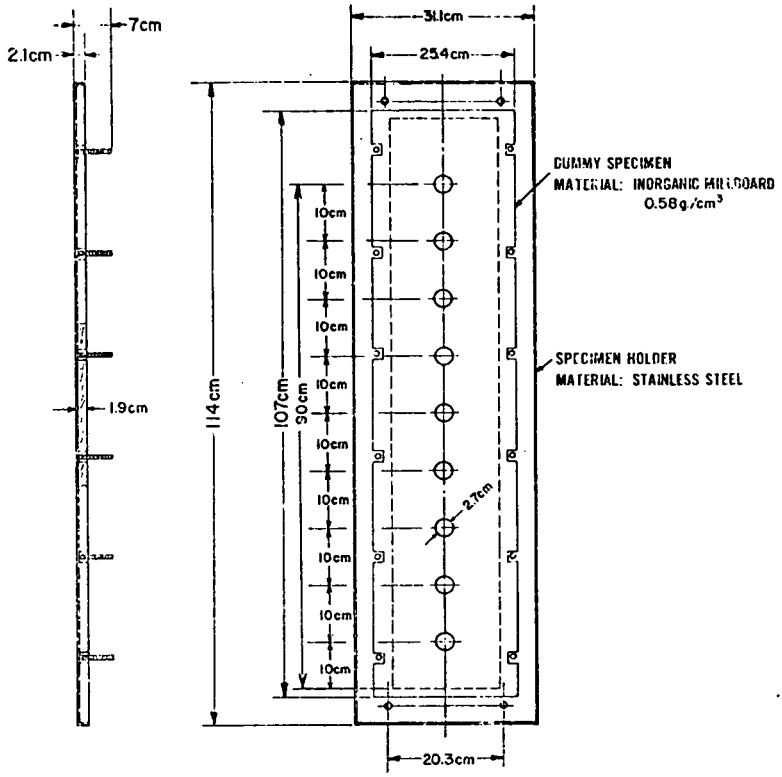

FIGURE 5 DUMMY SPECIMEN IN SPECIMEN HOLDER

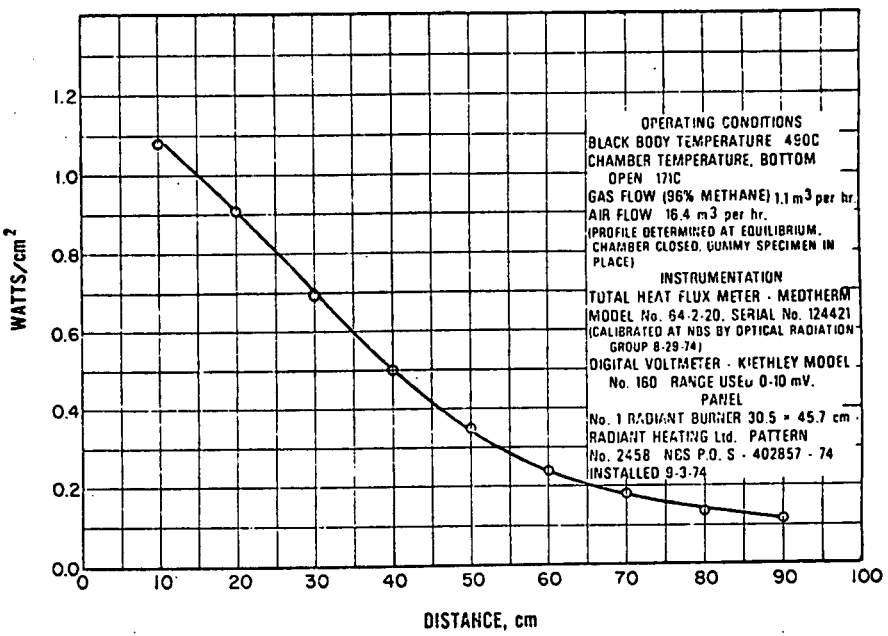

FIGURE 6 STANDARD RADIANT HEAT ENERGY FLUX PROFILE

RADIANT FLUX PROFILE

Date_____

Black Body Temperature_____m.v. _____°C (F)

Gas Flow _____NTPm^{3}H (SCFH) Air Flow _____NTPm^{3}H (SCFH)

Room Temperature _____°C (F)

Air Pressure _____ Gas _____cm. (in.) of H_2O

Flux Meter
Radiometer No. _____ Conversion Factor _____
From Calibration On _____

Distance (cm)	MV	Watts/cm^2
10	_____	_____
20	_____	_____
30	_____	_____
40	_____	_____
50	_____	_____
60	_____	_____
70	_____	_____
80	_____	_____
90	_____	_____

Signed _____

FIGURE 7. Flux Profile Data Log Format

Test Number _____ Date _____ Time _____

Laboratory _____

Specimen Identification/Code No. _____

Test Assembly: _____

Panel: Angle _____° Temperature _____°C (°F)

Flow: Gas _____NTPm^{3}H (SCFH) Air _____NTPm^{3}H (SCFH)

Pressure, cm. (in.) H_2O: Initial, Air _____ Gas _____;

Chamber Temperature (Initial) _____°C (°F)

Room: Temperature _____°C (°F) Hood Draft _____cm (in.) water

Total Burn Length _____cm (in.)

Critical Radiant Flux watts/cm^2 _____

Flux Profile Reference _____

Observations:

Signed _____

Figure 8. Flooring Radiant Panel Test Data Log Format

Report of the Investigation of the Wincrest Nursing Home Fire on January 30, 1976

Prepared By The Special Panel
Appointed By
Mayor Richard J. Daley
City Of Chicago

TABLE OF CONTENTS

Introduction

Purpose of Investigation

Mayor Richard J. Daley appointed a special panel to investigate and record all facts related to the fire and subsequent deaths which occurred at the Wincrest Nursing Home, 6326 North Winthrop Avenue, Chicago, Illinois on January 30, 1976, and to draw such conclusions as are supported by the facts and to make recommendations to prevent a similar tragedy from recurring.

Panel Members

The following people were named to this special panel:

Fire Commissioner ROBERT J. QUINN (*Chairman*)

Health Commissioner DR. MURRAY C. BROWN

Building Commissioner JOSEPH F. FITZGERALD, F.A.I.A.

MR. JACK D. TRAIN, F.A.I.A., Metz, Train, Olson and Youngren, Incorporated, Architects

MR. ELMER RESKE, P.E., Consultant to Metropolitan Chicago Loss Bureau

CONDITION AT THE TIME OF THE FIRE

BUILDING DESCRIPTION

General Features

The building had been designed as a nursing home for 88 permanent residents in 28 sleeping rooms and was constructed in three stages. The three additions are of fire resistive construction. The original brick building was removed prior to the second stage of construction in 1966.

The three stages of construction were as follows: (See Plan)

In 1959, a 47'-8" x 42'-0", 1,906 square foot fire resistive building consisting of two floors and a garden level, totaling 5,719 square feet, was added to the rear of the existing two story basement and attic brick nursing home. This addition was constructed with precast concrete floor and roof slabs on steel beams and columns. In 1966, the original building was demolished and replaced by a three story and garden level precast concrete floor and roof slab structure with 2,367 square feet of area per floor for a total of 9,466 square feet. At the same time, a third floor was added to the existing two floors and garden level building constructed in 1959. The roof of this third floor addition was of steel bar joist construction and gypsum roof deck with a 5/8" gypsum board suspended ceiling. In 1973, the third addition was added at the rear of the existing building. This addition was 40' x 20' with a connecting 10' corridor having 903 square feet per floor. It consisted of three floors and a garden level, for a total of 3,613 square feet of floor area. The construction was precast concrete floor slabs and metal roof deck on steel bar joists with a suspended 3/4" mineral acoustical ceiling. All partitions are 16" O.C. metal studs, covered with 5/8" thick one hour fire rated plasterboard or masonry with 1/2" plasterboard on 3/4" furring strips.

As each addition was constructed, there were changes in the use of certain areas. At the time of the fire the use consisted of patient care rooms with supporting services such as nursing station, lounges, small kitchens, (no cooking appliances), bedpan closets, bathrooms, toilets and small storage closets on the 1st, 2nd, and 3rd floors. The garden level was a non-resident floor consisting of the entrance and supportive facilities such as laundry room, boiler room, storage rooms, kitchen, dining room, examining room, lounge and offices. A combination chapel-lounge approximately 18' x 32' was located on the 3rd floor of the 1973 addition.

Stairs

There are two enclosed stairwells of two hour fire rated construction. The east stairwell door on the 3rd floor is located 5' from the east end of the corridor. The west stairwell door is located approximately 50' from the west wall of the lounge-chapel. The east stairwell exited at grade on the north side of the building and continued down approximately 4' to the garden level in the front lobby area. The west stairwell exited at grade on the north side of the building and continued down approximately 5' to the garden level floor in the boiler room area.

Elevators

One standard hospital size hydraulic elevator was provided across the corridor from the east stairwell.

Exterior Walls

The exterior walls consist of brick and concrete block backup with gypsum board on furring strips.

Interior Partitions

The interior partitions are 5/8" gypsum board on steel studs.

Structural System

The structural system consists of reinforced concrete foundation walls and footings below grade, floor slabs of 8" thick precast concrete with 2-1/2" of concrete fill, supported on fire protected steel columns and beams. The roof slab of the east section, constructed in 1966, is precast concrete, while the middle section constructed at the same time is gypsum roof deck on steel joists. The roof of the 1973 addition on the west end is also gypsum deck on steel joists.

Doors (third floor)

The doors leading to the two enclosed stairways are both 3'-8" x 6'-8" x 1-3/4" wood, class "B", one-hour rated fire doors with single 10" x 10" wire glass windows, operated by approved hydraulic type door closers.

All other doors, with the exception of one hollow-core door on the small linen closet adjacent to Room 305, are 1-3/4" solid core. The doors to all patient rooms are 3'-8" wide by 6'-8" high.

All doors are mounted on self casing metal frames with integral metal door stops.

Wall Finish Materials (third floor)

The 3rd floor contains five different wall finish materials: paint, ceramic tile, vinyl-fabric wallpaper, vinyl-paper wallpaper and a vinyl-asbestos tile wainscot.

All toilets and bathrooms have 4"x4"x 1/4" ceramic tile set in mastic over plasterboard, extending 4'-4" above the floor. The upper walls of these rooms are both painted and in some cases, covered with vinyl fabric wallpaper.

The walls in the new 1973 lounge-chapel section are all painted, over plasterboard, including the short corridor walls to the lounge-chapel.

All walls in the patient care rooms and the front lounge are covered with a vinyl coated fabric wallpaper.

The entire corridor, up to the 1973 section, is covered with either a vinyl wallpaper or a vinyl fabric type wallpaper, probably "Vinyl Weave."

A vinyl-asbestos tile, 12"x12"x1/16", formed a wainscot, approximately 4' high, adjacent to rooms 305, 306, and the west stairwell. It was covered with the vinyl-fabric wallpaper on the north side of the corridor.

Specifications kept by the management for the 'Vinyl Weave' vinyl fabric-backed wallpaper indicate a flame spread rating of 8, a fuel contribution of 2, and a smoke density of 8. Positive verification of receipts and identification of materials was attempted.

Ceiling Construction (third floor)

The 3rd floor contains 3 different types of ceiling construction: exposed flexicore, suspended plasterboard and suspended acoustical mineral tile.

Exposed (painted) flexicore ceilings cover patient rooms 301, 302, 303 and 304, both stairways, and the front lounge (built in 1966).

The entire corridor up to the 1973 addition, the nurses' station, all closets, toilet rooms, bathroom, janitor's closet, kitchen service areas and rooms 305, 306, 307 and 308 have suspended 5/8", one hour rated, plasterboard ceilings attached with sheet metal screws to metal channels and rails.

The lounge-chapel section and the short corridor leading to it contains a suspended 12"x12"x3/4" acoustical mineral tile ceiling with a one hour fire rating. The tile is set in metal channels, and interconnected with metal spleens. The upper tile surface is suspended approximately 8" from the bottom of the 14" bar joists spanning the lounge-chapel roof.

Floor Finish (third floor)

The entire floor is covered with vinyl-asbestos floor tile laid directly on the concrete deck. This includes all rooms, service areas, corridors and stairwells except for bath and toilet rooms which are covered with 1" x 1" ceramic tile.

The base in every room (except bath and toilet rooms) corridor and stairwell is 4" high rubber base attached to the wall with mastic.

There was no carpeting, throw rugs or runners evident on the 3rd floor.

Heating

With the exception of the 2nd floor recreation room and the 3rd floor lounge-chapel which are also partially heated and cooled by 220 volt G.E. electric 'through-the-wall' units, the entire building is heated by hot water radiant baseboard copper fin radiators supplied from two gas boilers: one supplying the basement only, and the other supplying the 1st, 2nd and 3rd floors.

Hot water is supplied by a high recovery gas-fired water heater. Combustion air is supplied to the boiler room through screened and louvered openings in the west exterior wall.

Ventilation

The 1st, 2nd and 3rd floor patient rooms, lounges and 3rd floor lounge-chapel are ventilated by natural ventilation means, employing sliding type and double-hung windows.

All bath and toilet rooms on the 1st, 2nd and 3rd floors are mechanically ventilated. Sheet metal ducts run horizontally above the dropped corridor ceiling to vertical risers and to the roof mounted exhaust fans.

The garden floor contains the admission and administrators' offices, lounge, nurses' office, examining room, kitchen, dining room and laundry room. All garden floor rooms are mechanically ventilated through the dropped ceiling with a sheet metal ducted air sup-

ply system utilizing a hot water heating coil supplied by the hot water boiler. The kitchen is mechanically exhausted through the kitchen range hood. The hood system is constructed of 14 gauge black iron and runs horizontally, through the west wall and up to the roof level exhaust fan.

Electrical System

The building has a 600 AMP, 3 phase, 4 wire, 220/440 volt service to a main distribution panel located in the basement boiler room, plus a separate 60 AMP, single phase, 3 wire, 120/240 volt emergency service.

Each patient floor has a 100 AMP general purpose circuit breaker panel to handle the floor's electrical load.

Separate circuits are provided for all special equipment such as the seven 220 volt electric heater-air conditioner units in the 1973 addition.

The building also contains the required System II emergency exit sign and corridor lighting system. This system operates on an automatic transfer switch, turning on the emergency corridor lights in the event of failure or power loss in the buildings' normal lighting circuits. This system is wired separately on special fused circuits, from its own separate and remote 60 AMP service.

Although not required, battery-operated emergency lighting was installed in two locations on the 3rd floor, set to illuminate the entire corridor in the event of a failure of the normal lighting and the System II emergency lighting. In the event of a neighborhood 'brown-out' or a total power failure within the building, these units would automatically activate.

Patient Room Furnishings and Contents (third floor)

Each patient is furnished with or shares a specific amount of furniture plus half of one free standing wardrobe.

Each patient is supplied with a bed and a bedside table, and shares one or two 4 drawer chests with other patients.

The rooms are also equipped with one or more movable servicing tables and have from no chairs to 5 chairs. All chairs have vinyl covered cushions (seat and back) on wood or metal frames.

The personal property of patients is limited to necessary clothing, toiletries, pictures, books, magazines and portable television sets and radios.

All of the furniture in Rooms 305, 306 and 307, including the wardrobes and head and foot boards on the beds were of wood construction. Rooms 301, 302, 304 and 308 had a mixture of metal and wood furniture and wardrobes in each room.

Room 303 had all metal furniture including bedboards and two metal wardrobes. There was no chest of drawers in this room.

All windows in the patient rooms, front lounge, corridor and rear lounge-chapel have single panel fibreglass draw drapes extending to the window sills. Each window is also equipped with a vinyl-fabric shade, most of which were in a rolled up position.

Each patient room is equipped with a metal 'through-the-wall' unit air conditioner sleeve under the window. The sleeves were sealed and secured with sheet metal covers. None of the sleeves contain an air conditioner.

Each bed consists of a metal crank-type hospital frame with open metal spring and a 7" thick hospital type, cotton felt, polyurethane and sisal mattress. The mattress is covered with a clear vinyl plastic cover, 3 cotton sheets, 1 or 2 cotton blankets, and 1 or 2 pillows filled with feathers. The pillow cases are cotton, covered with a clear vinyl plastic and cotton pillow cover. One bedspread of quilted nylon or white cotton is provided for each bed.

PRIVATE FIRE PROTECTION AND FIRE ALARM SYSTEM

Fire Alarm

The home was equipped with a manual and automatic fire alarm system that is connected directly to the main fire alarm office of the Chicago Fire Department. The alarm system is designed to give the code or box number of the alarm station activated.

Two manual pull boxes are located on each floor and an exterior city fire alarm box is located in front of the home.

Automatic alarms are transmitted by rate of rise 136 degrees fixed temperature heat detectors placed in areas as required in the Municipal Code. Heat detectors on the 3rd floor were located in the center of the lounge-chapel, small storage closet and in each stairwell.

In addition to the required fire alarm system described above, a local smoke detection system was installed with smoke detectors located at the entrance of

76-611 O - 76 - 22

the chapel-lounge on the 3rd floor, and also the lounge entrance on the 2nd floor. The 3rd floor smoke detector did activate, transmitting a house alarm to the 2nd floor nurses' station.

Private Fire Protection

The 3rd floor is equipped with (3) hand-held fire extinguishers and (2) automatic battery operated emergency lighting units, and a public address loud speaker.

The 3 fire extinguishers are hand held, 2-1/2 gallon, pressurized water type.

The 2 automatic emergency lighting units are dry cell operated, designed to switch on in the event of a power failure in the 3rd floor lighting system. Each have 2 beam type bulbs set to illuminate the entire length of the corridor.

Each floor is equipped with a one way loud speaker located above the closet door adjacent to the front (east) enclosed stairway. The speaker is connected to a public address system at the switch board in the garden level and is used to summon various employees and give messages to staff personnel on each floor.

INSPECTION REPORTS

1. Health Department

This facility was inspected on a monthly basis by the Health Department. The last visit was January 8, 1976. No significant violations of the Municipal Code were found at this time.

2. Fire Department

This building was inspected on a monthly basis by Fire Department lieutenants from the Fire Prevention Bureau. The last inspection was made on December 31, 1975. No violations of the Municipal Fire regulations were found.

3. Building Department

This building is required to be inspected on an annual basis. The last inspection was made on September 8, 1975, by an inspector from the Institutional and Assembly Bureau. No violations of the Municipal Building code were found.

BUILDING CONDITION

The building was well built, well maintained and well operated. The building complied with all city rules and regulations governing its construction and operation. Prior to the fire, this nursing home would be considered a good example of a typical and proper institutional use of this type.

CHRONOLOGY OF THE FIRE

At the time of the fire the building contained 83 permanent residents and was staffed by 3 nurses, 6 nurses' aides, 2 maintenance personnel, 5 office personnel and 4 kitchen and laundry personnel.

Approximately 28 of the residents were attending mass in the third floor lounge-chapel with an approximate total of 40 residents, 5 attendants and a priest on the entire 3rd floor.

Fire was detected in Room 306 at the approximate center of the single corridor which serves the third floor. Fire-fighting attempts were made by the priest and attendants. The fire alarm box was also activated by an attendant.

The initial alarm was received by the Fire Alarm Office at 11:43 A.M., Friday, January 30, 1976. This alarm was transmitted as Fire Alarm Box 31769 and was activated by either of the following two methods:

1. One or more of the heat detectors on the 3rd floor.
2. The fire alarm box located at the entrance to the west stairwell on the third floor.

Note: The fire alarm box was activated by nursing home employees and may have followed or preceded the alarm from the heat activated device..

These 2 devices are on a single circuit. Consequently, the device that operated or sequence of their operation cannot be identified.

The usual institutional box alarm response that is dispatched by the Fire Department to either a school, hospital, nursing home or similar occupancy, was sent. This response consisted of 4 engine companies, 2 hook and ladder companies, a flying squad, a snorkel, a division marshall and 2 battalion chiefs.

The first fire company arrived on the scene 3 minutes and 40 seconds after the initial alarm at 11:46 A.M., and verified the fire. They found the 3rd floor heavily charged with smoke and elderly patients, many in wheel chairs, gasping or unconscious, and in need of immediate evacuation and removal to nearby hospitals for emergency care.

Disaster Plan No. 3 was put into effect at 12:16 P.M., and other organizations, utilities, city officials and city departments, etc., notified by the Fire Alarm Office.

The fire was struck out at 1:28 P.M. Room 306 was completely gutted while the corridor sustained only moderate fire damage but intense to heavy smoke and heat damage. Three other patient care rooms with open doors to corridors suffered moderate to intense smoke and heat damage, while 4 of the 8 patient care rooms suffered no heat or smoke damage because doors to the corridor were closed.

No fire, smoke or heat damage was evident on the 2nd, 1st or garden floors of the building. Water damage was minor.

Total damage from fire, smoke and water was relatively minor.

The death toll from the fire, on the date of this report, 2/20/76, is twenty-three.

INVESTIGATION OF THE FIRE

ORIGIN AND CAUSE

Reports of eyewitnesses who fought the fire initially, indicated that it started in a plywood wardrobe located in the southwest corner of Room 306, on the 3rd floor. The room was occupied by four female patients.

Approximately 28 patients, including those in Room 306, were attending a Roman Catholic mass that was being held in the lounge-chapel at the west end of the 3rd floor and Room 306 was unoccupied at the time the fire was discovered.

Inasmuch as the cause of ignition could not be determined, it is the Committee's considered opinion that this fire was of incendiary origin.

A Police Arson Bureau investigation has resulted in the arrest of a temporary housekeeper who has been charged with multiple counts of murder by arson in connection with this fire.

FIRE AND SMOKE SPREAD

The blackened ceilings and side walls indicate that a large volume of smoke and hot gasses raced through the corridors and entered rooms where doors were left open. Whereas smoke damage was confined mainly to the 3rd floor, some smoke entered the front and rear stairwells as rescue attempts were carried out along with fire fighting operations. Standard fire fighting procedures require the closing of all doors and windows to confine fire and cut off oxygen supply, however, a nurse's aid opened a window in the lounge-chapel at the west end of the building. Due to the wind direction and strength (N.W. at 15-25 M.P.H.) this action appears to have reduced the amount of smoke and gas that would normally have entered the lounge-chapel area and undoubtedly saved lives. The pattern and direction of the heat and smoke are clearly demonstrated in the pictures included with this report.

FIRE FIGHTING OPERATIONS

Nursing Home Personnel

A nurse's aid discovered the fire in Room 306, summoned the priest who was conducting the mass in the lounge-chapel, and activated the pull box which summoned the Fire Department. The priest attacked the fire with a 2-1/2 gallon, pressurized, water type extinguisher, to no avail.

He was joined by the administrator who came from the first floor and two maintenance men from the 2nd floor. All were summoned by the sounding of the local fire alarm system throughout the building which was activated by a pull station or a thermal detector. Also activated was the smoke detector on the third floor which sounded an alarm at the 2nd floor nurses' station.

Each of the other three persons also used a 2-1/2 gallon, pressurized, water type extinguisher. The combined efforts of all four persons failed. Smoke and heat forced retreat and an unsuccessful attempt was made to close the door to Room 306.

Six of the 2-1/2 gallon extinguishers were found at the scene.

All fire extinguishment efforts having failed, efforts were then concentrated on evacuating patients from the lounge-chapel.

Fire Department

At 11:43 A.M. on January 30, 1976, the Chicago Fire Alarm Office (main) received an alarm from station 31769 which is in front of the Wincrest Nursing Home at 6326 North Winthrop. The following units responded on the box alarm: 4 engine companies, 2 hook and ladder companies, 1 flying manpower squad, 1 snorkel, 2 battalion chiefs and 1 division marshal (Deputy District Chief) with a total of 39 men.

The first fire unit on the scene was Battalion 27 arriving in 3 minutes and 40 seconds, with Engine Company 70 arriving a few seconds later from a station one mile to the west. Smoke was seen on the top floor but the fire was not visible from the front of the building because the involved room was located in a setback on the north side of the structure.

At 12:01 hours, 2 flying squads and snorkel squad 1 were dispatched with a total of 18 men.

A second alarm at 12:04 hours brought 4 more engines, 2 trucks, 2 Deputies, Fire Commissioner Quinn,

the Chief of Fire Services, 2 turret squads, 1 helicopter, 2 air bottle trucks, and 1 communication van with a total of 44 men.

Special calls brought 10 ambulances with 27 men, 4 battalion chiefs' cars to be used as ambulances, 8 men and 2 flying manpower squads with 9 men.

Disaster Plan No. 3 was put into effect at 12:16 P.M.

Fire Commissioner Robert J. Quinn responded on the second alarm and assumed command upon his arrival at 12:31 hours.

Victims were transported to 4 hospitals by fire and police vehicles.

CONCLUSIONS

Evidence to date indicates fire of an incendiary origin. No matter what the cause of ignition, this fire demonstrates that a modern, well-built, well-maintained nursing home that complies with present regulations is still vulnerable to a disaster of this magnitude.

Initial fire-fighting efforts by the staff were natural and proper reactions to a fire of this type. The attempts to subdue the fire with the available hand-held extinguishers proved futile and subsequent attempts to close the fire room door were also unsuccessful because of the heat. While these initial attempts to extinguish the fire were being made, heat detectors and/or a pull box alarm notified the Fire Department directly and a smoke detector in the lounge-chapel alarmed the 2nd floor nurses' station.

Fire personnel arrived on the scene and proceeded to rescue the residents and fight the fire without delay. An emergency plan summoned available ambulances for immediate transport of the injured to four local hospitals. The four receiving hospitals, having been notified that a Fire Department "Disaster III" plan was in effect, initiated their own "in-house" emergency action plans to treat the fire victims.

It appears that the opening of the window in the west wall of the lounge-chapel, assisted in reversing the flow of smoke, heat and gas that was moving towards the lounge from the room of origin. This may have saved lives in the lounge area.

There is no evidence of panic. The problem lay with the inability of the elderly residents to evacuate themselves from the fire floor, and the difficulty of moving wheel-chair patients down the available stairs.

Occupancies of this type must be capable of protecting the residents during the course of a fire without relying on evacuation. Toward this goal the following considerations must be kept in mind:

a) Limiting combustible personal items, furniture and bedding would not entirely solve the problem and would be in part dehumanizing;

b) Providing self-closers on corridor doors held in the open position with magnetic hold open devices activated by smoke detectors would be an inadequate form of protection for institutional sleeping rooms. These devices are too subject to various types of failure and could prove dangerous to older people who may accidently bump such a door, releasing the self closer. Facing the practical operational realities, wedges and furniture would very likely be placed to negate the effectiveness of the door closers;

   In addition, self closing devices activated by smoke may trap a number of residents in the fire room making it difficult for them to exit themselves or with attendants' assistance. Also, these devices are by no means an inexpensive solution in both their initial and maintenance costs;

c) Smoke detectors or heat detectors only notify that there is a fire. Many of the people in nursing homes cannot take proper action, themselves, but must then rely on attendants. There are not normally enough attendants to move all threatened residents to a safe enough location to endure the fire, smoke and gasses that may develop in an uncontrolled fire before the arrival of the Fire Department;

d) Smoke barriers in corridors protect the occupants on the non-fire side but are not a solution for those on the fire side;

e) The proper emergency action of attendants is important but again is not a complete solution. Their decision to fight a fire or use that time to remove residents from a dangerous area must be made in split seconds. Should the fire proceed beyond their control, they must have enough time and training to remove all affected people to a safe area. Quite often that time is not available or the training inadequate;

f) Sprinklers detect a fire, give an alarm and either extinguish or hold a fire in check until outside aid arrives. They also control, indirectly, the amount of smoke generated. They would limit a fire to a size that would be controllable by attendants and would also provide the time necessary to remove residents to a safe area. They will not, however, prevent fire nor will they prevent a person in the immediate vicinity of a fire from being affected by that fire. They will, however, protect other residents by controlling the fire and thereby the smoke, gas and heat, and will also give attendants the time necessary to affect the immediate relocation of threatened individuals.

RECOMMENDATIONS

The following list of recommendations have been separated into various parts. The recommendations for immediate code revisions are considered of primary importance. This should not, however, detract from the importance of the other recommendations which will, in certain instances, require extensive deliberations by the Mayor's Advisory Committee on Building Code Amendments in the consideration of additional code revisions dealing with other aspects of the general category of institutional occupancies. These studies could eventually lead to furnishing combustibility and other standards on a national basis.

The following requirements should immediately be made part of the Building and Fire Ordinances of the City:

1) Sprinkler systems to be installed in all new and existing nursing homes and be electrically interconnected with the fire alarm system for water flow. In addition, local valve supervision shall be provided;

2) Formal Fire Department emergency training to be required for all nursing home personnel every six (6) months to supplement the monthly inspection programs and existing training programs. The nursing homes themselves should also provide emergency training for all personnel at least each month;

3) Dead-end corridors to be disallowed in all new nursing homes.

The following recommendations should be enacted by the Board of Health:

1) Training of nursing home staff should include the following:

   a) The transporting of patients during an emergency;

   b) The keeping of patients not in immediate danger calm and comfortable;

   c) The maintaining of designated areas for family members;

   d) The establishment of a system of 'Round Robin' on-call nursing home personnel to be continually available for emergency duty.

2) Nursing home management shall require pre-employment screening of all employees as defined in the Illinois Department of Public Health Rules and Regulations concerning Long-Term Care Facilities;

3) Disaster plans and dates of drills shall be on file with the Department of Health as well as the Fire Department. Disaster plans are to be in written form, approved by both departments and posted at all nursing stations;

4) All residents shall have identification bands (wrist bands) which shall include name, medical diagnoses and age;

5) Smoking rules are to be enacted by the nursing homes which include the designation of smoking areas and the requirement of strict smoking supervision with a staff member in constant attendance.

Further detailed study and evaluation should be made in the following areas of concern:

1) The allowed location of assembly areas, or what might be utilized as assembly areas should be examined. This analysis should include a review of Section 48-12.2 Auxiliary Uses;

2) Standards for smoke detection and furnishing combustibility should be promulgated and considered for inclusion in institutional occupancy requirements;

3) An analysis of toxic gas emissions emanating from various types of building and furnishing materials as well as fire retardant treated materials should be made which would eventually result in adequate standards.

REPORT #7463
JUNE 1975

FULL-SCALE FIRE TESTS IN A NURSING HOME PATIENT ROOM

HEW CONTRACT #HSA 105-74-116

FINAL REPORT

PREPARED FOR
BUREAU OF QUALITY ASSURANCE
HEALTH SERVICES ADMINISTRATION
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PREPARED BY
AMERICAN HEALTH CARE ASSOCIATION
1200 FIFTEENTH STREET, N.W.
WASHINGTON, D.C. 20005

WITH THE TECHNICAL ASSISTANCE OF
GAGE-BABCOCK & ASSOCIATES AND IIT RESEARCH INSTITUTE

FULL-SCALE FIRE TESTS IN A NURSING HOME PATIENT ROOM

1.0 SUMMARY

A series of 14 full-scale fire tests were conducted to validate provisions of the 1967 Life Safety Code which are applicable to existing nursing homes. This code is the fire safety standard which nursing homes must meet if they are to be certified under the Medicare or Medicaid Programs. Five of these tests were conducted in a fire test laboratory which was representative of a nursing home of fire-resistive construction. Three tests were conducted in a vacated wood-frame nursing home and six in a modified apartment of brick-wood joist construction.

The primary conclusions of this program were that current fire-safety construction standards and corridor wall construction having a 1-hour fire resistance rating provide no significant firesafety function in buildings protected by automatic sprinklers.

The results also suggested that some changes in room door standards may be possible and that interior furnishings can be very significant in non-sprinklered buildings. However, additional experimental work is necessary before any standards can be established in these areas.

6.0 Conclusions

The conclusions of this program are directed to protection against the rapidly developing fire which poses a multiple life loss threat in an existing nursing home. The smoldering fire which generally poses a threat to a single life was not within the scope of the program.

The principal conclusions of the program was that ordinary non-combustible interior finish such as 1/2 in. gypsum board or plaster on wood, metal or gypsum lath commonly found in existing wood-frame and brick, wood-joist buildings, provides adequate fire protection for the combustible structure in sprinklered buildings. Although plaster on wood lath was not used in the test buildings, other fire tests have shown it to perform as good or better than the ordinary gypsum board that was installed, ref. 13. In the early stages, a fire develops and spreads in the same manner in a full fire-resistive building as in a wood-frame building with common non-fire rated gypsum board or plaster interior finish. With automatic sprinklers, the fire does not last long enough for its behavior to be affected even by Class C combustible wall paneling and ceiling tiles. Even in fire tests without sprinklers, the ordinary plaster or gypsum board walls resisted the fires very well.

These tests also indicate that in real room fires other common types of doors may provide a level of protection equivalent to that of the presently required 1-3/4 in. solid core wood door. These tests results are different than would be predicted from a standard ASTM Fire Test. More experimental work is necessary with real room furnishings to establish accurate and sufficient door criteria.

The Library of Congress
Congressional Research Service
Washington, D.C. 20540

August 9, 1976

TO: Subcommittee on Health and Long-term Care
Attn: Alan Zipp

FROM: Education and Public Welfare Division

SUBJECT: Cost estimate of a smoke detector system for a nursing home.

This is in response to your request asking us to obtain an estimate on the cost of purchasing and installing a smoke detector system for a nursing home. We contacted Simplex Time Recorder Company, Gardner, Massachusetts, a firm which installs smoke detector systems and asked them to give us an estimate on equipment and installation costs for a 1-story, 25 bed nursing home; a 2-story, 50 bed nursing home; and a 100-bed, multiple story facility.

Mr. Praskiewiez, Washington, D.C. sales representative for Simplex supplied us with the following estimates.

1-story, 25 bed nursing home: equipment cost--$5,000; installation cost--$5,000; total cost--$10,000.

2-story, 50 bed nursing home: equipment cost--$10,000; installation cost--$10,000; total cost--$20,000.

multiple story (4-6 stories), 100 bed nursing home: equipment cost--$25,000; installation cost--$25,000; total cost--$50,000.

Equipment costs would include the costs for fire alarm equipment, stations, gongs, and smoke detector units.

Mr. Praskiewiez cautioned us that the figures represented only estimated costs and these costs might vary higher or lower depending upon the amount of equipment and system purchased by the home.

We hope this information helps you. Please call if we can provide you with additional assistance.

Janet Kline
426-5863

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TRENDS IN LONG-TERM CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 27—NEW YORK, N.Y.

MARCH 19, 1976

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Trends in Long-Term Care:

Part 1. Washington, D.C., July 30, 1969.
Part 2. St. Petersburg, Fla., January 9, 1970.
Part 3. Hartford, Conn., January 15, 1970.
Part 4. Washington, D.C., February 9, 1970 (Marietta Fire).
Part 5. Washington, D.C., February 10, 1970 (Marietta Fire).
Part 6. San Francisco, Calif., February 12, 1970.
Part 7. Salt Lake City, Utah, February 13, 1970.
Part 8. Washington, D.C., May 7, 1970.
Part 9. Washington, D.C., August 19, 1970 (Salmonella).
Part 10. Washington, D.C., December 14, 1970 (Salmonella).
Part 11. Washington, D.C., December 17, 1970.
Part 12. Chicago, Ill., April 2, 1971.
Part 13. Chicago, Ill., April 3, 1971.
Part 14, Washington, D.C., June 15, 1971.
Part 15. Chicago, Ill., September 14, 1971.
Part 16. Washington, D.C., September 29, 1971 (Lil-Haven Fire).
Part 17. Washington, D.C., October 14, 1971.
Part 18. Washington, D.C., October 28, 1971.
Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
Part 20. Washington, D.C., August 10, 1972.
Part 21. Washington, D.C., October 10, 1973.
Part 22. Washington, D.C., October 11, 1973.
Part 23. New York, N.Y., January 21, 1975.
Part 24. New York, N.Y., February 4, 1975.
Part 25. Washington, D.C., February 19, 1975.
Part 26. Washington, D.C., December 9, 1975.
Part 27. New York, N.Y., March 19, 1976.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIX

TRENDS IN LONG-TERM CARE

FRIDAY, MARCH 19, 1976

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
New York, N.Y.

The subcommittee met, pursuant to notice, at 9:30 a.m., at 14 Vesey Street, New York City, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss and Domenici, Representatives Koch and Scheuer, Assemblyman Andrew Stein, and Assemblywoman Gerdi Lipschutz.

Also present: Val J. Halamandaris, associate counsel; David L. Holton, investigator; Caroleen Silver, legislative assistant to Senator Domenici; John Guy Miller, minority staff director; Kathryn T. Dann, assistant chief clerk; and Alison Case and Dorothy Miller, assistant clerks.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will please come to order.

We are pleased to be here this morning to conduct a very important hearing. This is a hearing by the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging.

Senator Domenici is sitting here with me, and he is an active member of this subcommittee. We are pleased to have Senator Domenici with us.

Congressman Scheuer and Congressman Koch are here, both from the New York area representing their districts, and Assemblyman Andrew Stein is seated with us.

We gave notification of this hearing to all New York Congressmen and invited them to come if they wished to sit with us and to hear the testimony we expect to have today.

We are here to examine alleged abuse and profiteering in New York's adult care homes.

Our subcommittee has conducted 29 hearings concerning the problems of the infirm elderly in the past 6 years. We have produced numerous reports and numerous pieces of legislation including the 48-bill medicare-medicaid reform package that I introduced last year. Following the hearings we had right here in New York, some of these bills were enacted. We expect others to be enacted when the Senate Finance Committee takes up medicare and medicaid reform later this year.

One of the issues we have been examining is the national trend of dumping thousands of former mental patients into nursing homes

and smaller community-based facilities. Today we are releasing our report on this subject entitled: "The Role of Nursing Homes in Caring for Discharged Mental Patients and the Birth of a For-Profit Boarding Home Industry."[1]

Minimal Supervision Given to Dischargees

Our report suggests that in virtually every State of the Union mental patients are being discharged wholesale into facilities that offer board and room with minimal supervision. These facilities go by various names. In New York you call them adult care homes, domiciliary care facilities, or private proprietary homes for adults. In other States they are called foster care homes or shelter care homes.

Our report suggests that since January 1973 there has been an increasing trend to move expatients from State hospitals into these facilities. A major reason was the enactment of supplemental security income—or SSI—the Federal welfare program for the aged.

The recent report by Assemblyman Andrew Stein and the grand jury report concerning the starvation of an adult home resident prompted me to come to New York to see things for myself. I visited the psychiatric ghettos in Long Beach and Far Rockaway, N.Y. I toured the old hotels and boarding homes where the forgotten Americans live. I have seen their world of cockroaches and peeling wallpaper, of flaking paint and falling plaster.

I have seen the broken windows letting the cold air into rooms without radiators. I have seen leaking roofs and holes in ceilings. I have seen exposed electrical wiring, overloaded sockets, and fire extinguishers that have not been inspected for years. I have seen sharp staircases with low clearances, and makeshift doors made out of cardboard or burlap.

I saw hungry people with their faces up against vending machines begging for a quarter. I saw three patients cooking eggs on a hotplate in their room while breakfast was being served in the dining room. I learned that they had bought these eggs with money they received from begging. These patients, distressed by the quality of food in this New York boarding home, had formed their own co-op. Pooling their meager resources, they had purchased a small supply of foodstuffs of which they were most proud.

I saw a patient who complained of a recent head injury who said she had asked to see a doctor several days before but nothing had been done by the boarding home operator.

I saw patients sitting in rows at 9:30 in the morning staring blankly at a television set in which the picture was continuously rolling.

I talked to patients who said that operators required them to work and paid them little. One man told us he helped out in the kitchen 8 or more hours a day for which he received $5 a month.

I saw medication rooms that were wide open. Almost anyone who wanted to could walk in and steal large quantities of amphetamines and barbiturates—some of which have tremendous street value at the present time. I met no licensed nurses in my tour; most drugs were being given by unlicensed personnel who probably could not

[1] Supporting Paper No. 7 in the series, "Nursing Home Care in the United States: Failure in Public Policy."

protect patients against possible adverse reactions and side effects from taking large numbers and kinds of drugs over a protracted period. There were no physicians or psychiatrists in any of the facilities we visited.

I saw activities schedules posted, but no activities in progress. I saw therapy rooms with no one using them. These discrepancies were generally explained by telling me that the therapist was on vacation and that if I would come on any other day I would see the normal routine.

"MENTAL PATIENTS ARE A GOOD INVESTMENT"

It became evident to me that operators were cutting corners every way that they could in order to be able to maximize profits. Apparently, mental patients are a good investment in New York as well as in Illinois. In that State we found one operator received $385,000 a year to care for about 100 former mental patients. He kept 13 percent of patient income—over $50,000—as profit. Another increased his investment—equity—in an old hotel from $10,000 to $250,000 in 10 years. He housed 180 former mental patients receiving $400,000 a year and managed to keep $185,000 of this amount—46 percent of total revenues—as profit. One of the ways he accomplished this feat was to spend 54 cents per patient per day for food. He defended this profit, telling us it was below industry expectation. A third partnership received over $1 million to care for expatients and kept 30 percent of it—over $300,000—as profit.

Given the marginal quality of life that we have found in these kinds of facilities in New York and all over the United States, I have every reason to believe that other operators are making similar profits. Since the source of these funds is the new Federal welfare program for the aged—SSI—which will cost the taxpayers $2 billion this year, I intend to do everything in my power to restore some accountability in this program. The taxpayers deserve to know how their money is spent. Right now it looks like the funds are going to line the pockets of the greedy who pretend to be offering care and services to the needy.

As my opening statement suggests, there are many significant problems in the use of SSI funds, and it is my hope that in today's hearing we can focus on some of the Federal issues. I hope we can find some way to improve the quality of life for these people who live in substandard boarding homes.

In this connection, I am informed that Mr. Charles J. Hynes, the New York special prosecutor for nursing homes, has some suggestions concerning large amounts of fraud and potential criminal activity in the New York domicile care program.

I am told that Mr. Hynes requested permission to follow these leads and that the Governor of the State, the Hon. Hugh Carey, agreed to pursue this, subject to the approval of the State Board of Social Welfare. I am further informed that the State Board of Social Welfare has jurisdiction over adult care homes, and that it has refused to give the special prosecutor its consent to go after the lawbreakers.

I find this action on the part of the board unconscionable. It is difficult to understand in view of the fact that many of the same people

who have nursing home interests also own adult care homes in New York.

I cannot immagine why the State Board of Social Welfare is blocking the prosecutor's effort to route out fraud and abuse.

We have here with us this morning Mr. Bernard Shapiro, the executive director of the State Board of Social Welfare, and I intend to ask him for some explanation.

State Cuts Surveillance Unit From Budget

While I am on the subject of blocking the efforts of the special prosecutor, I must say that I was appalled beyond words to learn that the State legislature eliminated $2.3 million that Mr. Hynes had requested to establish a permanent audit and surveillance unit in the State Department of Health.

In the first place, such units are required by Federal regulations, and they are preconditions to the State's participation in the medicaid program.

The State of New York has the responsibility to ferret out those individuals who are guilty of fraud and abuse.

It has already been pointed out that auditors in the New York State Department of Health have returned $15 for each dollar of their salary. Auditors trained by Mr. Hynes have returned $30 for every dollar of their salary.

In short, especially in these troubled economic times, failure to accede to Mr. Hynes' request for funds is not very farsighted. I can understand why some people charge there are political motives involved. But the question of the motive for the cuts really is beside the point.

I think we should assume that this matter is just an oversight, or the work of poorly informed, overzealous budget cutters.

To be sure, the State's elected leaders could do much to restore confidence and dispel the current mood of cynicism if they exercise their leadship role in a forthright manner and restore the requested $2.3 million for the additional auditors and investigators that are needed.

I would now like to call on my colleague from New Mexico, Senator Domenici.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator Domenici. Thank you, Mr. Chairman.

I want to compliment you and the Special Committee on Aging for scheduling these hearings today. The care and attention given the elderly in this country is an extremely important issue, and I am pleased this committee and, in particular, the Subcommittee on Long-Term Care is in the investigative forefront.

We are here today to examine the operation of the Federal supplemental security income program. As you know, in 1972 Congress wrestled with the question of whether we should federalize welfare. At that time, Congress decided instead to federalize only one part of it—the old age assistance payments. Under this program we call SSI, the Federal Government makes a flat payment of $157 per

month to those senior citizens with incomes below the poverty line. The SSI checks come directly from Baltimore, since this program is administered by the Social Security Administration.

Some States which had higher welfare payments to the aged were required by the Congress to supplement the $157 minimum SSI payment. New York, for example, adds $229 of its own money for a total payment of $386 per month.

The exorbitant profits made by boarding home operators which you described in your opening remarks, Mr. Chairman, are possible because operators can finagle other provisions left in the 1972 law.

Congress barred the payment of SSI funds to residents in institutions. The word "institution" is defined rather broadly to include nursing homes, mental hospitals, and the like—not adult-care centers or boarding homes. Congress also required that SSI funds be cut by one-third when recipients live with related individuals. Furthermore, Congress prohibited the use of SSI funds to individuals who need medical care. It was made clear that medicaid was the appropriate vehicle to take care of those people who needed nursing or medical care.

From these facts, it is clear that SSI was intended to be used only as a cash grant program for the poor elderly—those who are physically well and are ambulatory—who can decide for themselves where to live and how much of their SSI money they want to use for housing, for food, and for other expenses.

Misuse of SSI Funds

From what I have observed, it is clear to me that the State of New York is technically in violation of the law. In the first place, patients from State mental hospitals are discharged by the State and placed into particular boarding homes which are called domiciliary care facilities—DCF. Such facilities, I believe, would come within the definition of "an institution" for purposes of the SSI law. Second, New York has, for all intents and purposes, warped SSI from a cash grant program to a vendor payment program. The residents of these boarding homes are still the payees of Federal SSI checks here in New York, but yet the residents never see them most of the time. Residents endorse these checks over to the operator. In some cases, I understand, the endorsement is simply an "X" on the back of the check signed by the operator himself. Finally, several reports by State agencies and our own evaluation indicate that large numbers—perhaps as high as 40 percent—of DCF patients need medical attention. In short, SSI funds are being used to care for patients who need medical care, again in violation of the SSI Act.

I realize these are serious charges, particularly when those who transfer mental patients from State hospitals into DCF residences believe what they are doing is in the best interests of the patients.

As the report released today points out, there are several States besides New York that also have significant problems with discharged mental patients. I have visited facilities in Illinois and in my own State of New Mexico. I was shocked when I visited some boarding homes. I realize boarding homes are not designed or licensed to provide medical care to the elderly. But several facilities did take in

elderly residents whether they were well or not. Many boarding home residents suffer from gross neglect. The basic needs of the residents are ignored, such as: failure to provide adequate or nutritious food, failure to provide a change of clothing for helpless residents, and failure to perform such elemental services as cutting toenails—to the point they curl up under the feet making walking impossible.

In my own State, our hearings on this issue were successful in getting the State of New Mexico to increase its enforcement efforts. I am hopeful that today's hearing can produce similar results here in New York. I am also hopeful that we can come away from today's hearing with some suggestions for legislation to improve conditions in similar facilities across the United States.

Senator Moss. Thank you very much.

Congressman Koch, do you have any remarks? Congressman Koch has done a great deal of work in this field and has sat with our subcommittee before. He is a leader in the House of Representatives. Ed, I am very pleased that you are here looking at the problem and trying to help us find some solution.

STATEMENT OF HON. EDWARD I. KOCH, A U.S. REPRESENTATIVE FROM THE 18TH DISTRICT OF NEW YORK

Representative KOCH. I just want to thank you, Senator Moss and Senator Domenici, for bringing your subcommittee to the city of New York, because until the quagmire that exists here is totally eradicated, there is much that needs to be done. The special prosecutor has exercised good leadership in this area and he has done an outstanding job, but the fact is, had you not come to New York when you did many months ago, we would not be where we are today. So on behalf of the elderly people of the State of New York, I just want to thank you.

Senator Moss. Thank you very much. You played a part in our investigation a year ago, and I appreciate your participation again today.

Congressman Scheuer is also interested in this field, and he has done good work in it. I am glad you are here.

STATEMENT OF HON. JAMES H. SCHEUER, A U.S. REPRESENTATIVE FROM THE 11TH DISTRICT OF NEW YORK

Representative SCHEUER. I am very happy to be here, Senator.

I join with my colleague, Congressman Koch, in congratulating you in the work that you have done in this area, and I am very happy to join Congressman Koch in welcoming you to New York. It is a pleasure for me to be here this morning at this hearing to examine alleged abuses among New York's domiciliary care facilities.

Of course, the subject of this hearing is extremely important because I represent the 11th District, which includes the Rockaway's and which has about 48 or 49 percent of the nursing homes. We are sinking beneath the surface of the Earth with this population; out of a population of 100,000 people, we seem to have about 17,500 people living in nursing homes and health related facilities.

We have thousands upon thousands of expatients from the State mental health institutions. They are dumped upon our neighborhoods, as you indicate in your statement, with perhaps very little more, as Senator Domenici pointed out, than room and board. They lack the tender loving care and compassion they need.

My district is saturated with these people. It is not good for them, and when they are uncared for, when they are unwatched, and when they are unloved, they do wander around the streets. Their conduct to other people in the neighborhood is bizarre and sometimes offensive, even though pathetic and touching. They are a great danger to themselves, and we have had recent accidents where they left their beds in an aimless state and walked out onto the roof or walked out into our streets. One patient froze to death under the most tragic and pathetic circumstances.

It is a subject, as you have both indicated, that literally cries out for government solution. I think the fact is we have not met that challenge at the Federal, State, or local level.

Congress Shares Responsibility

Most of the funding seems to come from the Federal Government. I am on the Health Subcommittee of the Interstate Commerce Committee. We had hearings that I chaired a couple of weeks ago right here in New York, and I would be the first to say that Congress has by no means done its job or met its challenge in watching where the Federal dollars go—to make sure that some of the concerns and professionalism follow those dollars. I think this is the challenge that all levels of government share, and I congratulate you for bringing us here to face our portion of the challenge too.

We have a number of problems that have been highlighted by your committee.

First and foremost: These residents who were recently released from mental hospitals generally find themselves in facilities that are unable to deal with their complex medical and social problems.

Second: Family members often stand by to watch as their loved ones are placed in facilities far from home. There is a distinct lack of any programs to help these families to maintain their loved ones in their own homes.

Third: The communities in which these patients are placed find their resources taxed to the limit. Angry citizens have written to all of us complaining of the presence of these people in their neighborhoods and of the bizarre behavior they often exhibit.

Fourth: Mental health personnel are finding it impossible to keep track of discharged patients and to insure that appropriate followup care is provided.

Fifth: State health and welfare officials appear incapable of resolving the conflict between meeting the needs of this population and the high cost of providing these services. One answer may be the direction that Senator Domenici pointed out, that perhaps we ought to make it more financially feasible for the family to take care of these people.

Sixth, adult home operators often find themselves caught in the gap between community expectations for care and the reality that the only way to make a profit is to cut care, food, and services.

I want to make it clear that I join with my colleagues here in the House and Senate in an effort to find some solutions for this important problem. Solutions will not be easy to find because the issues involved are so complex but we must make the effort. Working together, I am sure we can help improve the quality of life for the frail elderly who live in our domiciliary care facilities.

I congratulate you for holding these hearings. I think we are well on the road to finding some solutions. They will not be easy to find, because the issue is complex, but we must make the effort together. In working here today, and in working together, I am sure that with the assistance of legislators like Assemblyman Stein at the State level, we can improve the quality of life for the elderly who live in our domiciliary health care facilities.

Thank you very much.

Senator Moss. Thank you, Congressman, for that fine statement, and your continued concern and efforts to finding a solution to the problem.

I also want to recognize Assemblyman Andrew Stein, who has worked on this program at the local level. He was involved in our hearing in New York last year, and I ask him if he has any comments to make.

STATEMENT OF ANDREW STEIN, NEW YORK STATE ASSEMBLYMAN

Assemblyman STEIN. Thank you very much, Mr. Chairman.

First of all, I would like to personally thank you. Since you were here approximately a year ago—your committee, and Senator Domenici—we have achieved many results in our nursing home investigations which has improved the quality of care and saved tremendous amounts of funds. I do not think it would have been possible without both of you Senators, your committee, your fine staff, and of course my Congressman—Congressman Koch—who has done such an excellent job, and Congressman Scheuer.

I would like to say, Senator, that in New York State the fiscal crisis we have been having here, and you have been feeling in Washington—it is amazing to us; we spend $70 million of Federal and State moneys without one single audit being performed.

We do have a fiscal crisis here, and there has not been one audit done by any State or Federal agency since $70 million in funds have been given out.

You and I have been privately to some of these homes and we saw these terrible conditions—similar to conditions in many of the nursing homes.

There is another element too, Mr. Chairman, which I think is very important. That is a bill that passed the State senate last year that would have provided audit funds. It passed the Senate, but then it went to the Committee of Government Operations in the assembly where it was supposed to have been reported out of the committee. This bill would have given power to conduct audits. All of a sudden it was sent from the Government Operations Committee in the assembly to a health committee which had already ceased business. This meant the bill had met a very certain and quiet

death. I think it may be of interest to this committee to look into why this bill was killed, because if it had passed, we would already have had an auditing procedure for this important industry.

Mr. Chairman, I want to take this opportunity to welcome you to New York. This investigation is essential if we are to clean up the adult home industry in this State and in this Nation.

Unfortunately, we have had to meet before in this room to consider problems similar to those we examine today; earlier, it was disclosures of fraud and inadequate care within the nursing home industry that held our attention. This time we meet to consider a new industry, one that grew almost unnoticed, yet one that in New York alone already consumes 70 million of the taxpayers' dollars.

"Human Tragedy of Vast Dimension"

As we found before, so again we are finding a human tragedy of vast dimension. The improper medical care, inadequate diet, poor supervision, and almost total lack of Government regulation that marked nursing homes are now becoming the sad trademark of adult homes.

Mr. Chairman, as it did with nursing homes, the stink of fraud permeates this industry.

Once again, a few powerful individuals—through coercion, manipulation, and harassment—are monopolizing control of essential human services.

Once again, politicians are protecting the interests of money at the expense of people.

Once again, corruption and the pursuit of the almighty dollar have replaced the simple compassion our elderly, and now our mentally ill, have a right to expect.

As you know, here in New York we have begun to investigate this industry, and the catalog of abuses we have unearthed is as distressing as it is long:

Residents are tranquilized beyond necessity, even when they object.

Physicians and psychiatrists provide minimal care, sometimes "examining" as many as 40 patients a visit.

Inadequate diets are provided on a take-it-or-leave-it basis.

Overcrowding abounds, with up to four residents in a bedroom.

Social and recreational activities are virtually nonexistent.

Drugs are stored and dispensed by unqualified personnel, with little regard for their potential danger.

Thousands of former mental patients, who have been tossed into these homes, receive care inadequate to their special needs.

These are only examples and, clearly, not all adult homes permit such travesties. But such instances of abuse must be accepted for what they are: symptoms of the unseen rot which pervades the adult home industry, here and around the Nation.

The inescapable truth is that when hospitals report admitting adult home patients who are encrusted with filth or who give signs of severe physical neglect; when residents fear to speak to outsiders, knowing that they risk whatever meager benefits they do receive; when custodial staff demand tips for serving food or helping with baths or assisting with dressing—something is very much wrong.

Till now Government has not acted as it must to deal with these problems. Regulation is all but nonexistent.

Insufficient Inspection Force

In this State, for instance, only 27 field inspectors are available to scrutinize the 428 proprietary adult homes which hold more than 17,000 elderly and disabled persons. This kind of meager enforcement is all the more disturbing when we recall the similar circumstance which led to nursing home abuses.

It is time for government to end its neglect and devote the resources required to do a proper job of regulation.

Mr. Chairman, unfortunately, though the need for adult home regulation has been clear for some time, what we have seen in New York has not been government action but a continuation of politics as usual. In adult homes, as in nursing homes, political indifference—if not political influence—has blocked effective regulation.

The fate of recent regulation in the New York legislature is a case in point. The aim was modest: to establish a basic auditing system to determine how State and Federal dollars were being used.

Apparently, however, even such obvious safeguards could not get through the legislature. Although the bill cleared the senate without major difficulty, it was quietly killed in the assembly.

When one committee—government operations—showed that it was prepared to approve the legislation, the assembly leadership immediately sent the proposal off to a second committee.

But this time it was guaranteed that the bill would not be seen again. The committee chosen was no longer meeting, and the bill was dead.

Mr. Chairman, such practices have been all too common. The results are visible across the State: the scandalous treatment of elderly and disabled individuals.

As we proved last year with nursing homes, only this kind of national investigation, coupled with vigorous State investigations, can bring such practices to a halt in adult homes.

Mr. Chairman, the abuses we find in our nursing and adult homes represent the culmination of a traditional social policy to dump our elderly out of sight and thereby put them out of mind.

To walk through many of these homes is to see the human devastation this policy has wreaked. That we still permit these institutions—that we still force into them those who are able to lead active lives—does not speak well for this society.

This is why I welcome you to New York today.

Though we in this State intend to carry on our efforts to end the abuses, this national investigation will strengthen our attempts to reverse the years of neglect that have done such harm. The efforts of this committee will help us fashion a better way to treat our older citizens and our mentally ill—a way that recognizes that they are people, not piecemeal problems.

If we can fashion this new way, we will begin to provide these citizens with the kind of life they require. We will begin to provide them with the kind of life they deserve.

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

We are now ready to begin our testimony. I am going to ask first if Mr. Charles J. Hynes, the deputy attorney general of the State of New York and the special State prosecutor, will please come to the table, and you are accompanied by?

Mr. HYNES. Robert Schwartz, my first assistant.

Senator Moss. Mr. Schwartz, we welcome you.

STATEMENT OF CHARLES J. HYNES, DEPUTY ATTORNEY GENERAL AND SPECIAL STATE PROSECUTOR, STATE OF NEW YORK

Mr. HYNES. Mr. Chairman and members of the committee, my name is Charles J. Hynes and I am deputy attorney general of the State of New York and special prosecutor for health and social services.

I would like to begin by saying how much I appreciate this opportunity to appear before the members of the committee to testify on the problems facing the elderly today.

Mr. Chairman, I would like to read you something:

> Beyond the specific instances of fraud and deceit as they may be revealed and must be dealt with, we are bending every effort to produce constructive results that will prevent recurrence of cheating and misrepresentation—results that will strengthen administration of regulatory and medical care programs of city departments and, above all, results that will upgrade proprietary nursing homes in respect to operational effectiveness and quality of patient care—all in the public interest.

Mr. Chairman, these words were spoken some 16 years ago by Louis J. Kaplan, then New York City investigations commissioner and author of the now celebrated Kaplan report.

I chose them to demonstrate what I perceive to be a major problem facing me as special prosecutor for nursing homes—namely: How to prevent a recurrence of the problem once the prosecutions are completed. And by "problem," I mean the dreary sordid history of aggression practiced against helpless old people by unscrupulous entrepreneurs in the nursing home field.

What we saw in the days of the Kaplan report was a cycle of exposure, outrage, and, I am sad to say, indifference.

Mr. Chairman, we must not permit the cycle to be repeated. Instead of exposure, outrage, and indifference, we must make it exposure, outrage, and remedy.

This is where the role of government—local, State, and Federal—can complement the role of a prosecutor. It is not sufficient simply to indict, try, and convict those who are victimizing our elderly today. We must do our utmost to make sure that this situation does not recur again. Otherwise, Mr. Chairman, our work will only be half done.

"ENORMOUS SQUANDERING OF TAXPAYERS' DOLLARS"

As a result of some 14 months' experience investigating nursing home abuses in New York State, I have seen at first hand the conditions that have led to an enormous squandering of taxpayers' dollars through fraud and gross mismanagement.

I have proposed to Governor Carey a program designed to end this situation now, and to prevent its recurrence—while at the same

time assuring that a substantial portion of these wasted moneys will be recovered.

For your information, I will briefly outline my program.

I requested funding for 164 additional positions: 96 auditors and 68 additional support staff, including some 30 investigators and 9 lawyers. This addition to my existing staff would provide the essential personnel to carry through to completion several main thrusts of my investigation:

The audit and investigation of reimbursement claims submitted during the past 6 years by all nursing home facilities in order to recapture the funds misappropriated from the State;

The determination of the extent of medicaid fraud in other public health areas;

The development of a permanent fraud control mechanism to prevent any recurrence of medicaid abuse once my office goes out of existence.

Unless those objectives are achieved, my investigation will make but a temporary contribution to the sound management of the medicaid system and the provision of decent care for the elderly. The funds misappropriated at their expense will be beyond our reach forever as the statute of limitations runs.

It has been suggested that a workable alternative to my proposal would be for my office to use 120 of the 288 new auditors provided in the State's new budget for the State department of health. I think this suggestion needs careful analysis and clarification. The department of health is only gaining 120 new auditors. The remaining 168 positions will be filled by patient-care survey personnel. Under legislation you passed in the 1975 session, you required the department of health to make at least two inspections annually in order to review the adequacy of care in all residential health facilities. These 168 positions presumably will carry out that obligation. They are not fiscal auditors.

Additional Auditors Sought

In actuality, the legislature provided the department of health with 120 new auditor positions. These are not a resource we could effectively draw upon to do fraud audits covering 5 years of past reimbursement claims of nursing home operators.

This addition of 120 auditors will give the department of health a total of 204 auditors. Perhaps that figure sounds impressive, but not when it is measured against the department's obligations. These auditors must:

One: Audit the current year's returns of all nursing homes and health related facilities, a total of 780 institutions with 1975 medicaid expenditures of $1.25 billion. This requirement was imposed by the legislature in their 1975 session.

Two: Review the Blue Cross and Blue Shield audits of 360 hospitals, with 1975 medicaid expenditures of over $1 billion.

Three: Audit the construction, under articles 28A and 28B of the public health law, of nonprofit health care facilities—both hospitals and nursing homes. The current workload is 120 projects with a total construction cost of approximately $500 million.

Four: Audit all other facilities, such as home health care agencies and clinics, under the department of health's jurisdiction—more than 400 facilities with 1975 medicaid expenditures of some $500 million.

Five: Address the problems of some 700 medicaid mills, currently operating without any effective supervision.

This is a staggering task that will easily consume all health department audit personnel, both existing and newly budgeted.

Moreover, the proposal to use health staff in my investigations bears no relation to the way my office functions. My office conducts sophisticated fraud audits, which take my staff behind nursing home books to scrutinize vendor dealings and to identify the nature of and participants in potentially corrupt transactions. I must have my own audit staff trained and skilled in sophisticated fraud audit techniques. Equally indispensable are the legal, investigative, and support personnel who do the fieldwork and develop materials for prosecution.

My proposal is carefully structured. It grows out of the experience of my office in more than a year of investigation and prosecution, where I found the common thread among nursing home operations to be a sweeping pattern of improper claims for reimbursement.

It comports fully with the desire of Governor Carey to identify and deal swiftly with misuse of medicaid funds in other health areas, as part of his long-term goal of reforming health care management in New York State.

Finally, it was based on my own personal belief that these abuses, which undermine high standards of patient care, must never be allowed to recur; that the sequel to this office shall not be another round of scandals once the public expressions of concern have faded. Only the development of an effective and permanent fraud audit unit to supplement the day-to-day work of the department of health can guarantee this.

The size of this budget request is modest, particularly in the context of the size of a $3.2 billion medicaid program. I envision that if this budget request is approved, my work can be completed by the spring of 1978, and the diversion of medicaid funds from patient care eliminated.

Estimated $70 Million Could Be Returned

My proposal offers immediate and concrete fiscal benefits to the State, far in excess of its cost. My audit of nursing homes' past claims would identify a minimum of $70 million in overpayments for recovery and return much of this money to local, State, and Federal governments. These millions are to be lost if my request is denied.

The identification of overstated costs in past returns will play a real role in controlling spiralling medicaid costs. Once overstated, many costs remain permanently in a nursing home's rate base, falsely inflating expense ceilings, depreciation allowances, and equity returns. Identifying and correcting cost overstatements will insure that future medicaid reimbursement is limited to the amount actually expended on patient care, and reduce the rate of growth of medicaid payments to nursing home operators.

These conclusions are not based upon speculation. Rather, they are founded upon analysis of the findings of our audits to date. My

auditors have already identified more than $13 million in overpayments which will be available for recovery by the State. I have received actual restitution, in hand, of $237,000; moreover, additional restitution is to be made in several other cases.

I would like to take this opportunity to give the committee some background of my investigation conducted over the past 14 months.

I was appointed January 10, 1975, by an executive order of Governor Hugh Carey after widespread allegations of nursing home abuse.

In the many years preceding my appointment, hundreds of millions of dollars in medicaid funds have been reimbursed to nursing home operators in New York State with relatively minor attention to auditing the validity of expense reimbursements. No attempt was made by the New York State Health Department auditors to look beyond the vouchers of expenses offered by nursing home operators for reimbursement; and indeed, there was no authority for them to do so.

It was in this posture of events that I established seven regional offices throughout the State and that I commenced an intensive investigation to confirm and identify fraudulent claims for medicaid reimbursement, and those responsible in the nursing home industry. A number of investigative techniques were applied, the most prominent of which was the coordinated investigation by my special auditor-investigative staff, aimed at unravelling suspect complicated financial transactions and disclosing fraud.

Our original suspicions were quickly confirmed. Every single audit has established significant overpayment of medicaid funds to nursing home operators.

Working as independent units, lawyers, special investigators, and special auditor-investigators have reviewed the books and records of nursing homes, vendors, and suppliers, analyzed nursing home reimbursement expense claims, interviewed hundreds of proposed witnesses, and presented evidence to grand juries throughout the State. The results so far are encouraging from a prosecutor's point of view.

Twenty-One Indictments Filed

As of today, my office has presented substantial testimony and physical and documentary evidence before 24 grand juries throughout the State of New York. These presentations have led to the filing of 21 indictments. Thus far, 11 defendants have been convicted.

Since my appointment, the thrust of my investigation has been threefold:

(1) To examine allegations of fraudulent misuse of medicaid funds;

(2) To examine allegations of human suffering implicit in questionable standards of patient care; and

(3) To examine allegations of intervention by public officials in the nursing home approval process.

Each of these investigative objectives has borne fruit. Since June 1975, 21 indictments have been returned throughout the State.

The investigations to date indicated more than merely isolated instances of nursing home fraud. More significantly, they appear

to confirm widespread financial skulduggery and wholesale misappropriation of taxpayer funds. The common thread is sweeping fraudulent application for reimbursement for expenditures that have nothing whatsoever to do with nursing home patient care.

The evidence suggests that the taxpayer has unwittingly subsidized personal maids, private residential landscaping expenses, personal travel expenses, personal food items at phenomenal levels, personal luggage, personal business interests, works of art, vast quantities of liquor, interior decorating expenses, personal dental and medical care, personal pharmaceuticals, heating fuel for private residences, personal charitable contributions, political contributions, profits to investors, private pension plans, extensive vacation expenses, real estate taxes, private automobile expenses, mink coats, personal investment stock, personal servants, renovations to private residences, entertainment, legal fees, theater tickets and tickets for sporting events, private stereo equipment, and extensive secret personal profit.

The investigations into allegations of patient abuse are among the most difficult to prove beyond reasonable doubt because of the frequently deteriorated physical and mental condition of the victim-witness. We have successfully commenced criminal prosecutions in a number of instances. One complaint of assault has already resulted in the conviction of a nursing home employee, and other complaints of assault and reckless endangerment are currently under active investigation.

Public inquiries conducted by Chairman Morris Abram's Moreland Act Commission, and other investigations, have brought to light apparent activities and intervention by elected and appointed public officials in aid of private nursing home entrepreneurs.

Based in part upon these disclosures, I have focused my investigation upon the questions of whether or not particular public officials have violated the law by their actions and interventions. The continuing active nature of these statewide inquiries prevents a disclosure here of the investigative techniques and subjects of these efforts.

This avenue of our investigation is aimed at reconstructing just what actions were taken by public officials, who those officials are, whether these actions were motivated by profit, and whether their actions or their accounts of their actions have risen to the level of provable crime.

Restoring Public Confidence

The permanent elimination of patient abuse patterns, the appearance and fact of excesses by public officials, and wholesale fraudulent profiteering in the nursing home industry is essential if public confidence in the quality of government-funded health care delivery is to be deservedly restored.

It is my sincere hope that, through the efforts of your committee, my investigations, and investigations like mine in other States, our elderly will be able to live out their last years in human dignity.

Senator Moss. Thank you very much for your fine statement.

Mr. Hynes. Thank you. Only yesterday I received a commitment from Governor Carey to make every effort to restore these funds

and I think it is just one further example of what Governor Carey has done in terms of supporting this investigation, and having a real interest in doing something about the conditions in the nursing home as it affects the elderly.

There is a series of bills being offered on Monday, which is an amendment to the budget, and Governor Carey has given me full assurance of his total commitment to have this budget restored.

In addition, I have received enormous support from the commissioner of the Department of Health of the State of New York, in which he has indicated that there is a pressing need to have this budget restored, and for us to get about the business of aiding the elderly.

There have been a number of legislators, Mr. chairman, who have contacted my office over the last several days, and they have indicated their total support. I am, at this point, very hopeful that on Monday there will be at least one amendment to restore that budget.

Senator Moss. Actually that money enables you to recover funding, often, that far exceeds any expenditures.

Now, in addition to punishing those who do wrong, there is the fact of recovering funds that are improperly paid out. What has been your experiences and what have you been able to do in that area?

Mr. HYNES. Mr. Chairman, we have, in terms of the criminal prosecution, received almost $4 million in restitution in just 12 cases. There are a number of indictments for fraud currently pending.

In addition, we have turned over to the State department of health a package which would amount to something more than $1 million of civil fraud recovery. That is one of the two purposes of our investigation—to prosecute—and we hope to get restitution as a part of that prosecution. But in addition to identifying civil frauds, we turn those cases over to the department of health for recovery.

At the time I submitted the annual report to Governor Carey in December of last year, I had indicated that in just 40 homes we identified $12 million. As I sit here today, that figure has risen to over $19 million, and if we are given the budget to look at the entire industry, from 1969 to 1974, I am fully confident a minimum of $70 million will be identified and ultimately recovered by the State of New York.

EXPANDED JURISDICTION NEEDED

Representative SCHEUER. In addition to getting more funding to do the job, would you like to see your jurisdiction expanded to include the very domiciliary care facilities we are talking about now?

Mr. HYNES. Yes, I would. May I say, in December last year the Governor's office made inquiry, and I indicated at that time, on the basis of complaints and some preliminary investigation that we had done in the seven regional offices that we have throughout the State—the principle cities—that we are certain substantial evidence would lead us to these investigations that we feel are necessary.

We have not yet been given that jurisdiction.

Representative SCHEUER. I very much hope that Assemblyman Stein will join with our colleagues and with Representative Koch to urge this be restored. It is the preventive medicine we need.

Senator Moss. I have been informed that Assemblywoman Lipschutz is here, and if she would like to join us, fine.

Senator DOMENICI. I would like to ask a couple of questions.

You have indicated you would like to extend your jurisdiction into the domiciliary care area, and plan some very strict legal responsibilities on the operators in the same way as on the operators of nursing homes.

Without getting personal about the individuals, could you tell us some of the reasons you want to extend your jurisdiction? What do you expect to be the violations of law?

Mr. HYNES. I try to make it a policy not to be specific concerning people under investigation.

I can tell you, Senator, that as of December of last year, we had received more than 60 complaints from various areas of the State and in our seven regional offices.

Those matters are currently under investigation for the simple reason there is ample evidence of abuses in the adult home area as there has been in the nursing homes. But I am limited in the way I can answer the question because of my prosecutorial role.

Senator Moss. There is not much of a line in going from the nursing homes to the adult homes, except a little absence of medical care.

Mr. HYNES. I suspect that is correct.

Senator DOMENICI. Let me ask you if your investigation at this point supports some remedial legislation. Your very excellent remarks indicate it is not going to be enough to find fraud and misrepresentation.

ONGOING INVESTIGATIONS ESSENTIAL

Mr. HYNES. One of the things that must happen, Senator—at the time that the investigation ends, I fully expect it can be wrapped up within 1 more year, unless there is an ongoing procedure within the State department of health—a self-contained fraud audit unit—to have a constant vigilance that we never return to pre-1975. It makes little sense to spend the type of money that has been spent for any investigation, wrap it up at the end of 2 years, and close shop. What we indicated in our report to the Governor was that, No. 1, there must be a concentrated effort to evaluate every home in the State, to do a full audit of every home in the State, to review the medicaid reimbursement formula, and bring it into a reasonable proportion. No. 2, to turn over to the State department of health a self-contained unit of criminally trained fraud investigators—I am happy to see that Dr. Wells issued a statement yesterday conceding we have the facilities to train these people—to turn over to criminal lawyers who work with us and turn over to investigators, keep that unit ongoing so that they can operate as an investigative check of not only nursing homes, but in every area where medicaid funds are used.

Now, we have a $3.3 billion medicaid budget in this State, half of which is paid for by the State of New York. I would that members of the legislature should not engage in penny-wise and pound-foolish conclusions.

Senator DOMENICI. Mr. Chairman, might I just make one comment. It does appear to me, in reference to medicaid, we have a couple of problems on SSI with the concept you described. But with reference to medicaid, if there is one thing that is absolutely positive—if we see no upturn in the State process and exercising a willingness to investigate, audit, and supervise, it appears to me that a minimal standard of the Federal Government ought to be proposed. Even if it is difficult to monitor, one should exist. And if that is in the law, we would have some reason to find out whether it will work.

As it is now, it is left totally up to them, and you are only describing a chronic illness across the land, with few exceptions.

Thank you, Mr. Chairman.

Senator Moss. Congressman Koch?

APPARENT RESISTANCE FROM STATE BOARD

Representative KOCH. First I want to say that Governor Carey's nomination of you for the appointment of special prosecutor is one of the major achievements of his administration, indicating a desire to root out the corruption that exists in the industry. I am very interested in your comment on the resistance that you have apparently received from the State board of social welfare with respect to your desire to investigate the facility end of the nursing home business.

I wonder whether you could give us some insight with respect to their opposition?

Mr. HYNES. I wish I could answer that. I was happy to hear that Mr. Shapiro is going to be here. I simply cannot answer your question at this point.

Representative KOCH. But it is your desire to engage in investigations and, under the existing law, without the board's consent, or without a change in your mandate by the legislature, you simply do not have the lawful authority to do that; is that correct?

Mr. HYNES. Congressman, someone has to take a look at these homes. What we have now are allegations, and it leaves a cloud over many of the owners of these homes.

I would be more than happy to take a look.

Representative KOCH. And at this moment you are prevented from doing so by virtue of the resistance of the State board of social welfare.

Mr. HYNES. That is correct. I have no jurisdiction at this time.

Senator Moss. I would point out that in the State of Georgia, the Governor down there ordered an audit of every nursing home, and the results were astounding—what they were able to uncover in the way of fraud, of overcharges, and various things. I suppose one of the most healthy of pictures we could have is consistent audit of these places. This is what you are seeking to have funding for, isn't it?

Mr. HYNES. Yes; sir.

Senator Moss. Assemblyman Stein?

Assemblyman STEIN. Mr. Hynes, supposedly the reasoning for cutting out your funds for additional auditors was for financial reasons. Did you make a statement or issue any report in which you said

that if you had those auditors, you could save many times that money?

AUDITORS SAVE TEN TIMES THEIR SALARY

In our investigations, we found that every auditor saves 10 times what he gets, based on all of the medicaid reimbursement charges. Is it your impression that it is really penny-wise and pound-foolish, that it is not a budgetary savings but, in fact, it is a loss?

What is your figure that you say you could save?

Mr. HYNES. I think the most interesting figure we have come up with is every time you turned an auditor into the field, he recovers $2,500 worth of fraud—that is, every day.

Senator Moss. Thank you very much, Mr. Hynes. We appreciate your appearance.

Before you leave, Congressman Scheuer has a question.

Representative SCHEUER. Mr. Chairman, Mr. Hynes, I take it part of your problem is money—part of the problem of the State legislature is that there is no money up there.

I put in a bill that provides where any county, city, or State sets up a prosecuting unit to develop medicaid or medicare fraud, that the Federal Government will pay the preponderance of the costs of that prosecuting unit. The Federal Government, of course, will recover a substantial part in restitutions.

Do you think that kind of provision, if it becomes law, would make it easier for Governors—like Governor Carey—who have financial constraints on them, that this would encourage them to set up prosecuting units to discover medicaid and medicare fraud?

Mr. HYNES. Without a doubt. I commend you for that, and I would strongly support such an action.

May I add one point to your question? The $2.3 million, which I have heard several times, is reimbursable by 75 percent, so we are not talking of $2.3 million—we are talking of something less than $600,000.

Representative SCHEUER. Thank you very much.

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

Mr. HYNES. Thank you.

Senator Moss. Before we call our first panel, Mr. Gerald Fried has asked that he be heard. We are pleased to accommodate you, sir, and will hear from you before we call our first panel.

STATEMENT OF GERALD M. FRIED, EXECUTIVE DIRECTOR, STATE ASSOCIATION OF HOMES FOR ADULTS, INC., NEW YORK CITY

Mr. FRIED. Mr. Chairman, on my side is Mr. Julius J. Rosen. He is my general counsel for the State Association of Homes for Adults, Inc., Mr. Chairman.

Senator Moss. We are glad to have you.

Mr. FRIED. Mr. Chairman and gentlemen, I have been requested by the State Association of Homes for Adults, Inc., a not-for-profit corporation which represents private proprietary homes for adults—PPHA's—in the New York City metropolitan area, to submit to you a statement in behalf of its members. The purpose of this statement is fourfold:

(1) To clarify what appears to us to be a basic confusion among legislators and the public of the purpose and functions of PPHA's;

(2) To describe the physical and operational characteristics of PPHA's;

(3) Review the costs and the remuneration for these homes for the services and facilities provided; and

(4) The methods of supervision of and remuneration to the operators of PPHA's.

Senator DOMENICI. May I ask a question? In your opening paragraph, you indicate the corporation you are representing is nonprofit.

Mr. FRIED. Yes.

Senator DOMENICI. But the members that make up your corporation—they are not nonprofit?

Mr. FRIED. No, sir, they are proprietary homes for adults.

Senator DOMENICI. Are there any nonprofit homes that belong to your association?

Mr. FRIED. No, sir.

SOURCES OF MONEY QUESTIONED

Senator DOMENICI. Where do your clients—the members of your association—get their money from?

Mr. FRIED. They get it from the Federal Government, generally; 25 percent is paid by the State government.

Senator DOMENICI. I know where it comes from, but I am just wondering why the paragraph in your statement seems to indicate that you are not getting paid from public moneys. Actually, it seems to me almost all of it is either State or Federal money that is being paid to sustain these homes. When your residents turn the check over to you, is that not SSI money—State and Federal money?

Mr. FRIED. What I said in my statement was, as opposed to statements that were heard here previously, that that money was paid to nursing homes, directly to the facilities, but that no SSI check is made out directly to a facility that is an adult home.

My name is Gerald M. Fried and I am the executive director of the State Association.

The State Association of Homes for Adults, Inc., represents 50 homes in the New York metropolitan area with an aggregate bed capacity of more than 9,000. This is more than 50 percent of the total number of proprietary adult home beds in the entire State of New York.

The association was established to serve as a spokesman for the proprietary adult home industry, to represent members before Federal, State, and local agencies, to provide representation in union negotiations, and to inform and educate the public as to alternative programs for those elderly who require residential care facilities. To this end the association is actively, in conjunction with State authorities, attempting to improve the quality of the lives of residents in each member home. For instance, the association voluntarily contributed substantial funds directly to the New York State Board of Social Welfare to assist the board in establishing a pilot recreational program for residents of PPHA's. In addition, we also initiated efforts several years ago to develop a "need" criteria for approval of certificating new PPHA's. The result of our efforts, finally

joined in by the State board of social welfare, was the present moratorium on establishment of new PPHA's as well as a limitation of the number of beds in any future certificated PPHA. Our primary concern in contributing to the recreational program and in endeavoring to limit the number of new beds in the industry was to improve the lives and living conditions of residents at PPHA's.

Member homes are certificated, supervised, and regulated by the New York State Board of Social Welfare and fall between medical facilities and independent living; that is, for individuals who do not require either skilled or custodial nursing care but who do require some assistance in daily living.

Two Categories of Adult Homes

The association basically is comprised of two types of adult homes. One category serves those who, because of advancing years and/or moderate physical disabilities, need to dispense with housekeeping for themselves, and choose to be with their peers in a congenial residential atmosphere. The second category is adult homes that provide aftercare for persons who had been in State institutions and who have been medically certified as competent to reside in a nonmedical facility with minimum restrictions until they are able to resume fully the normal life of the community.

Certificated PPHA's provide assistance in daily living for people who can substantially tend to their own needs and requirements, with moderate staffing for aid in daily living, and so forth.

The purpose of adult homes to the extent economically feasible is to provide an atmosphere that will give all residents: to the aged, the ability and the will to savor life, to participate in activities that will be physically and mentally invigorating, and enjoy their later years to the fullest possible extent; and to encourage those younger ones who are physically able to return to full, independent living and community life. In this regard, member homes in the association provide, among other services, recreational and educational programs, libraries, hobby classes, and current events sessions that enable the aged to remain informed, and various other programs—some with pay—for younger residents. PPHA's receive no direct payment for the services they furnish from either the Federal, State, or local authorities. The operators receive no medicare or medicaid payments for any services they provide but rather are paid directly by each resident out of the $386.70 per month supplementary security income payments they receive. Unless the resident is on social security, he normally retains a spending allowance out of his monthly SSI check. Thus the payment made to the facility by the resident is less than $12.72 per day.

Gentlemen, I think that you will agree that at $12.72 per day none of you would be able to obtain a decent or even halfway decent room in a hotel or motel in the metropolitan area, let alone food and the other services our homes provide.

The elderly poor who require residence in PPHA's are the political and journalistic footballs of our society. Indeed, so startling is the lack of concern by the State, Federal, and city governments for these elderly poor that all too many times these individuals arrive at an adult home from a hospital or State institution with no more cloth-

ing than a hospital gown. No funds are made available to these individuals through their SSI payments for the purchase of decent clothing and if it weren't for the fact that individual proprietors dig into their own funds and solicit charitable organizations, these individuals would remain in the same poor condition as they were under State care when the State was receiving from 8 to 10 times the amount that the residents receive to pay for their residency at the adult home.

Representative SCHEUER. [Discussion off the record.]

Senator DOMENICI. You may proceed.

Mr. FRIED. The only category of residential care—which includes furnishing aides to assist in tasks of daily living, such as assistance in feeding, dressing, washing, and walking; establishing recreational and vocational rehabilitation programs; safe, clean, comfortable quarters; properly nourishing and dietarily sufficient three meals daily; two snacks daily, and a good living environment—in which the cost-of-living factor has not and does not merit consideration, is the proprietary homes for adults.

PHYSICAL STRUCTURE REQUIREMENTS

PPHA's are required to be physically equal in almost every respect—for instance, room area, corridor widths, dining and recreational areas, sanitary and kitchen facilities, furnishing, fire retardation and safety devices, and so forth—to the physical structures and furnishings of health-related facilities, which are medical facilities. Yet they receive from their residents' SSI payment a maximum of $12.72 per day.

How do those who allege PPHA "ripoffs" explain medicaid payments of $35 to $40 per day to pay for almost identical services in a physically almost identical facility merely because it is called a health related facility and is defined as a medical rather than a residential facility based on allegedly established actual operating cost? How can PPHA's be expected to continue to operate on less than $12.72 per day when such proprietary adult home may be located on the same block or within a few blocks, be almost identically constructed, have the same labor union, pay similar real estate taxes, furnish substantially similar services, and, at worst, have a very slightly smaller staff than the HRF?

Much criticism has been directed against alleged real estate profiteering by PPHA's because a large percentage of the moneys paid them goes toward rental and/or mortgage and financing costs.

It should be pointed out that a 50 percent real estate cost for a large, newer metropolitan PPHA equals only $6.45 per resident per day.

It is a known fact that the HRF's average a real estate cost recognized as "reasonable" by New York State and medicaid of approximately $8.50 per patient per day. The average medicaid rate paid to HRF's located in the metropolitan New York City area is approximately $37.50 per patient per day. This reflects an average real estate percentage cost of HRF's of 23 percent of their total rate.

Accordingly, it is clear that critics of PPHA real estate costs are playing a numbers game. Your committee is aware that a similar physical facility in a similar area, subject to similar construction

and financing costs, must reflect such costs regardless of the gross rate paid. In short, gentlemen, the cost of construction, real estate, and financing is a real cost which is paid by the operator. This, rather than being a cause for criticism, should be a cause for serious concern, and only highlights the gross inadequacy of $12.72 per day.

Our association is deeply concerned over the fact that the government and the public appear disinterested with the fate of residents in PPHA's. If the resources known as PPHA's are forced into bankruptcy, where will these residents go? The alternative will be chaos and the return of thousands of residents to State hospitals or to the department of social services who will then have no alternative but to pay the much larger costs of caring for these individuals at other facilities. But even more devastating will be the impact on these individuals who do not require medical care and whose last remaining years must be spent in turmoil and inappropriate surroundings, compliments of the State, city, and Federal governments' callousness with their lives and the affairs of those individuals who have, under the most adverse circumstances, endeavored to perform an extremely valuable and necessary service to the community and these individuals by operating the PPHA's.

Two Facilities File for Bankruptcy

This chaos has commenced. Last summer, 1975, two of the State association's newer facilities filed petitions in bankruptcy. I have available with me for the committee's consideration a transcript [1] containing the bankruptcy judge's remarks which conclude that these two facilities could not survive even if fully occupied on $12.72 per resident per day. The history of efforts to obtain a proper rate is as follows:

Prior to 1974 when SSI payments came into existence, the rate paid to residents of adult homes was a negotiated rate for New York City and established by the commissioner of the Department of Social Services of the City of New York, who at that time was Henry Rosner. Commissioner Rosner, in March of 1973, while indicating that he was well aware that the then rate of $366 per month was grossly inadequate based on figures in his possession, stated that due to the President's wage-price stabilization freeze he had no power to give more than a 2½ percent raise which would increase the rate to these individuals to $375 per month. He stated that as soon as the freeze was lifted he would negotiate a fair rate which would be in excess of the then-established rate of $375 per month.

In December 1973, the proprietors met with the commissioner of Social Services of New York State, Abe Lavine, and his assistant commissioners in Albany. They were advised that due to the tremendous inflationary pressures since the Arab boycott, the previously inadequate $375 plus $28.50 personal allowance rate was now impossible for the homes to survive on. We requested an emergency fund as immediate aid. Commissioner Lavine sympathetically advised he would assist the proprietors to get this increase in a reason-

[1] Bankruptcy proceeding in the matter of Klein's Forest Manor, Inc. (75-B-1566) and Klein's Golden Manor, Inc. (75-B-1567) D.I.P. Aug. 4, 1975, U.S. Courthouse, Brooklyn, N.Y. Retained in committee files.

ably brief period. The implication clearly was that this assistance, even if emergency until all legislative problems which took longer to resolve were concluded, would be forthcoming in a matter of weeks.

Nothing happened for several months. Then we were advised that a financial survey would be made by Peat, Marwick, Mitchell to determine actual costs in order to justify immediate increases. Our member homes fully cooperated with Peat, Marwick, Mitchell in making available to that organization all relevant records and financial data requested with regard to operational expenses. Since this survey covered the costs of operation for the calendar year 1973, it was to have considered the inflationary factors of labor increases, food, fuel, energy, construction, interest, and so forth, taking into account a 1974 inflation projection. New Home costs were essential to be considered since, by 1975, over 50 percent of all beds in proprietary adult homes in the New York City metropolitan area would be in new construction and the cost of new construction and financing thereof were substantially above similar construction in existing facilities. The results of this financial survey were to be completed prior to June 1974, and a new proposed rate promulgated by July 1, 1974.

SURVEY RESULTS DELAYED

Even though this survey was completed in June 1974, the division of the budget for the State of New York, for some reason known only to itself, refused to reveal the results of this survey until April 11, 1975, and then only because counsel for the association demanded the release of this financial survey pursuant to the Freedom of Information Act.

Mr. HALAMANDARIS. A few minutes ago we extended you the courtesy of giving some time and to even placing you at the beginning of the witness list, because you asked in the name of fairness to give a brief opening statement, and to lay the foundation for forthcoming testimony.

We have been sitting patiently listening to your exhaustive remarks. I would appreciate it if you would stick to our agreement. Could you take a couple of minutes in summarizing your statement? We will see if the Senators have any questions to ask you, and thereafter if you feel a need to continue your statement, then we can arrange something at the end of the day.

Mr. FRIED. Fine. We can finish after the other witnesses finish today.

Senator DOMENICI. Proceed to summarize in a couple of minutes, and if you feel a need to testify further, we will try to work you in.

Mr. FRIED. May I say there are only 3½ pages left. It is a total of 4 or 5 minutes.

Senator DOMENICI. We can all read. I think you have made most of your points from what I can tell.

Mr. FRIED. The survey did not consider new construction costs, other inflationary factors such as labor increases, and so forth, nor a 1974 general inflationary projection. Subsequently, after numerous emergency letters, calls, and conferences we were advised that a supplemental audit of several new homes was being made. The survey

results reflected the gross inadequacy of the SSI rate of $375 in effect in 1974. To date, we have been advised the Governor cannot do anything without Federal cooperation—and so nothing has been done.

The proprietary adult home owners in the New York City metropolitan area have been advised most recently by the State that it is the "Feds" who have reneged on their obligations whereas the State can do nothing about it because if it does, it will bear the entire burden of such increased costs. The Federal Government must bear a large portion of the blame for this deplorable and inhumane situation. However, the State cannot so easily disregard its own major share of its responsibility. Over the past several years, it has discharged literally multiple thousands of former mental patients from State institutions into proprietary adult homes. When these individuals resided in the State institutions, the State contributed 25 percent, the Federal Government 50 percent, and the local government 25 percent of the costs of supporting them in the State institutions.

Since the average hospital cost per patient per day is $90, the total monthly cost per patient in these State institutions is $2,700.

Referrals Reduce Costs

The referrals of such individuals, when considered and declared competent by State psychiatrists for residence at adult homes, immediately reduces the cost via the vehicle of SSI payments, as follows: Federal $156.70 per resident per month, State $114.50 per resident per month, and city $114.50 per resident per month.

This creates a massive savings on each such referred individual of $1,193.30 per resident per month Federal, $536.50 per resident per month State, and $536.50 per resident per month city.

In gross, the savings on these referrals to the State and city alone aggregates hundreds of millions of dollars.

Nevertheless, the governmental authorities refuse to pay a survival rate which will enable PPHA's not only to continue to provide their essential services but also to continue to save massive dollars for the Federal, State, and local governments.

Finally, the incongruity of having three separate New York State departments control proprietary adult homes becomes apparent when it is considered that the New York State Board of Social Welfare has the authority to oversee staffing, construction, and operation of these homes. It can formulate rules which increase construction requirements, which increase staffing requirements, and which generally increase substantially the costs of operation of these facilities. However, it has no authority to compensate these facilities for these excess costs imposed upon them.

The department of social services which contributes to the payment has thus far indicated that it has no control over the Federal Government and therefore cannot increase the rate even though it has clearly determined it inadequate and even though it could justify such increases. It does not want to do so because it might cost the State money, or at least more money than it believes the State should contribute. The New York State Department of Mental Hygiene

is also imposing additional requirements without additional compensation. Insofar as medical facilities are concerned, the same department which calls for added costs—or even which is notified of legitimate added costs—can and does increase the rate of these facilities to compensate the hospital, nursing home, and health related facility operators for such increased costs. The sole department handling such factors is the Department of Health. By this means, medical facilities are able to withstand the inflationary costs, provide required services, and yet receive their costs plus a profit margin.

INEQUITIES MUST BE CORRECTED

This statement is submitted for the purpose of indicating that this industry affects every single individual in this State. Most individuals, upon arriving at an age where they require this type of assistance—and this pertains to 98 percent of the population, regardless of current age—will require adequate care and residence, preferably at an adult home. The denigration being achieved by paying a rate which is inconceivably low at this point in time and which has been maintained at this low level for a full 3 years, despite all other areas of the economy requiring substantial increases to merely stay even, is well on the road to depriving the Federal, State, and local governments of an invaluable resource. It is factually and historically true that the Government is incapable of providing equivalent services directly at even triple the rate currently being paid by SSI to PPHA residents. Further, it would take years and billions of dollars to duplicate on a public or voluntary basis the existing proprietary facilities. Therefore, every effort should be made by the State and Federal Governments to correct the flagrant inequities outlined herein and to preserve the integrity of the existing facilities.

Senator DOMENICI. I have a few questions of you, but I will yield first to the Congressman.

Representative KOCH. Thank you.

I remember that almost a year ago we heard testimony similar to yours. Those hearings were held as a result of the desire of public officeholders to examine an industry which had not previously come under public scrutiny. I suspect that as a result of those hearings a number of people now hold a different point of view with respect to the nursing home industry. There are several people, as you know, who have since been indicted and perhaps even some will go to jail.

Now, you tell us we ought not be interested in the domiciliary end of the industry, in the sense of having hearings and determining whether people are receiving adequate care. You have pointed out that these homes are getting only $12.72 a day for each individual, and you ask where a person could receive the kind of care provided in these proprietary homes—provided to people who are the direct recipients of Government payments which they sign over to the home. And you say that is not Federal money.

Having made that premise, I am perplexed by the special prosecutor's statement that he has come up against considerable resistance in his efforts to investigate the nursing home industry, including the proprietary homes. You say there is no resistance to looking into this matter.

Mr. FRIED. May I interject?

Representative KOCH. In one minute, and then you may.

You say there are already three State agencies in some way or other controlling the investments of these homes. Is that not what you told us?

Mr. FRIED. Yes.

Representative KOCH. Apparently they are not doing the job, according to the special prosecutor, so why do you think your industry should be exempt from scrutiny?

INVESTIGATION WELCOMED

Mr. FRIED. Congressman Koch, first of all, I would like to explain. I do not believe, in any part of my statement, that I am trying to exempt the adult home from being investigated. On the contrary, I would welcome an investigation. I welcome this opportunity. I want to thank Senator Moss and Mr. Halamandaris for giving me the opportunity to express my views.

We have been trying for 3 years to get somebody to pay attention, to explain that we are not nursing homes—that there is a difference between $12.72 and $60 a day.

Representative KOCH. Maybe we are not so far apart then.

Mr. FRIED. In reference to Mr. Hynes—we have no objection to Mr. Hynes coming in.

Representative KOCH. That is the key, because at this moment, although I am not aware that any of your member homes is in violation of existing laws, there ought to be an investigation, because allegations have been made that the kind of care given is inadequate. You just told us that you welcome such an investigation. Is that correct?

Mr. FRIED. That is a fact.

Representative KOCH. And are you not coming before this committee with basically a plea for an increase in your rates? Is not that what you are telling us?

Mr. FRIED. First of all, it is to educate the public—to differentiate between nursing homes and adult homes.

Representative KOCH. I understand, but all I am saying is that you feel that your rates are not adequate; you do not want to be compared in terms of care with the nursing home; and you would like to receive more money than you do at present. For what purpose? Explain that.

Mr. FRIED. I am requesting an increase in rates for the proprietors of the adult homes, but for the sole purpose of trying to comply with all the rules and regulations for the residents in the facilities.

Representative KOCH. I understand, but this is not a rate agency body.

Mr. FRIED. This is a factfinding commission.

Representative KOCH. Exactly.

Mr. FRIED. I want to give you the facts, and to let the public know what they are, so that everyone will judge on that basis.

Representative KOCH. And the facts as to whether the nursing homes or domiciliary facilities are providing the level of care that they are required to give will not be established over this table. It will be established by an independent audit to be made by the special prosecutor. And you have no objection to that?

Cooperation With State Audit

Mr. Fried. On the contrary. I explained to you before, when the State budget department audited, we volunteered the information.

We have sent the commissioner of social services a telegram, volunteering financial statements. We never got any result.

Representative Koch. Let me conclude my questioning by saying this: I hope such an audit takes place, and I hope after the audit has taken place by the special prosecutor that we do not find what we found in the case of Dr. Bergman.

Mr. Fried. That is why I came here—to avoid that kind of allegation; that is why I requested the opportunity to speak.

Senator Domenici. Congressman Scheuer?

Representative Scheuer. I am impressed by your answer to Congressman Koch. I hope that you would feel that with some extra funds you could also perform the additional functions, something in terms of looking after these patients.

Do you have provisions for emergencies—the kind that have been widely covered in this paper? For example, bed checks, perhaps several bed checks, one at 11 and then one at 1:30 a.m., to see that people are not missing from their beds. What about adequate staff for recreation, entertainment, and various kinds of therapy programs?

It is perfectly obvious that you cannot afford that on $12.72 a day, but I would hope that with more funding, you could provide the kind of services, facilities, and protective support necessary for these patients. They are urgently needed.

Mr. Fried. I believe in your file you should have a letter from your office to mine, and a reply from mine to yours, whereby you requested a few months ago that you were doing a report on adult homes, and you requested information.

I believe in my letter, I volunteered all of that information to you—and my help and my office's help at any time.

As far as your statement is concerned, yes, we request, and we would like to have an investigation of the industry to give us a chance to get publicity, but perhaps good publicity, and an opportunity for residents to get the extra care that we feel they need and deserve.

Representative Scheuer. I agree with you, and I hope that when you get extra Federal funding it will include guidelines for such facilities. This should include fire and safety measures, adequate inspection of services and programs, as well as professional standards for the administrator and other personnel.

Mr. Fried. May I explain——

Representative Scheuer. We should have really thoughtful and meaningful control, not only over the quality of the food and board and the real estate and sustenance, but over the quality of care, quality of TLC—tender loving care—the missing element.

Mr. Fried. I do not want to go into it too lengthily, but I just have in front of me—I am glad the executive director of the State board of social welfare is here, but this is his testimony at a joint public hearing before the Committee on Mental Health in Albany, in which Mr. Shapiro states—and I am sure he will reaffirm—that there is extensive supervision, that there are extensive laws, that all

of these homes must be fireproof, even though the homes must have sprinkler systems, and there is a constant inspection day and night.

Fund Shortage Thwarts Adequate Supervision

However, I would agree. It is impossible to completely supervise these homes, because there is a lack of funds, and the homes themselves cannot comply with what they would like and what the State and local agencies would like because of a lack of funding.

Mr. Rosen. The thing that appalls us, the proprietary operators, at least in our association—you must recognize that these homes are the mainly large homes located within New York City, in Nassau County, and the metropolitan environs; the result of that is that they face the largest real estate taxes, the highest cost of operation, the highest union costs in the State, and they have the problem of inflation.

As a result, if any facilities are to be provided before the shell—that is, the facilities available for these people—there must be certain costs to be met.

What we are concerned with—both Senators, in their statements, implied that various physical facilities, as well as the services, were not being provided satisfactorily in these homes.

It is inconceivable that these homes can support these large, necessary, and very complex constructions, these facilities, particularly in the New York metropolitan area, on $12.72 a day.

There is no room for ripoff. The reason staffing is not fully complied with in many homes is that they cannot be foreclosed, they have to meet their rental or their financing costs, which in many cases comes to $7 to $8 a day per patient.

If you get $12.72 a day, and in order to have that facility survive and not have it close down, you must pay these costs, which are considered completely reasonable. You must keep in mind that these are not medical care facilities and they will not have the care of a nursing home. But for 4 years, most urgently, the last 2 years, these homes have been going before the New York State Senators—that is, the Federal Senators—their Congressmen, the assemblymen, the State senate, and the facts are important here, these are facts. What is of concern to me is that we got no reaction, except we got these very denigrating remarks, and that is because there is not a clear distinction in the mind of your committee between domiciliary care facilities and medical facilities. It is crazy to think that there can be a ripoff on $12.72 a day, comparable—as the comments that Congressman Koch made—to someone getting $40 to $50 a day. There is an awfully lot of difference, and there is room for ripoff.

Again, one of the reasons it appears to me that Mr. Hynes is unable to get the permission of the board of social welfare—and I cannot speak for them, I did not know that until today—it would appear to me the board of social welfare has no control whatsoever over funding or financing or payments of the rates of these people.

Criminal Activity Denied

Medicare and medicaid are not involved; therefore, it would appear if there is any crime—that is why we so urgently invite an investigation, more than just welcome it. Mr. Hynes cannot find a criminal

activity here that you could find with nursing homes because all we have here is an approved agreement, one that has been approved by the board of social welfare, which is an agreement between the residents and the homeowner.

Obviously, who are they ripping off at $12.70 a day? What crimes can they possibly have committed?

Mr. Hynes indicated there is some connection between nursing home operators. To our knowledge, at least in our members' homes, that is absolutely untrue.

Senator DOMENICI. All right. We have a very lengthy agenda to go through yet.

Senator Moss. We have given you the courtesy of putting you on at the beginning of the agenda, when you came forward and asked us to do it.

We have heard you fully, and we appreciate your statement. We will consider it very carefully. But we do have a pressure of time. We are running about an hour late at this point from where we had planned to be.

Mr. FRIED. Thank you, Senator.

Assemblyman STEIN. Mr. Chairman, just very briefly.

As you know, I have been to many of these adult homes, and I think there is a lack of definition in what we are talking about. It seems to me they are not really adult or boarding homes. The majority of the people there are really people from mental institutions. I went to one last night where the owner told me that 95 percent of the people were former mental patients—some with 40 percent, some with 50 percent mental disabilities.

It seems to me, and I have talked to many of these patients—it is a bad idea to mix these former mental patients with ordinary elderly people who are just going there for residence. We are running behind now, and some of what you say is true.

I think other things you said are not true. There is a lot of bad care going on in these homes, and in many cases the funds are insufficient. I think Mr. Hynes would do well to investigate, and I think you would find a lot of criminal activity.

Let me ask you this question: What do you think about mixing the number of mental patients with people who need a place to live?

Mr. FRIED. First of all, let me explain, that I know—I have been apprised of the homes you have visited. You have visited just a few of the homes so far.

Assemblyman STEIN. I visited six.

Mr. FRIED. You did not visit any of the real nice homes. You picked out one or two individual homes that are comprised of former mental patients of the State hospitals. Your question specifically was: Is it a good idea to mix?

I believe that the New York State Department of Mental Hygiene, in an agreement with the State board of social welfare, limits the residence of former mental patients to 40 percent of the facility for the expressed purpose, and keep this in mind, that the adult home is not the final point that the nursing home is.

HOMES USED AS "STEPPING STONE"

It is a stepping stone for the individual from the hospital to be reintegrated into the community, and this will give them an oppor-

tunity—these former mental patients, who have been certified by any competent psychiatrist to leave these hospitals—to go into these homes, mix with the population, and use these homes as a stepping stone to return to the community.

We have many of the homes that absolutely have none, and I would invite you and the committee to possibly visit some of these.

Assemblyman STEIN. I have been to eight. My staff has been to two dozen of them. All of those places we have been to have had an overwhelming number of mental patients.

Mr. FRIED. As I explained to Congressman Koch, we would welcome an inquiry.

Assemblywoman LIPSCHUTZ. If I could state—I am wondering why people would want to go into the adult home business if they are not making a profit.

How many of the adult homes in the Rockaways are members of your association—the State association?

Mr. FRIED. Well, I would say 95 percent of the adult homes in the Rockaways are.

Assemblywoman LIPSCHUTZ. All right.

Was that unfortunate incident that we had of a resident freezing to death—was that from a home that was a member of your association?

Mr. FRIED. No, and I would like to explain. That is a medical facility—a health related facility that had nothing to do with an adult home.

Senator Moss. Well, we do have a long agenda, and we must go on.

We thank you very much. Your documents have been received—the public assistance programs analysis [1] and the transcript in the matter of Kleins' Forest Manor, Inc., and Klein's Golden Manor, Inc.[2]

We will now turn to the panel made up of Mr. Charles Platzner, Far Rockaway, N.Y.; Mrs. Sarah Klein, Palace Home for Adults, Long Beach, N.Y.; Mrs. Joffe, Cornish Arms, and Mr. Ted Connolly, Sutton Place.

All of the members of the first panel please come on up.

Let us start with Mr. Platzner.

Mr. Platzner, I am told you are a retired plumber, is that correct?

STATEMENT OF CHARLES PLATZNER, FAR ROCKAWAY, N.Y.

Mr. PLATZNER. Yes, sir.

Senator Moss. Where do you live now?

Mr. PLATZNER. I am now living with my son.

Senator Moss. You formerly lived in the Paradise Home?

Mr. PLATZNER. Yes.

Senator Moss. When did you move into the Paradise Home?

Mr. PLATZNER. May 14, 1975.

Senator Moss. Will you tell us how old you are, Mr. Platzner?

Mr. PLATZNER. Seventy-six.

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[1] "Public Assistance Programs Analysis: Medicaid, SSI, and Home Relief for the Aged, Blind, and Disabled," by Mark E. Hamister, president, Upstate SSI Action Coalition of Adult Homes, Inc., Rochester, N.Y., dated Jan. 20, 1976. Retained in committee files.

[2] Retained in committee files. See footnote, p. 3557.

Senator Moss. You were telling us when you moved into the Paradise Home, now will you tell us why you moved into the Paradise?

Mr. PLATZNER. My wife died on the 17th of November 1974. My children did not want me to continue down there, so I came up north, and I got very lonely.

My daughter went to work. She left home for work at 8:15 in the morning, and I was going crazy.

Senator Moss. You were alone all day long?

Mr. PLATZNER. Yes. I cooked my own breakfast and lunch, and I finally joined one of these senior clubs, which gave me about 2 or 2½ hours a week, and it got pretty lonely.

I moved in with my son, and he was out of work. He is still out of work. He is a New York plumber, and he gets a job here and there. I asked him, at Long Beach, I said: "Let us take a look at one of these things."

I told him that I cannot go on like this any more—that I had to be with people, if you call them people. I finally wound up at the Paradise.

Senator Moss. And that is when you moved into the Paradise—you decided to move in there at that time?

PRESSURE USED BY THE ADMINISTRATOR

Mr. PLATZNER. Yes. When I talked to him, he tried to pressure me to move in the next day. I told him my daughter is away for a few weeks, and I could not move in right away. He says if you move in right away, I get my money more quickly, and I said I would move in on the 14th. It looked pretty good. The food was not bad. I am of the Jewish faith, and it was not too bad.

Senator Moss. It looked like it suited you very well from your appearance.

Mr. PLATZNER. I lost weight.

Senator Moss. You are back with your son now?

Mr. PLATZNER. Yes. There are five or six points that I would like to mention.

There were several problems. There were five or six people at a table in that home, and the flatware, I had to take the flatware and put it in a glass of water, and take a couple of paper napkins to wipe it off. The plates were dirty, and the food stuck to the plates.

Well, anyhow, the elevator would break down seven or eight or nine times a week.

I walked by the men's room one morning and I saw a young person—not young—I mean a short man about this tall, may his soul rest in peace; he is dead now. He was using the waste basket for putting his urine.

I just happened to walk by, and I said to him: "It is going right over the top of your head if I see you do that again." I walked over to the desk and I told them that I saw this man using the waste-basket, and I told them if I see him do it again, I will turn it upside down and put it over his head. I got a laugh from them.

Senator Moss. Did the elevator break down frequently?

Mr. PLATZNER. Very frequently. Some people had to walk up five or six floors.

Senator Moss. How many floors are there in the Paradise?

Mr. PLATZNER. I think six. I was in 603.

Senator MOSS. Six floors?

Mr. PLATZNER. Yes.

Now, immediately opposite my room there is a fire exit door. We could not open it, but if you got it open by kicking the door with your foot—you might open it that way. The lock was shot. I fixed the lock a few times. I reported it, and if that door is in that same condition—Lord forbid, if a fire ever broke out, nobody could ever open that door.

You can just close it, and that is it. And the firehose there ought to be replaced.

Now, it was at this time I made up my mind that I was going home. I think in the course of about 9 weeks seven or eight went out horizontal. One lady took an overdose; she was in her bed dead, covered. A policeman was sitting outside her door for 3 nights and 2 days.

Senator MOSS. Well, was there a doctor that came to the Paradise? Did you have a doctor that visited with you frequently?

Mr. PLATZNER. Periodically, at the end of every month, I was checked.

QUALITY OF MEDICAL CARE QUESTIONED

I doubt very much that the kid was licensed. Back in the lobby, two young girls came there before the doctor did and would take the names, what was wrong, and—the main thing—then we had to sign the medicare slip.

Senator MOSS. The medicare form?

Mr. PLATZNER. The form for the money.

Well, the doctor would finally sit down, take out his stethoscope, and that was the end of the examination.

Senator MOSS. Did he examine you one at a time, or several at a time?

Mr. PLATZNER. Several at a time.

Well, I made up my mind that I was going to do a little bit of checking around. One month they had about 25 or 30 people there. I sat in the lobby, and it took them 10 or 15 minutes. What kind of an examination can a doctor give in that amount of time?

I was told the next morning to come in for the results. I got a cardiogram and I got a chest X-ray. The nurse said to sit down outside of this room. I said, "What is next?" She said, "Blood test." I said, "I am sorry; I am not taking any blood test here."

She asked why, and I said I was not going out of there with an arm full of holes.

You take this blood test, and sometimes they hit the right spot. If they do not, you get a blue mark on your arm for a week. I said I would not take the test here, and I would go somewhere else.

Now, there are some people that should not have been there.

Senator MOSS. Are there a lot of sick people in there?

Mr. PLATZNER. Yes.

Senator MOSS. Very sick?

Mr. PLATZNER. There were three sisters. One of them was sick at the time I was there; one of them was blind; and then the third sister was pretty spry—she was mobile. She just pulled along the

other; she fed her. Then they went back up, and that is all these two girls had ever done. That is all I ever saw them do.

Senator Moss. Did you have trouble with the heating at all over there?

Mr. PLATZNER. Yes. At the time I was there, I did not need any heat. I went out on the 17th of September. We did have some cold nights, but the heat was not bad.

Well, I declared myself. I said I was going out. I said I could not stand it there any more. I told my son that the food is rotten. When they serve you sour cream, you need a straw to drink it.

I said to the waiter, "Joe, why don't you get me some good sour cream?" He said, "Yes; I like you."

I said, "Will you do me the favor? Whenever you serve my sour cream, just make sure it is good."

Senator Moss. You wanted sour cream which you could pick up with a spoon and not use a straw?

Mr. PLATZNER. That is correct. He said, "I know," and he patted me on the shoulder. He said, "OK, Charlie, you will get good sour cream."

Assemblyman STEIN. Mr. Platzner, did the manager of the home ever suggest that you sign over the SSI check to him, even if you went on vacation?

Mr. PLATZNER. Not in the Paradise.

Assemblyman STEIN. No, in the Jackson Home.

"SSI CHECK GOES TO MANAGEMENT"

Mr. PLATZNER. I could mention that one party I know of goes there every summer. I did see him—when he disappeared, he went away to see his son, and someone told me the story that when he goes away for a period of time, he keeps his social security check, and the SSI check goes to the management. I had this approach made to me, that if I could jump to the Jackson Home—I had been contemplating for about a month to go to Florida in January. I told one of the new owners, supposedly—I said to this guy, "Nat, I met a nice lady, and I am contemplating going to Florida for the month of January."

So he said, "Are you coming back?" and I said, "I don't know, Nat."

I said I might stay a month; I might stay 2 months. I said, "I am going to want my SSI check, and when I come back, I think I will move in with my son. I cannot stand these places anymore."

He said, "Don't do anything with the social security check. You go to Florida, and you let me know where you will be. I will mail you both checks, you keep your social security check, and mail me back the gold check; just endorse it."

I may sound stupid, but I said, "What are you going to do? Are you going to keep the check?"

He said, "At least, you will come back to a room, and I will hold the room for you. I will keep the gold check, and you keep your social security check."

I said, "Wait a minute. I do not live that way." So I gave him a deal, I said, "Suppose we split the gold check—you keep half, give me half?"

Senator Moss. That is the SSI check?

Mr. PLATZNER. Yes. He said, "Look, I am keeping the room for you."

I said, "Nat, don't keep the room for me; rent the room. When I get back, maybe I will come in here. If you do not have a room, I will go elsewhere."

Well, anyhow, I said, "When the check comes, I am going home, because I have got to take this check to the city hall building on Friday afternoon," and that was December 5, which I did. I went off SSI, and I reapplied for medicaid.

Now, I think it was the 2d, the 3d, or the 4th of December—this could be verified—at 10:30 or 10:15 that night. It was 24 degrees and you could not close the window.

You hit it, and it would jam a quarter of a inch high. That is it. I went to bed that evening but I could not fall asleep because of the cold.

I came downstairs for the night man. I said, "Can you send some heat up here? I am frozen up here."

He said, "I cannot get heat up until tomorrow morning." Well, my roommate, they gave him a warm room on that cold night. I told them that I can stand it better than he can, but when it gets down to 24 or 26 degrees, it is cold.

LAMP USED TO KEEP WARM

I took the lamp off the night table; I took the shade off—it had a 100-watt bulb in it—and I stuck it by my head. I got dressed, and I went down to the lobby. I figured if I sat in a soft chair, maybe I could fall asleep, but I could not.

Well, the same thing happened the next night. I went back up into the room about 2:30 and I packed my clothes—packed everything up. Then after breakfast, I called my son, and I said, "Will you come down for me?"

I got my things down. Now, I might add, I beat it out of there, because I was in there enough to owe them something. But my son was a little late; I had most of my things downstairs, and I had my little refrigerator.

When I came up for the refrigerator, this guy was already in my room. He took my refrigerator out, and my son came in. He demanded $114 from us.

I said to my son, "Have you got that?" and he said, "I don't have it with me."

Senator Moss. So you wound up at the Jackson, and then you went back with your son?

Mr. PLATZNER. Yes.

Senator Moss. Well, we do have some other members of the panel, and then we have a couple more panels, so I think we better move on and hear the other members of this panel.

We will now hear from Mrs. Sarah Klein of the Palace Home for Adults, Long Beach, N.Y.

You are Mrs. Sarah Klein?

STATEMENT OF SARAH KLEIN, PALACE HOME FOR ADULTS, LONG BEACH, N.Y.

Mrs. KLEIN. Yes.

Senator Moss. Where do you live?

Mrs. KLEIN. At the Palace Home.

Senator Moss. How long have you been there?

Mrs. KLEIN. Since July 12, 1973.

Senator Moss. And can you tell us what is wrong with the Palace Home, if anything?

Mrs. KLEIN. Everything is wrong. I cannot see one thing that is right.

First, I went there on a 2-week vacation from where I lived, and it had become a nightmare. It was a jungle where I lived. I got sick. I went for 2 weeks' vacation, and I figured, why go back to the same thing, and I stayed at the Palace. Then I started with this nightmare; when I got my mail, they opened it.

They look over everything, they sort everything, and they call you in. He opens up the mail, and he turns around and says "Sign it."

Senator Moss. This is the manager?

Mrs. KLEIN. Yes.

Senator Moss. And he opened the mail, took the check out, and asked you to sign it?

Mrs. KLEIN. Yes, and that is not all. I have quite a bit to tell you.

Now, I got $300 per month. I was short $46, with my union pension and my social security.

TIPS NECESSARY TO OBTAIN FOOD

My son went to Mineola to apply for the difference. I was allowed $20 spending money. I did have it, but I had to pay the tips—if I did not pay the tips, they would not give me anything to eat.

I went to Mr. Appel and said that I had a problem. I said the waiter would not give me anything to eat, because he raised the tipping from $2 to $2.50, and I cannot afford it.

He said to give him a little extra money. I said, "You want me to run the hotel and pay him?"

I have not got the money. I am still being treated as a stepchild because, at the present time, I do not pay my tips because I cannot get along on $20 per month.

Another thing: They made the mistake and sent $451 retroactively. It was retroactive for July.

In January, they kept on asking me for the $75 a month extra, because they had made a mistake. They sent it to me retroactively, and I said to him, "Why do you want me to give you the $75? Where is it to come from? Do you want me to rob a bank?" He insisted that every month, "When are you going to give me the $75?"

I said, "You write to them; that is your problem. You are asking for an increase, and every time we get an increase, you take it out of us."

I said "You not only take it all, but you take money that you are not supposed to take."

Now, there is something wrong with my union pension, which was $71.50. Then the computer machine made a mistake, and he did not get the money, so he asked me for the gold check—the SSI check.

They sent me $29, and he then took $9 out of it, and I could not get along with the $20 either.

To finish up, there was a lovely lady there, and she was the only one to help me. I have been all around, asking where I stand, what happens here, but whenever I went anywhere, they told me that I have no trust in anybody in Long Beach. Another time I was sent a check for $611. I never asked for one penny, and then they asked me to endorse a check and send it back.

I did, but I had a photostatic copy made of it.

Anyway, I wrote a letter, and after consideration, they wanted me to keep this $611. But the social security office had it over there.

Senator DOMENICI. Who asked you?

Mrs. KLEIN. The social security office in Freeport. In fact, I gave a gentleman—Mr. Feldman of Andrew Stein's staff—all of the mail. I am ashamed to say what he—Mr. Appel—called me. This was before I gave my mail to Mr. Feldman, in reference to the money.

He was afraid of me. He thought I knew too much, and that I was talking to too many people.

Those people don't like me because I can read the letters, sew on the buttons for the people that live there, and they look to me for help. He does not like that. One day he grabbed my wrist and called me a—I am afraid to say it—but it was "son-of-a-bitch," and he grabbed hold of my wrists and said I can go to the Crown or to the Jackson. So I am afraid of him.

ALLEGED THEFTS OF CHECKS

He is very handy with his hands, and many a person there do not get their checks for the $20. He keeps them. They confide in me and tell me.

Senator Moss. What you are saying is that he keeps the spending money?

Mrs. KLEIN. Yes.

Senator Moss. I see.

Mrs. KLEIN. The check I get is mine, and it is not to be spent on tips. I stopped giving tips, and I am being treated like a stepchild. Four times the waiter refused to give me my food just because I did not give him tips, and I got so angry. I said I will eat what I have upstairs, and the waiter said, "You see this boiling water? The next time you say that, I will throw it at you." I told the waiter the other day, "You forgot again to give me something to eat," and he said, "I am not afraid of you."

I said, "I am not afraid of you." He said, "Hit me."

I said, "I cannot hit first. You hit me, and I will hit you back."

Well, I am afraid of this man, and I am afraid of Mr. Appel. If he finds out that I am here, I will have an accidental death.

Senator Moss. We thank you very much, Mrs. Klein. We'll try to make sure that doesn't happen.

We will now hear from Mrs. Joffe.

Mrs. Joffe, do you have a problem?

STATEMENT OF REBECCA JOFFE, CORNISH ARMS, NEW YORK CITY

Mrs. JOFFE. I am not on SSI. There are other people on SSI, and they pay extra money besides what the SSI allows the home.

I do not believe they—the owners—are making money. They claim they are not, and I believe they are not. But there are a lot of things that could be corrected with the money they are receiving.

I live at the Cornish Arms, a home for adults. Most of the residents here are aged, with a sprinkling of younger residents who are mentally ill, blind, or otherwise disabled. There are alcoholics here too. None get rehabilitation services.

The mentally ill deteriorate mentally and physically. I have noticed in the past year they have lost a good deal of weight, and they talk to themselves more than ever.

Occasionally, when one gets out of hand, the switchboard operator will give the person a tranquilizer.

No one bothers talking with them. They live in their own world. No one, including the aged, get any assistance in bathing or dressing. As long as one can walk with the help of a walker or cane, the resident is admitted. The blind depend on other residents.

There are many deaths here. Evidently the residents do not realize their illness is very serious, because they do not get a physical examination here when they are ill. Some will ask to go to the hospital—sometimes too late. Others say nothing; they just call the switchboard operator to have their meals sent up.

The management often does not know that the resident is ill. When one is missed in the dining room—at the dining room table—a friendly tablemate might call to find out why.

ELEVATORS IN DISREPAIR

There are two elevators, but they break down often. When in use, they are overcrowded, with no one in charge.

Over 200 have to come down to the dining room for their meals. When those elevators are out of order, the freight elevator is used, which is not insured. Some residents use the stairway. Most residents do not navigate very easily.

The windows do not open or close easily because they are stuck and are very dirty. They have not been cleaned since the hotel became a home for adults. The rooms are carpeted and have drapes, which makes a first good impression. There is quite a staff, but none for assisting those that need assistance for bathing and dressing. As a consequence, they have body odors. Their clothes are not clean.

Senator MOSS. Who wrote that letter?

Mrs. JOFFE. I wrote that letter to the Moreland Commission, but since last week, all of a sudden, there is a lot of activity.

They have thrown out the dirty furniture on the 12th floor where they want us to sit with these people who are fighting all the time, drinking, and smoking. Some of us do not go up there. What we do is stay in the dining room a while after our meals. We sit until the cook chases us out and turns off the lights. He uses very vile language, because we do not want to go up to the 12th floor.

Senator DOMENICI. What is the name of your home?

Mrs. JOFFE. The Cornish Arms, and this is at 315 West 23d St.

Senator DOMENICI. In Manhattan?

Mrs. JOFFE. Yes, New York.

Since I wrote this letter, they—the management—have started doing things that they could have done a long time ago. I got the code on smoking from the health department. They handed it right back to me after I showed it to them—that no smoking is permitted in the elevator and in the dining room. Most of the people who smoke blow the smoke in the others' faces, and when we asked them not to smoke, for spite they blow the smoke right into our faces.

This week they changed the seating arrangement. They put the smokers in one dining room and nonsmokers in another.

Last week they threw out the dirty, burned furniture.

Senator Moss. They are making some progress?

Mrs. JOFFE. Yes; somebody called me up and said that there were going to be changes, because I wrote to the Moreland Commission.

I know there will be reprisals against me when they find out that I testified at this hearing.

Senator Moss. This is what we will try to make sure does not happen.

Mrs. JOFFE. And when they fight with each other——

Assemblyman STEIN. What do you mean by "they"?

Mrs. JOFFE. Just some very mean, bad-tempered residents who are alcoholics, not the mental patients.

There are a lot of alcoholics, and only last week they put a mental patient in the hospital. One alcoholic was transferred a few months ago.

I am afraid to go into the elevator. I got a karate chop across my wrist one time for holding the button for those that wanted to come in. There are those that want to go down in a hurry, and they do not want to let anybody in, so you have to be careful.

I walk downstairs now, which are poorly lighted and very dirty, but I want to escape being hit.

Senator Moss. I would like now to hear from Mr. Ted Connolly of Sutton Place.

STATEMENT OF TED CONNOLLY, NEW YORK, N.Y.

Mr. CONNOLLY. Thank you.

Senator Moss. And you are Ted Connolly?

Mr. CONNOLLY. Yes.

Senator Moss. And you are the son-in-law of Henrietta Stuve, and she has been missing from Leben Home since August of 1975?

Mr. CONNOLLY. She has been missing since November 17, 1975.

Senator Moss. Will you explain how she was lost?

Mr. CONNOLLY. The first report any member of the family had of her being missing, or of anything irregular happening, was approximately 32 hours—the next day. At approximately 5 p.m., the family was notified—not that she was missing, but a call came to the family: "Do you know where she is? Is she with the family?"

My wife—the daughter specifically got the call.

She naturally became excited. She said, "No we do not know where my mother is. She is supposed to be there."

We immediately started making calls—investigating. My call was made back to the home, and I was told, "I am sorry; we cannot notify the police. The police cannot be notified until somebody is missing for at least 48 hours."

I said, "This is kind of irregular," and I just wanted to verify it.

I called the local precinct, which is the 110th precinct, and asked the desk officer to explain the situation. He said, "By no means do they have to wait 48 hours. We are supposed to be notified immediately."

He said, "I will send a police officer to get the details."

He said that was being done. This is now Wednesday morning, 2 days after my mother-in-law had been missing—or at least reported at the time of her disappearance from the home. The actual time is in question, and my wife and niece went to the home to try to determine from her belongings what, possibly, she was wearing to help the police identify her.

Home Delays in Notifying Police

When they got to the home, the police still had not been called. When the home said that the family was extremely agitated, they very haggardly called the police. The local police precinct—the police officer—arrived and started to get the details.

The representative of the home said to the police officer, "This is not necessary; we do not require a missing person's alarm to be sent out. We have our own means and methods of investigating these things."

The police officer immediately turned to the family, and then he said, "Are you declaring her missing?"

The family said yes. The police officer informed the home, and then the family's request took precedence.

They proceeded to fill out the details—what she was wearing. I might say, on this date in November, quite cold, all that we know is that she was wearing a pair of blue house slippers, a black and gray dress, no coat, no sweater—no outer garments whatsoever—and yet, this was the middle of November and very cold.

The 110th precinct filled out the details and said it would be filed with the missing persons bureau. That evening, as a matter of procedure, I called the missing persons bureau to list an additional telephone number that we could be notified at, and which was in operation 24 hours a day.

The missing person's bureau advised me that, "We cannot even talk to you about this case." The home interceded, and they said the family was not to be notified—that there was a mistake made, and that the home was to be notified.

I said this is not the case at all.

He said to call the 110th precinct to get it corrected. I did that. The 110th precinct called the missing person's bureau and said that the family was to be listed—the two telephone numbers were to be listed. I can say that the missing person's bureau—the detective in charge of the case—has been most cooperative.

Also, I would like to say that the police officers of the 110th precinct have been most cooperative.

Subsequent to this, I was at the 110th precinct, at the invitation of the officer, to address all of the police officers at 7 a.m. to appeal to them, with a picture, for help.

They have been commended for this, but by the same token, I would say for the record that the home has been very negligent—and I would emphasize that, negligent—in withholding information and in not cooperating.

It can only be emphasized by the fact, when calling there for information, the manager was not available. He was always too busy.

I finally had to get the social service department to give the name of another one of the owners—which, up until that moment, did not even know of the problem—to intercede and to get the information.

The home has not cooperated in any manner with a fulfilling of this investigation—to the contrary. After 2 months had lapsed we felt it best to go to the home to remove her clothing. The home was called during the day and told we would be out that evening to get her belongings.

When we arrived that evening, the office had not communicated with anyone about us removing this.

Staff Reports "No Patients Missing"

Going back to the police investigation and to prove negligence, when the police from the 110th precinct went to the home to get information, they were very politely turned away by the staff, saying "There are no patients missing from our home." They said that every one of their patients had been accounted for.

It was only after many hours that there was an admission that she was missing at approximately 9 a.m., and this is only their time of disappearance. This cannot be substantiated by them in any fashion. This was the second time on record of a disappearance from the Leben Home. In July 1975, Mrs. Stuve disappeared from the Leben Home sometime in the morning, and we cannot be sure of the time. She was found to be wandering, incoherent—apart from the fact she was found 6 miles away by the police department.

The police department did some investigative work, and found a family contact. The granddaughter was told to go to the Jamaica Hospital to retrieve her grandmother.

She called the Leben Home and they said they have no means of going out there: "You take a cab, and you go out there and bring her back. We will reimburse you."

To this date, there has been no effort made on the part of the Leben Home to reimburse.

We immediately resisted the Leben Home's answer and insisted that Mrs. Stuve be seen by a doctor.

We were told that she would be seen the following day. I said, "No; we want her to be seen now."

She was seen, and it was said the following day that she would be seen by a medical doctor and the psychiatrist, if it was found necessary.

We asked the Leben Home if it was not advisable to remove Mrs. Stuve from their premises, because of lack of security. If she had

been able to walk away once, what would prevent her from walking away in the future? We were told that they had very, very tight security there now.

She could not have possibly gone out through the front door. The only way they could suggest that she had disappeared from the home was through the service entrance gate being left unlocked for a truck delivery.

The proprietor of the home said, "You can rest assured that the best thing is to leave her here. It is not necessary to take her out of here. We have informed our entire staff that that gate is to be kept locked at all times, and that Mrs. Stuve was not to be allowed out of the home under any conditions unless escorted by a member of the family or a trusted friend."

We understood this as a tightening of their security.

We removed Mrs. Stuve for a weekend, and we took her to the country. We signed her out on the log in the office.

Home Denies "Signing Out" Restriction

Within one month after her going in the home, she lost her husband of 55 years. She was taken out for the funeral. The home was notified, she was signed out, and there was no problem. I emphasized this to refute statements made in the press by the home saying that the patients could come and go as they wanted, and specifically, that Mrs. Stuve had done this. This was not true by any stretch of the imagination.

Assemblyman Stein. Mr. Connolly, did you receive notice that medicare was billed by the Leben Home for ambulance service when your mother-in-law was hospitalized? How, in fact, did she get to the hospital? Was it by ambulance that medicaid was paying for?

Mr. Connolly. We were notified that she was in the hospital and, again, the family had not even been notified that she was in the hospital.

Assemblyman Stein. She was hospitalized?

Mr. Connolly. She was hospitalized, and we were told by the Leben Home that she was taken there by ambulance. We investigated and found under no circumstances was she taken to the hospital in an ambulance. She was taken there in a private automobile.

Assemblyman Stein. If that is true, then there was a falsified medicaid form that was filled out.

Mr. Connolly. Yes.

Assemblyman Stein. That is the kind of thing that Mr. Hynes should be able to investigate.

Mr. Connolly. Yes, definitely.

Senator Moss. Thank you. It is a tragic story. There have been no clues that turned up as of this time?

Mr. Connolly. No, sir, we have had articles in the paper, for which we paid. Just last evening, on the 11 o'clock news, Mrs. Stuve's picture was on television for anybody who could have noticed her, to notify us.

Senator Moss. Well, we do appreciate your report on that, and we do appreciate all of the witnesses coming in to talk with us.

We regret that our time is as limited as it is.

Mr. CONNOLLY. Could I just add one additional remark to this?

For the record, the social services department—when they referred Mrs. Stuve to the Leben Home—did not even mention that the home had any patients from the mental institutions.

To the contrary, they denied that there were any mental patients in the Leben Home. I think this should be a matter of record, that the social services department recommended this home, and stated emphatically that there was 24-hour-a-day medical attention.

MEDICAL COMPETENCE QUESTIONED

They said there were qualified medical personnel on the premises for administering medicine. We questioned this. We saw medication being administered by questionably qualified personnel. We also saw the patients in the home standing in line to draw their part of their $20 spending money from social security.

I saw, in fact, these patients stand in line from 2 to 3 hours—sitting on the floor, mind you—waiting for the doling out of money which was rightfully theirs. In many cases, patients had never gotten the money that was rightfully theirs.

Assemblywoman LIPSCHUTZ. One question, if I may. I would like to address my question to both Mr. Platzner and Mrs. Joffe.

He stated that he kept a refrigerator in his own room. I would like to know whether there were other patients—or other guests in the home, let us put it that way—who also had to administer medication to themselves, whether they were capable of judging whether medication was necessary, and so forth. I would like to direct the same question to Mrs. Joffe, when she speaks about alcoholics—were they under medication and, if so, who administered the medication?

Mrs. JOFFE. I do not know whether the alcoholics were on medication.

Assemblywoman LIPSCHUTZ. You do not know?

Mrs. JOFFE. No; but I do know some people are not capable of taking medication themselves.

Assemblywoman LIPSCHUTZ. Do you know if medication was administered by a nurse?

Mrs. JOFFE. I would take my own, but for those that the management feels cannot take care of themselves, someone at the desk or switchboard gives them their medication.

Senator Moss. Thank you very much, ladies and gentlemen. We appreciate your coming here to help us fill out the record and to give some of your direct personal experiences. As I said, I hope we can assure you that there will not be any reprisals.

Mrs. JOFFE. I would like to add—after I wrote to the commission for the aging and I called various people, I wrote to the Governor and he sent two people to talk to me. They made me the culprit, and told me, "Why don't you get out of there and why don't you mind your own business?" I spoke for the people who are inarticulate and do not know how to go about anything or do not know where to go or how to help themselves. I try to help those people. That is the answer I got.

Senator Moss. These are State people?

Mrs. JOFFE. These are people that were sent by Governor Carey who investigated me.

HOME FOR ADULTS—$225 PER WEEK

I went to another place, and they wanted $225 a week, also a home for adults—a private home for adults.

I cannot afford to pay that kind of money. They think if you are not on medicaid or if you get no assistance from anybody, they can tell you to get out. What do you do?

We also need help. Just because we did take care of our money—we put money aside for a rainy day—that does not mean that we should be neglected completely.

Only those on SSI are taken care of. The private people—they do not listen to us at all. They say, "If you do not like it, get out."

Senator MOSS. Thank you, Mrs. Joffe, for your comments, and thank you, Mr. Connolly, and the others.

Mrs. JOFFE. Thank you.

Senator MOSS. We have told Mr. Bernard Shapiro, the executive director of the State Board of Social Welfare, that we would permit him to leave by 12:30. We did not quite do it, but we will ask Mr. Shapiro to come up at this time.

Mr. SHAPIRO. Mr. Chairman, Mr. Maull, the chairman of the board of the State Board of Social Welfare, is here with me, and with your permission, I indicated to Mr. Halamandaris that Mr. Maull would be with us and would make a statement. Mr. Maull would also like to address himself to your remarks, and to the remarks of the special prosecutor.

Senator MOSS. You may proceed, Mr. Maull.

STATEMENT OF BALDWIN MAULL, CHAIRMAN, NEW YORK STATE BOARD OF SOCIAL WELFARE

Mr. MAULL. Thank you, Mr. Chairman.

I am Baldwin Maull, chairman of the New York State Board of Social Welfare. Mr. Shapiro, our executive director, and I are very happy to speak to this distinguished group today.

The board is a 15-member group of citizens appointed by the Governor with the consent of the State senate. The chairman is selected by the Governor from this group and serves at his pleasure. Formed in 1967, the board has a long history of involvement with the social needs of New York State. Its duties and responsibilities come from the State constitution itself and from statutes in the executive law concerning the care of children and adults living away from home, the regulation of charitable fundraising, and certain nonprofit corporations. It is an enforcement arm, working for the health, welfare, and safety of the children and elderly and infirm persons under its care, but also a coordinating and planning body and advocate for these most vulnerable groups.

Enforcement is based not only on State laws but also on board rules which have the effect of law. Guided by these rules and also by board procedures and administrative letters, staff in six area offices actively inspect the facilities supervised by the board, including

adult homes—to check their compliance with the law and board rules.

The adult homes under our jurisdiction are intended for persons who are basically well, though they may need help. They do not require the continuous nursing care that is provided in nursing homes and health related facilities—intermediate care facilities under its Federal designation—which are supervised by the State department of health.

THREE-FOURTHS OF ADULT HOMES ARE "FOR PROFIT"

According to our latest census, as of January 15, there are 547 of these adult homes under the board's supervision. About three-fourths of them—426—are private proprietary homes for adults, or PPHA's, operated for profit. The other 117 are not-for-profit facilities, operated by voluntary organizations, counties, or other government units. The total population of these homes is 22,000—17,000 in PPHA's.

The key to enforcement, of course, is our staff who inspect. The law requires the inspection "from time to time," but board policy is to make at least two surveys a year of each of these homes scattered across New York State.

The great majority of these inspections are unannounced and 15 percent are made at night. Besides reporting violations of board rules, the staff works with the proprietors of homes and advises them on how to bring matters into compliance and improve quality of care.

We have only 22 field staff to inspect all these homes and these 22 must spend an estimated one-half of their time on other duties. The State budget cuts and budget freezes have badly hurt our enforcement program but we have been asking for more adequate staff since 1971 when the board was given these responsibilities. It is quite clear that the board cannot satisfactorily perform its statutory duties with this limited staff. I cannot stress too strongly our need for greater quantity and quality of staff.

The board strongly supported legislation in 1974 under which operating certificates are issued to the facilities the board is responsible for. The board can suspend, limit, or remove the certificate from any facility in serious violation of its rules.

Mr. Shapiro will outline in more detail both the board's accomplishments and our remaining problems.

Let me only repeat that we welcome the assistance of this honored group in our advocacy for what is a most dependent element of society. We are eager to supply you with any information you need, and we welcome any recommendations you may make on the national scene.

I would like to add, Mr. Chairman, that we have proposed a bill in the legislature which would give us the power to require financial statements from these homes, and the power to audit and investigate.

If that legislation should fail, we have considered whether we could do it by rule, and we were advised very clearly and strongly that we have no authority to do it by rule.

I might add, before I arrived at this hearing, I am told, it was stated our board had been asked by the Governor to request some

authority for Mr. Hynes. That is not correct. We have had no request either from the Governor or Mr. Hynes in that regard.

Authority Questioned

I had a letter from Mr. Berger, the commissioner of welfare, suggesting there was a question as to Mr. Hynes' authority in relation to PPHA's, and suggesting that we should suggest to the Governor it be expanded. Let me say, first, that we are no judge of Mr. Hynes' authority. We do not know whether he can expand to include the PPHA's or not. No. 2, the Governor does not need anything from us if he wants to expand that authority. No. 3, what is really needed to put this house in order is to give us the tools to do our job, and I so notified Mr. Berger.

I would be glad to offer my letter in evidence.

Senator Moss. We would be glad to have that for the record as a part of your testimony. Is this your letter to Mr. Berger?

Mr. Maull. Yes.

Senator Moss. All right. That will be included in the record.[1]

Did you have any objection to any investigations?

Mr. Maull. We have no objections. Our job is to get the needed job done. We want to be able to do our own job, and we have no objection to any investigations.

Senator Moss. I am wondering if I got the wrong connotation from the last sentence of your letter.

You appear to conclude that an investigation would not do any good in this area.

Mr. Maull. I will modify that. I will say anything that brings close attention to our needs or that calls attention to our needs will help the elderly. We will cooperate with that.

Senator Moss. We had the prosecutor on earlier, and he said in order for him to exercise investigatory authority he would have to have approval of your board, and that it was not forthcoming.

Mr. Shapiro. Mr. Maull was not here when Mr. Hynes testified, but I was. He indicated he had received a number of complaints and he was looking into these complaints.

We have worked with Mr. Hynes on all of these complaints that came to his attention, and we have made our records available. We have cooperated in every possible way in regard to the complaints that have come to his attention and this is for the record.

Senator Moss. I am sorry Mr. Hynes is not here now. However, he stated that he has been denied permission to investigate in this area.

Mr. Shapiro. He has not been denied access, and we will cite actual records he and his staff have read and have pursued on the basis of individual complaints that have come to his attention.

Representative Koch. Mr. Chairman, Mr. Maull, what you are saying in the last sentence is that in your judgment the investigation would not serve any purpose. Could you expand on that?

Do you think the powers of the special prosecutor would not provide the necessary help to the elderly people living in the adult homes?

[1] Not received at time of publication.

Mr. MAULL. What I am saying is that that is a one-shot job, which would not provide adequate——

EXPANSION OF DUTIES INITIALLY RESISTED

Representative KOCH. All I am saying is that you seem to indicate a negative attitude to expansion of the special prosecutor's duties. The special prosecutor said, in his judgment, that it was necessary in one or two ways to secure jurisdiction, and one way would be your permitting him access, and the second way would be the legislature authorizing it.

Now, it is apparent from that letter that you were not encouraging it, but that it is OK. As I understand that, you welcome it now.

Mr. MAULL. We are very glad to cooperate with the special prosecutor, and we said at the start that we would be glad to cooperate, and we welcome it, if that is what is necessary.

Representative KOCH. Fine. So if the request is made of you that the special prosecutor's jurisdiction should include the homes under your supervision, you will respond by saying we welcome it. Is that a fact?

Mr. MAULL. Yes. I said that in advance, and I said we would be glad to cooperate, but believe me, it is not up to us to tell the special prosecutor. That is the Governor's job.

Representative KOCH. The problem I have found with agencies is one of a defensive mechanism that they all have, and it is not related to you. You are not paid?

Mr. MAULL. Right.

Representative KOCH. And you maintain this position because you are good government minded, and I appreciate that.

Mr. MAULL. Our board receives a fee for attendance at meetings.

Representative KOCH. But what I want to state is that in almost any case involving an investigation in which Government is concerned, whether the people involved are former employees, or volunteers, as the nature of your position is, there is a defensive mechanism, which is: "We are doing our job, and we do not need outside overseers. If you would only give us additional money and additional power, we would do a better job."

Mr. MAULL. I recognize that.

Representative KOCH. Our purpose today is to obtain your consent now, that you welcome the introduction of the special prosecutor's office into this area, if that is what is required for him to enter. And you have already told us that you will do that, that you do not have to respond any further.

Mr. MAULL. Yes, and if the Governor wants him to, we would be glad to have him, but we are not the one that deals with it.

Representative KOCH. I understand.

Now, the second question I have concerns the special prosecutor's earlier statement today, that for every investigator out in the field, it has been his experience that the State picks up some $2,500.

You were not here when he said that, but I think Mr. Shapiro was. You will verify he said that?

Mr. SHAPIRO. Yes.

Representative KOCH. As I understand, your people spend half of their time investigating, so it is approximately 11 people working full time.

Will you tell us what your experience is with respect to recovery of money based on their investigations into these areas?

RECOVERY OF COSTS "NOT RELEVANT"

Mr. SHAPIRO. They do not produce any return, because they do not look at finances, and also these homes are not paid on a cost-plus basis the way the nursing homes are, which is that the recovery of costs are not relevant here.

There is a fixed amount paid regardless of costs, and I would guess from my observation that some homes are run at a loss, but also that some are making a profit.

It depends on how they are run and also probably on whether they have low or high building costs.

Representative KOCH. I understand. Your investigators do not relate to the financial aspect. They relate more to the life saving code.

Mr. SHAPIRO. Yes, and even if they did, it would not affect the amount that was paid, so I do not see the savings.

Representative KOCH. I understand. It makes perfect sense. Your investigators are not related to the financial aspect. Now, who is?

Mr. SHAPIRO. State Social Services Commissioner Berger is the one that makes the payment.

Representative KOCH. Do you know of any department investigating the financial aspect? Perhaps Mr. Shapiro could respond to that since you are only a part-time employee, so to speak, as a volunteer.

Mr. MAULL. I will say that I just don't know of one.

Representative KOCH. Maybe Mr. Shapiro can answer that. Is there anyone looking to the financial details?

Mr. SHAPIRO. No. The statement made here from the committee itself and the distinguished members at the table indicated exactly what we have said, and that is, that in 1975, the State board had a bill sponsored to request financial disclosure.

That bill passed in the senate, and it failed to pass the assembly. We again have that bill in the assembly and in the senate, and we hope it will pass at this time.

Representative KOCH. So at this moment, to your knowledge, there are no investigators looking into the financial aspect of these homes. Is that a fact?

Mr. SHAPIRO. That is a fact.

Representative KOCH. Would you not say that is outrageous?

Mr. SHAPIRO. That is the purpose we requested the legislation, to be able to do it.

FINANCIAL INVESTIGATION NEEDED?

Representative KOCH. Does the fact that there has not been, over the years up until the present time, a financial investigation in these homes indicate a special urgency that the special prosecutor should get into this?

Mr. MAULL. We know what is needed. If he can produce something, fine.

I would say that we think we know what is needed to be done, and if he can produce it, well and good—so much the better.

Senator DOMENICI. Of course, you think you need more authority and more investigators so you could get a better performance.

He could be looking at something completely different from that.

Mr. MAULL. Outside of our jurisdiction, it could well be.

He will not be looking in the nursing home in relation to financing, because that was to establish costs, and that is not pertinent to payments under our jurisdiction.

He will be looking for some other type of criminal activity.

Senator DOMENICI. Who has jurisdiction over acts of neglect that might be criminal?

Mr. MAULL. We do. We have jurisdiction over their performance, yes.

Senator DOMENICI. And those 22 inspectors are part time?

Mr. MAULL. They look at it, in the first place, and we have building inspectors. Then those who go in and look at the way the place is run, the personnel, the food.

We had two nutritionists. They are both gone, and we have not been able to replace them. We have no nutritionists now, either in this or in the children's field.

Senator DOMENICI. You indicated in your prepared remarks that operating certification is part of your role.

Mr. MAULL. Yes.

Senator DOMENICI. That is not too old a role. In fact, it is rather recent—I think you said something like September 1974.

Mr. MAULL. Yes.

Senator DOMENICI. What is the criteria for granting operating certificates? Perhaps Mr. Shapiro would have it in writing. Do you ever set up criteria?

Mr. SHAPIRO. Adequate performance in accordance with the rules of the board and we will be glad to make all of these rules available to the committee.

Senator DOMENICI. Will you make these rules as they apply to certification of domiciliary homes available for the record? [1]

Mr. SHAPIRO. Yes, I will.

Senator DOMENICI. Let me ask you this, with reference to the kind of services required under your regulations. Can you just briefly summarize for this committee, aside from adequate shelter and physical plants and food, what are the services and capacities for services as required by your certification?

Mr. SHAPIRO. Nutrition, recreation, health, safety, comfort, well-being of the residents.

Senator DOMENICI. You said recreation?

Mr. SHAPIRO. Yes, adequate nutrition, adequate building and equipment, adequate space requirements suitable and comfortable beds, adequate supply of clean linen, hospital beds shall not be used, and recreation.

Senator DOMENICI. I know we are running late. I want to ask you just one more question.

[1] Not received at time of publication.

Do you have any qualifications in writing as to the 22 inspectors you turned out?

Mr. SHAPIRO. Yes, these are all people under the civil service; they do have to be college graduates; they have to have a number of years of experience in the field in which they are working.

Senator DOMENICI. What procedure do you have to protect the SSI funds, with regard to sick people not going to these kinds of homes?

MEDICAL CERTIFICATE REQUIRED

Mr. SHAPIRO. We have a requirement that they produce a medical certificate that, in effect, requires that they do not require medical care upon admission.

That certificate must be produced within 30 days, and we require a followup medical examination once a year to indicate for those under 65 to the effect their medical situation has not changed, and that they can continue to stay there.

We have a rule which requires those over 65 to have a medical statement three times a year, which means three examinations per year, that they are suitable to stay there. The regulations further require that anybody who does not belong there should not be accepted and should be moved.

Senator DOMENICI. Mr. Shapiro, if, as a matter of fact, there are many sick people in these kinds of domiciliary homes, wherein does the fault lie in their being there, and how come we have not caught them?

You do not have to believe it is true, but I am asking you in your answer to assume it is true in this statement. If it is true, where does the blame lie?

Mr. SHAPIRO. I think the blame lies among a number of agencies and a number of people.

I think in the first instance, a doctor is not supposed to give a statement when, in fact, somebody does not belong there.

The department of mental hygiene, on behalf of the first deputy commissioner, Dr. McKinley, with whom we work very closely—he is here, and he is ready to testify before your committee to indicate a screening of persons is required before they are placed in these homes. We have a cooperative agreement with that department. The State Board of Social Welfare and the State Department of Mental Hygiene have agreed with regard to the screening of patients with regard to notification to the local social service commissioners in advance, with regard to the appropriateness of placement, and this will be borne out, as Dr. McKinley will indicate to all of the medical directors in the State institutions.

I understand this was not always so. This is something we have developed by working very, very hard over the past year and a half with the department of mental hygiene.

Before that, I think you indicate in your remarks, throughout the Nation there has been a wholesale discharge of mental hygiene people. In New York State, discharges are about 30,000 to 40,000 each year, of whom a certain percentage—over 1,000 a year—wind up in our institutions.

Senator DOMENICI. We could go on all day. I just want to ask this simple question. Is there one agency in this State responsible for enforcing that basic rule, that people should not be in these kinds of homes if they are sick?

Mr. SHAPIRO. We have promulgated such a rule.

Senator DOMENICI. I did not ask you that. I said is there one agency responsible to see that that is the case?

Mr. SHAPIRO. We are.

Senator DOMENICI. I am asking you, are you satisfied that this State has set into motion the machinery to enforce that?

Mr. SHAPIRO. No, we have not.

Senator DOMENICI. Thank you.

Representative SCHEUER. You are responsible for the recreation, safety, comfort, and well-being of the patient for their nutrition, space, and so forth.

DUTIES OF INSPECTORS QUESTIONED

When your inspectors go to a home, what do they find out about the adequacy of all of these elements you are responsible for?

Mr. SHAPIRO. We have our own inspectors here, and they will testify.

Representative SCHEUER. I am asking you to tell me what they do. Don't you know what your inspectors do?

Mr. SHAPIRO. Yes. There is a very long, very comprehensive list of items that we need to look at.

Representative SCHEUER. Do you have a checklist? How do they check, for example, inadequate nutrition, recreation, and so on?

Mr. SHAPIRO. On adequate nutrition, we have two nutritionists that made unannounced visits, and during the unannounced visits, they made sure that they tasted the meals at the time they visited. Also, they asked for the actual menu; this is where we first came upon the idea that we need a disclosure of information, because the two items the board really was concerned about basically were staffing services and nutrition—we emphasized that—and when we began to ask the operators, not only for the daily menu and the daily meal, but to give us their purchases over a period of a whole year—as related to the number of people that they have—so that we could get a picture whether the three meals per day cost $1 a day, $2 a day, $3 a day, or what.

Senator Moss. Did you say the industry resisted that disclosure?

Mr. MAULL. Yes.

Representative SCHEUER. Do you have that information now?

Mr. SHAPIRO. No.

Representative SCHEUER. You did not get the information on how much they spend per day?

Mr. SHAPIRO. Some do not keep adequate records.

Representative SCHEUER. Do you require them to keep adequate records?

Mr. SHAPIRO. No, because we did not get passed by the legislature the disclosure of information required under the law.

Representative SCHEUER. Do you mean that you cannot require them to tell you how much they spend for food per patient per day?

Mr. SHAPIRO. They will tell us, but we cannot get the records that we need to determine that what they say is correct.

Representative SCHEUER. Do you have authority to find out how much they are spending for recreation or safety?

Mr. SHAPIRO. We have asked for legal authority to give us the complete disclosure of information statements.

I will file with the committee the material that we have developed, and it is quite comprehensive.

Representative SCHEUER. Let me go ahead.

VIOLATION OF RULES WARRANTS SUSPENSION

You say you can suspend or remove the operators' certificates from any facility in serious violation of the rules, is that correct?

Mr. SHAPIRO. This is in my statement. That is correct.

Representative SCHEUER. But you do not have the right to get needed information?

Mr. SHAPIRO. We are asking for it, and we hope it will pass the legislature.

Representative SCHEUER. There seems to be a void or vacuum in the law right now?

Mr. SHAPIRO. That is correct.

Representative SCHEUER. Now, you have the right to suspend or to remove the operators' certificates for violation of the rules?

Mr. SHAPIRO. Right.

Representative SCHEUER. In how many cases of the 426 private proprietary homes have you commenced proceedings for suspending, limiting, or removing the operating certificates for gross violation of your rules?

Mr. SHAPIRO. We have four we have actually removed. We have a number of others in process.

Representative SCHEUER. How many?

Mr. SHAPIRO. About 3 or 4 additional ones in process, and we have a number of wildcat operations, operations that pawn themselves off as a hotel, but actually they are homes of that nature, like the private proprietary homes. Those have been referred to the attorney general for enforcement.

Representative SCHEUER. For criminal prosecution?

Mr. SHAPIRO. Yes.

Representative SCHEUER. Have you commenced any prosecutions?

Mr. SHAPIRO. There are a number of them in progress, yes.

Representative SCHEUER. Criminal prosecutions going on?

Mr. SHAPIRO. Well, we started the investigations. We do not know if it is of a criminal nature or not.

Representative SCHEUER. So you have three or four in progress?

Mr. SHAPIRO. Four have already had their licenses removed.

Representative SCHEUER. Plus another four?

Mr. SHAPIRO. Yes.

Representative SCHEUER. So that is a total of eight or nine—out of 426, that is about 2 percent.

Mr. SHAPIRO. Yes.

Representative SCHEUER. Would you say that 98 percent of the institutions are operating up to snuff?

Mr. SHAPIRO. No, but we have one counsel who does all that work, and that is what Mr. Maull was talking about, need for staff for enforcement.

Representative SCHEUER. You do not have any legal and inspection ability to enforce your requirements and to prosecute those that are in violation of your rules?

Mr. SHAPIRO. Not inflagrant violations, violations of the rules—but we have indicated we have revoked certificates.

Representative SCHEUER. You have four in progress, and another four that have been revoked.

HEARINGS HELD TO CONSIDER REVOCATION

Mr. SHAPIRO. During 1975, the first full year of the new program, I called to your attention that the board arranged for hearings as required by law to determine whether to remove certificates.

Two hearings resulted in revocation, the third home surrendered its certificate the day before the hearing. The fourth is in process of releasing its operational certificate and transferring its property to a new owner acceptable to the board.

Representative SCHEUER. How about the other 98 percent?

Mr. SHAPIRO. Wildcat operations are referred to the attorney general. Four actions of this type are in litigation, and two homes have been closed.

Representative SCHEUER. How about the 98 percent? Are they running in substantial compliance with your regulations, would you think?

Mr. MAULL. I am sure a lot of improvement is needed.

Mr. SHAPIRO. There is a lot of improvement that is needed, as the chairman has pointed out.

Only half of the inspectors are available for this type of investigation.

Representative SCHEUER. Do you have authority over deciding what percentage of their time is spent on inspections?

Mr. SHAPIRO. Yes.

Representative SCHEUER. Why don't you increase the half to 75 percent?

Mr. SHAPIRO. We would not get the new applications done.

Representative SCHEUER. Is it not more important to make sure that existing institutions are running properly, rather than licensing new institutions that you will also not be able to supervise adequately?

Mr. SHAPIRO. I agree with you.

Representative SCHEUER. So maybe you have your priorities wrong.

Mr. SHAPIRO. It is to do a total job.

Representative SCHEUER. But if you cannot do the total job, then you have to have priorities to do the more important things first. Before you license institutions, would it not be intelligent to make sure that existing facilities are functioning properly?

Mr. SHAPIRO. Yes.

Representative SCHEUER. I suppose the nonprofits are doing a better job than the for-profits, are they not?

Mr. MAULL. Yes.
Representative SCHEUER. By and large.

NONPROFIT HOMES REFUSE MENTAL PATIENTS

Mr. SHAPIRO. The nonprofits—and this is a very important point—the nonprofits by and large have refused to take mental hygiene patients. They have mainly, with the exception of a very few, people who are aged and infirmed, and not the mental hygiene people.

Now, I think what your committee can do, and the Congress can do, is to encourage more funding for the voluntary agencies—to give them an incentive to go into this.

Representative SCHEUER. We are talking about the job you are doing.

It seems to me you ought to look at the functions of these 22 inspectors. If any of them can be deferred from licensing new facilities, I would think you would be able to put them on inspecting old facilities.

Mr. SHAPIRO. It would still be 22 inspectors.

Representative SCHEUER. It seems to me, that if you take them away from certification and concentrate more on criminal prosecutions, you will capture the minds of a lot of the operators of these institutions.

If they want to keep their franchises operating, they will have to perform up to standard. Maybe we'll get a little self-enforcement in the industry if you send a few to the cooler.

I think Dr. Bergman, if he goes to the cooler, and I hope he will, it will be a lesson for a lot of other operators who would think twice before committing the outrageous abuse against these pathetic people who cannot take care of themselves just to make an extra buck.

They'll notice a significant chance of their being brought in a criminal proceeding. It seems to me it would behoove you to spend more time with those inspectors to bring into line more of the 426 that are doing a grossly inadequate job.

Let me ask you one last question. As you may have heard, I am sponsoring legislation whereby the Federal Government will pay the costs of prosecution in medicare and medicaid fraud and abuse cases. If the funds come from the Federal Government for this kind of inspection and preparation of criminal cases, do you think that would help you do your job better?

Mr. SHAPIRO. It would help us very much to do the job better. The basic thrust is that we need staff to do that job, and that includes attorneys, enforcement officers, auditors, and inspectors.

Representative SCHEUER. Thank you, Mr. Chairman.

Senator MOSS. Assemblywoman Lipschutz?

Assemblywoman LIPSCHUTZ. Mr. Shapiro, I was just asked by the chairman of the Assembly Committee of the Aged to form a Subcommittee on Safety and Security.

CUSTODIAL SUPERVISION NEEDED

I would like you to tell me, many of these persons released from the mental hygiene institutions—do you feel these people need custodial supervision?

Mr. SHAPIRO. They need custodial supervision very much, and that is why I am waiting to read my statement in connection with the mental hygiene situation, if the chairman will permit me, and then a lot will fall in place.

Assemblywoman LIPSCHUTZ. That is up to the chairman. May I ask you, are you familiar with the term "transitional services"?

Mr. SHAPIRO. I am familiar with it, but I think Dr. McKinley, deputy mental hygiene commissioner, is the one to talk about it, because that is a mental hygiene term.

Assemblywoman LIPSCHUTZ. Will that come partially under your supervision as well?

Mr. SHAPIRO. Basically it will come under mental hygiene supervision.

Assemblywoman LIPSCHUTZ. Would it involve the 22 inspectors in any way?

Mr. SHAPIRO. No, it would not involve services that are needed to be given to persons who are located in the homes who are discharged from mental hygiene facilities.

Assemblywoman LIPSCHUTZ. So there is no relationship?

Mr. SHAPIRO. For whom there is an outreach service, doctor care service, and actual placement of staff in many of our homes.

Assemblywoman LIPSCHUTZ. I see. Then there is an interrelationship.

Mr. SHAPIRO. There is an interrelationship there, and also between the local departments of social services. This is a very important point because before the advent of SSI, January 1, 1974, it was the local commissioner of social services, and I am talking about some 58 jurisdictions—New York City, Nassau County, Erie County and so forth—it was the local social services commissioner who negotiated the rate.

It was the local social services commissioner who knew his client—who issued the check—and therefore the local social services commissioner delivered the service.

The moment SSI came into being on January 1, 1974, the checks are all coming out of Washington. They are received directly by the client, and very little local social services are being delivered to these homes and to the people who need the services.

Now, when we asked them—the local social services commissioners—and cajole them, and direct them that they should give services, we also asked the State commissioner for social services that the social services be given, that efforts be made by the social services departments; they say there is a closed-end budget for services, and we have to determine where to deliver the social services most needed—to the children or to the people in these adult homes. One of the things Congress can do is allow more money for social services. The thing to do is get the job done.

Assemblywoman LIPSCHUTZ. Are you going to refer to transitional services?

Mr. SHAPIRO. No; Dr. McKinley, the mental health commissioner, will. He is here.

Assemblywoman LIPSCHUTZ. Fine. I did want you to know that some of the legislation being asked for in your statement—it, in fact,

went into the hopper as of late Thursday afternoon—it is legislation that will be introduced into the assembly by myself.

Mr. SHAPIRO. Thank you very much. It is very worthwhile, and we will support it.

Senator Moss. We have all jumped into questioning this witness and Mr. Shapiro has never given his statement. You may go ahead and read your statement.

STATEMENT OF BERNARD SHAPIRO, EXECUTIVE DIRECTOR, NEW YORK STATE BOARD OF SOCIAL WELFARE

Mr. SHAPIRO. Thank you, Mr. Chairman.

The State Board of Social Welfare is responsible for the health, welfare and safety of more than 22,000 persons in 547 adult care homes—domiciliary care facilities—throughout New York State. Three-fourths of the facilities are private proprietary homes for adults—PPHA's; the others are owned by nonprofit organizations or governmental units, usually counties.

The traditional population of elderly and infirm persons has been joined in recent years by large numbers of dischargees from mental hygiene facilities, following a policy decision several years ago by that department to shift patients from institutional to community living.

Domiciliary care is distinct from that provided by skilled nursing homes and intermediate care facilities since it does not include medical and nursing care services. Domiciliary care facilities focus on meeting the nonmedical needs of persons who, because of old age or disability, cannot function in totally independent living arrangements.

The board, through its rules and through inspections by staff in six area offices, monitors the safety and adequacy of buildings, the physical care of residents, and activities to maintain their mental and emotional as well as physical well-being.

The board welcomed new enforcement legislation which was effective September 1, 1974. The board now issues operating certificates and can limit, suspend, or remove the certificate from a facility which violates its rules.

During 1975, the first full year of the new program, the board arranged four hearings, as required by law, to determine whether to remove certificates. Two hearings resulted in revocation; the third home surrendered its operating certificate before the hearing; the fourth is in the process of surrendering its operating certificate and transferring its property to a new owner acceptable to the board.

Wildcat operations—homes which have not applied for board approval—are referred to the attorney general for action. Four cases of this type are in litigation and two homes have been closed.

PROPER PLACEMENT IMPORTANT

A most important concern is that residents be in the appropriate level of care. Adult care homes offer help in getting about, eating, dressing, and bathing.

Upon entering an adult home, each resident must have a physical examination and a physician's statement that this level of care is

appropriate. A new board rule concerns annual physicals for residents.

The board has requested the cooperation of other State agencies in urging local health, sanitation, mental hygiene, and social services staff to supplement board inspections by reporting inappropriate placements as well as any deficiencies.

Between 30,000 and 40,000 patients a year have been discharged from mental hygiene facilities under the 1968 policy. Over 1,000 persons a year enter adult care homes. Now 30 percent of the residents in board-supervised homes are former patients—more than 5,000 of its 17,000 PPHA residents.

Percentages are highest—up to 72 percent—in counties which have mental hygiene facilities. In 93 adult care homes where 40 percent or more of the residents are former patients, they form 80 percent of the total.

Formal agreements between the board and the departments of mental hygiene and of social services have set procedures, including plans for needed services before a patient is discharged and for continuing aftercare in the adult home or its community.

Since most expatients take prescription drugs, the board worked with health and mental hygiene to formalize medication procedures. These specify how much a home's employees may help a resident to take medicine, how to store medicines—especially controlled drugs—and what records are necessary.

Nearly 70 percent of the residents in board-supervised homes receive U.S. supplemental security income—SSI—which went into effect on January 1, 1974, amounting to over $80 million. While this flat payment avoids abuses revealed in the cost-plus medicaid reimbursements to nursing homes, other problems are created.

The flat SSI payments provide for $386.70 for each resident. This same amount is paid no matter what the quality of the home—it may be excellent, good, or just plain or minimal. As a result, when SSI came into being on January 1, 1974, some homes received windfalls, whereas others who charged above the flat rate claim that they are suffering losses because they cannot keep up with the quality of care they wish to provide on the basis of the SSI reimbursement rate.

Technically, an SSI check goes directly to the resident, who negotiates a rate with the home. Practically, however, a resident with no other income will likely have no money for personal expenses if the rate equals the whole SSI payment.

When the SSI statewide payment for congregate care rose this year from $375 to $386.70 a month—$229 of it given by New York State through the Federal Government—the board strongly urged operators, through an administrative letter, to allow residents to keep the additional $11.70 as an allowance.

Senator DOMENICI. Are they doing it?

Mr. SHAPIRO. Some are, and some are not. It is very regrettable, and I will have to make a recommendation at the end of my statement which I hope the Congress can do something about.

CHANGES IN SSI PROCEDURES URGED

The board continues to work with other State agencies—social services, budget, and mental hygiene—in urging changes in Federal SSI

procedures. One suggestion is that the Federal Government send separate checks, one to be turned over to the home and one to be kept for personal use.

The board is again supporting legislation, which failed to pass in 1974, to require each home to file an annual financial statement of its operating and capital costs. Such information is essential for State recommendations to the Federal Government on the level of SSI payments. It is most important for us to have such financial disclosure so that we will know how much is paid for administration and general expenses, for leasing or rental, for equipment leasing, if any, for plant operation and maintenance expenses, for dietary expenses, for laundry and services, for housekeeping services, for social and recreation expenses, and gross income, and drawings of proprietors or partners. Our main concern is to assure quality of care and to analyze how much is available for proper staffing, for services, and for nutrition.

Domiciliary care facilities offer an enterprising alternative to the very expensive nursing home and health-related facility care.

The administrator of an adult care home—this may be the owner or a person he hires—is the key to the quality of its care.

A new board rule spells out qualifications for administrators—age, education, experience, et cetera—and requires them to continue training in such subjects as business management, geriatrics, recreation, and recordkeeping.

Senator Moss, I understood you were to visit one of the homes yesterday—Queens Manor. I visited that home. There were three recreationists there, and it makes all the difference whether you have a recreation program or not. The place is alive. There is a reason for living.

Recreation is especially important for persons whose time is almost all leisure. We do not want people to just sit all day long and stare vacantly into space; they become alive when there are recreation or other activity programs. Activity programs are emphasized in board rules. Project Recreation, funded by members of adult home associations, has completed its first year with notable successes.

In a pilot project to be applied statewide, the board's recreation specialist worked with 43 adult homes in the Rockaways, Long Beach, and Rockland County.

As a result, several homes have added full- or part-time recreation staff. One home bought a schoolbus for trips and outings, and other homes are cooperating on joint projects. Staff of the homes have attended workshops and courses about activities for older or mentally disabled persons.

Some improvements cost nothing: moving lobby chairs into conversation groups, getting on mailing lists for announcements of local events, arranging for a bookmobile to bring large print books, records, and films.

For little cost, homes can add a radio, record player or piano, an aquarium or pet, a gardening project, or just outdoor seating.

Volunteers Participate With Residents

Community groups have welcomed residents at senior citizen centers, and volunteers take residents to parks, shopping centers, movies,

or just come to the home to visit. Some funding has come from local and State government agencies and voluntary groups.

Through Project Recreation, the Associated YM/YWHA's of Greater New York ran a pilot project from its senior citizen centers in the Rockaways. With funding from the New York community trust, three recreation workers have started programs at homes and urged residents to use the centers.

To make sure that residents understand their rights, the board is requiring each home to post an information statement the board has prepared and to distribute copies to the residents.

This statement explains admissions agreements; the right to privacy for visitors, mail, personal business; freedom to move to another home; and the availability of help from staff in the board's area offices.

The rapid discharge of mental hygiene patients over the past 7 years is a major problem in the metropolitan area and an increasing concern upstate. This development has intensified the board's concern with medication procedures, activities suitable for these generally younger persons, placement criteria and agreements with State agencies about care for these residents.

The board is working with the department of mental hygiene in developing community residences for the mentally disabled. These were supervised jointly by that department and by the board in order to obtain public assistance funds. Since the start of the Federal supplemental security income program on January 1, 1974, however, these residents now receive a flat $386.70 a month—before $375—from SSI and the department of mental hygiene has now taken complete responsibility for the community residences.

Programs to adapt our adult care homes for mentally disabled residents include a 200-bed ceiling on new facilities, a staff specialist in recreation and diversionary activities, guidelines on PPHA staffing and on qualifications for administrators, and procedures on medication.

A new board policy limits approvals for new facilities according to the vacancy rate in the relevant planning region. Applications are not accepted where the vacancy rate is 20 percent or more, and are more stringently evaluated where the vacancy rate is between 10 and 20 percent. The board is proposing legislation that would strengthen its enforcement power in requiring a demonstration of need for new facilities.

The board has encouraged training of adult home staffs on the special problems of serving the mentally disabled. In Rockland County, for instance, in response to accusations between local mental health agencies and PPHA operators, the board has arranged regular meetings between the homeowners and other agencies. These help to resolve problems and have resulted in workshops on nutrition, recreation, recordkeeping, medication, and other matters.

Guidelines Developed by Board

The board has developed a statement of principles with the department of mental hygiene to assure predischarge planning, appropriate placement, and suitable aftercare within the facility or the com-

munity. In Far Rockaway, for instance, board staff has met with representatives of the public agencies to encourage expanded mental health, health, and vocational programs in that community.

Assemblywoman LIPSCHUTZ. Mr. Chairman, Mr. Shapiro, when you refer to recreation workers, how many workers did you say there are in the Rockaways?

Mr. SHAPIRO. We indicated that our staff members gather the home operators together and try to teach the homes——

Assemblywoman LIPSCHUTZ. How many homes?

Mr. SHAPIRO. We have one recreation worker for the State.

Assemblywoman LIPSCHUTZ. One for the State?

Mr. SHAPIRO. Yes, for the whole State. That was done with private money.

Assemblywoman LIPSCHUTZ. There are no qualified on staff recreational workers for the adult homes, is that correct?

Mr. SHAPIRO. There are some in some homes.

Assemblywoman LIPSCHUTZ. But not in the Rockaways, sir. I would also advise you——

Mr. SHAPIRO. We have the person here, Miss Dolores Pascarelli. who works on Project Recreation and can fill you in as to the work she does in the Rockaways.

Assemblywoman LIPSCHUTZ. She does it on a visiting basis, which is not on a regular basis.

Mr. SHAPIRO. I am talking about getting the people involved, getting the operators involved, and some of the things outlined that can be done that do cost money, but some that do not cost money.

Assemblywoman LIPSCHUTZ. The other thing I would like to know, that is in the senior citizen centers, which operate under the city, or under a combined program with the Y—the people of the Rockaways that work the senior citizen day centers that go to visit the guests of an adult home—it is not the other way around in most instances is it?

Mr. SHAPIRO. Either way. It is very helpful if we can get them out from staring into space.

Assemblywoman LIPSCHUTZ. But it is a question of who is going to whom, is it not?

Mr. SHAPIRO. Either way is our concern. I must frankly admit the problems caused by the influx of discharged mental hygiene patients. Admittedly, problems stem from the prejudices of our residents, most of them elderly and infirm. Some stem from the lack of services in the community. Some stem from the home staffs' lack of training and experience in this special field.

The board is now working with the department of mental hygiene to set down principles to guide us in solving these problems. These include the ideal locations for mentally disabled persons: not too large a home, and one with access to services, in a safe enviroment, et cetera.

"REAL LIFE MIX" OF RESIDENTS DESIRABLE

Ideally, too, mentally disabled persons should not form a separate ghetto within an adult home—there should be a real-life mix of men and women, black and white. We have not answered one question, however, whether a wide spectrum of ages is also desirable—whether

young but severely disabled persons should be placed with our elderly residents.

The board's genuine concern, for what affects its policy on permitting the commingling of the increasing number of mental hygiene dischargees and the aged resident population has on the residents in board-supervised facilities, impelled it to seek the answers through a research project.

A proposal for the project was developed and submitted to the National Institute of Mental Health recently with the objective to determine if commingling should be continued as at present, ended, or encouraged. The major outputs of the research would be a set of policies for dealing with commingling which could be implemented by the board.

In addition to determination of policies by the board, the findings would be of real national significance since there has been within the last few years a nationwide trend in the policy of mental hospitals and institutions toward the releasing of large numbers of patients into the community.

There have been a number of arguments over the issue of commingling: Advocates suggest that both groups benefit from commingling; that is, the aged residents benefit from the stimulation of living with the generally younger former mental patients and that former mental patients benefit from living in a protected environment with persons who have never experienced the dehumanizing effects of a mental hygiene confinement.

Opponents of the commingling process have been concerned that the aged residents may be harassed or in other ways disturbed by the generally younger former mental patients. Further, domiciliary care facilities—PPHA's—have been geared to the aged so long they cannot easily make adjustments necessary for the new resident group of former mental patients such as in the areas of nutritional, activity, and recreation needs.

If our research proposal is approved by NIMH, we should be in a position to address the question of commingling to the benefit of the present and future residents of DCF's.

To uncover any evidence of rentals and purchases from related companies, the board adopted a rule requiring a detailed financial report on any real estate companies that lease their property for domiciliary care facilities. Under State law, the owner of a home cannot be a corporation. This form, required of any new owners and including changes in partnerships, requires a list of all partners, stockholders, and shareholders in companies which rent property—with the amount of their investments.

The board has urged legislation to require annual uniform financial reports from every home, covering operating and capital costs. This legislation failed to pass last year and the board is urging it again this session.

Suggested Changes in Regulations Listed

Flaws in the administration of SSI, however, cannot be remedied at the State level. We strongly recommend the following changes in Federal regulations:

One: Differential payments based on facilities' quality and perhaps on the area cost of living.

Two: A point system based on the type and age of physical plant; such routine services as housekeeping, food, maintenance; and such special services as recreation, activities, and special programs.

Three: A separate check for personal allowances in addition to the check turned over to the home for the monthly payment.

DCF's are a preferable environment for those who do not need intensive care in a nursing home. And it offers savings, too—an average of no more than $400 a month compared with $900 in this State for health-related facilities and $1,600 in nursing homes.

What we need is more monitoring of costs, more efforts to improve quality, and more coordination to provide homes that operate efficiently and with commitment to the welfare of their residents.

Adult care homes are not inferior nursing homes. They are a separate category. It would be short-sighted to eliminate this type of care because some residents should be in health facilities, some programs need improvement, or because some operators are motivated solely by profit.

It is possible—and can be profitable—to operate this type of home with quality care and with commitment. It is Government's duty to provide the leadership and enforcement needed.

In conclusion, I must stress the commitment of the board members and staff to the well-being of those vulnerable persons. In many ways the board stands as their advocate—between operator and resident—guarding residents' safety, comfort, and happiness.

This is the point we make constantly to individual operators and to their associations and to State and local representatives of government.

As I told proprietors from across the State at a conference in January:

> For many of our residents, old age is a time of peril and loneliness. They are threatened by poverty and infirmity. All too many have been neglected. They have no contact with relatives, old friends, old interests. What I urge is not so much to spend more money as it is to spend more feeling, more mercy, more respect, to provide the best life possible for those in our care.

At the heart of our concern is to assure that those who need service receive it, that the quality of care is adequate and that it is provided at reasonable cost.

Senator Moss. Thank you, Mr. Shapiro. That is a fine statement. I concur with you very much on the need for more than just the minimal services.

Mr. SHAPIRO. Thank you. I appreciate your being here. I think we are both crusaders. That is the way it should be. This is the only way to improve this country of ours.

Senator Moss. I do appreciate that very much and I know we have had quite a long session.

We have time to finish up with a few questions, if there are any that remain.

Senator DOMENICI. I just want to make a comment to Mr. Shapiro.

Mr. Shapiro, I am impressed with your suggestions, regarding the national legislation. However, it seems to me that the thrust of the SSI payment at the national level was never intended to be used the way it is.

I will not be so harsh as to say it is being used illegally. I think in a very real way, however, technically, it is being used illegally. It was intended that you receive the check. Then you turn it over to someone furnishing you a service, and that service charge is related to the SSI payment. It seems to me that when you recommend that we have a personal allowance check, we have also a regional disparity for costs of providing care. A third consideration might be that mental patients in the transition be treated differently from others. What we need to do is look at the whole concept of SSI in this area. It is not just an add-on. The whole thing has to be looked at again. Is that correct?

Mr. SHAPIRO. That is correct. We did not establish SSI for that purpose. Instead of having SSI, as now is established with something like five groups and different rates for each group, and then you have the situation when the check comes in to the PPHA people—the SSI check—these home operators get that whole check, which leaves the residents without money for personal needs.

There were some homes, when SSI came into being, that were getting only $200 a month. All of a sudden they are getting $375. These homes received a real windfall.

Who do you think is getting the money? The operators are.

Senator DOMENICI. That is a very good observation. I wonder if there is any area——

Mr. SHAPIRO. Perhaps the State department of social services can also do this. We will be working with the State department of social services, negotiating with SSI. We—the board—will be doing that, because every time we get into it, the department of social services says the Federal Government will not pursue that. We need your help in that; that is, the help of Congress.

One other item in regard to the personal allowance in turning over the check. Perhaps it would be a good idea, considering all of these people who are mental dischargees—they have been in mental hospitals for the last 20, 30 or 40 years. I want to stress this—and not to apologize for the homes—because we are here to do the best that we can. These dischargees have many problems, and this is why we have our inspectors and this is why we ask the department of social services to do their job and why we have asked the mental hygiene people to do their jobs. The thing that we really need is to guard against this kind of thing, the taking away their personal allowance, particularly with the mental hygiene discharged people.

They do not know how to handle the money. There should be a requirement that there be a guardian appointed to handle the money function for them—whether that guardian be the local social services commissioner or someone else, a relative or a voluntary agency.

This would cut out many of these abuses, and this would have to be a Federal thing. It cannot be done just by the State, because the State would lose the Federal money and be cut off because they are restricting public assistance grants.

Senator DOMENICI. Mr. Shapiro, we are looking for a lot of reform, but let me ask you a very basic question.

NEW OPERATORS SHOULD BE APPRISED OF COSTS

It would seem to me, with reference to the costs of the particular parts of that which goes into a home—how much are the real estate and building costs, how much are the basic health costs, how much are the kitchen costs, the food—you could almost predict in advance to certain new operators that they cannot make it and provide adequate services. Because if the real estate costs vary, as I understand they do in New York, you can have a potential operator going in the home that has 40 percent of its operational budget in real estate taxes and the mortgage, so he would not make it. Or he would provide nothing else. Are you developing those kinds of facts?

Mr. SHAPIRO. That is part of the disclosure of information requirement which is in the legislation we are sponsoring, because then we would really know how much is being spent for each because the real estate costs—it must be known exactly what these costs are—and these people, the owners, that may not be called Bergman's, they could be called something else, some other name, but the builders are the ones. They build and then they lease. This is where the profit is—where the money appears to be made.

We should know how much goes for rental, and how much goes for lease. Then our most important concern is to figure out how much is left for services, how much is left for staff, and how much is left for nutrition. Those are the things we are concerned about.

Now, together with the department of social services, we are in favor of sponsoring the legislative bill to get that disclosure, and then to get the auditors and analyze all of these figures.

Senator DOMENICI. Thank you.

Senator Moss. Mrs. Lipschutz?

Assemblywoman LIPSCHUTZ. No questions. Thank you.

Senator Moss. Thank you very much, gentlemen.

You have given us very good testimony, and some insights as to what the problem is. You are, of course dealing with the new phase, really, and you are just getting started.

Mr. SHAPIRO. We are happy that you are holding these hearings, Mr. Chairman. This is the way to solve the problem, before it becomes a real nursing home scandal situation. We are very happy that you are here and that you are holding these hearings. It will prevent in the 1980's what happened in he 1970's with nursing homes.

Senator Moss. That is our purpose in coming. We have been much longer than we planned, and obviously, we will have to have a brief recess for lunch.

At the recommendation of Mr. Stein, we will recess until 2:30, at which time we will return and continue with the panels.

The subcommittee stands in recess.

[The subcommittee was recessed at 2 p.m.]

AFTER RECESS

Senator Moss. The subcommittee will please come to order.

We have two panels to hear. Panel No. 2 is composed of Dr. Bernard Lanter of Peninsula Hospital; Detective Gary Messina, the 101st precinct; and Morris Schneider, the city manager of Long Beach.

We are pleased to have you before the subcommittee and anxious to hear what you have to say as we try to understand and simulate the situation that exists here in New York and in other parts of the country—this matter of adult homes.

First, we will ask Dr. Lanter if he would proceed.

STATEMENT OF DR. BERNARD LANTER, PENINSULA HOSPITAL, FAR ROCKAWAY, N.Y.

Dr. LANTER. Mr. Chairman, members of the panel, I am Dr. Bernard Lanter, director of Emergency Service at Peninsula Hospital.

We are one of the two hospitals that Congressman Scheuer mentioned, that it is in an area surrounded by 17,000 senior citizens who live in nursing homes, health-related facilities and senior citizen hotels. Here are some of the numbers that we have accumulated providing the health care for this population. The entire group represents 12 to 13 percent of our total emergency room visits. A breakdown of these patients is:

One: Of the patients who come from the nursing homes, 40 to 45 percent require admission to the hospital.

Two: Of the patients from the health-related facilities, 35 percent require admission.

Three: Of the patients coming in from the senior citizen hotels, 25 percent require admission.

Comparing this population against the cross section of the average population that appears in a voluntary hospital emergency room, 5 percent of the average population that utilizes the emergency room requires admission. It becomes quite apparent that this population—nursing home, health-related facilities, senior citizen hotels—is in need of closer medical supervision than the average population. In caring for these patients, we feel some of these recommendations might be helpful.

PHYSICAL EXAMS INADEQUATE

The senior citizen hotels do not require having a physician on the premises. They are required to have a preadmission history and physical. These exams are very rapid and often inadequate. There is no central record kept of these examinations. When the patients appear in our emergency room they are often filthy, wearing all the clothes they own, and are totally ignorant of the medications they are on. These people are often senile and wander off. We suggest since we are the providers of the care, when these people become acutely ill, that we create an outreach department and do the initial physical examinations, maintain a central file, and make an identiband that the patient wears which would identify him, his medical illnesses, and the medication he is receiving. There should then be a mechanism whereby the social services department of the hospital would be able to follow through to make sure that the patients receive their required diets and are receiving the necessary medications.

This would not cost the government any additional funds since examinations are being paid for at present by medicare and medicaid.

Most of the people in this situation are on medicaid. We treat all medicaid people, so there is no expense to the patient; it is of no expense to the hotel, and these people would get a good physical examination.

Senator Moss. If they have a medicaid card, then that is billed off to medicaid?

Dr. LANTER. That is right.

Senator Moss. Is that 25 percent you mentioned—are all these people from the domiciliary homes?

Dr. LANTER. No. We are surrounded by nursing homes and health related facilities.

The 25 percent of the patients comes from these hotels and they are ill enough to require hospitalization, so this number really stands out. These people are ill.

Senator Moss. What condition are these people in when they come in?

Dr. LANTER. We see some of them completely disoriented. Some have three pairs of trousers, two pairs of jackets; some of them have all of their belongings on them.

Senator DOMENICI. With all these patients being released from these mental hospitals, does that have an impact on you?

Dr. LANTER. The only way it would have an impact on us is that they would all come to us. We do have some that do come into our hospital and some are retarded, but we do render care to them.

Senator DOMENICI. Do you have any observations as to the state of their health with reference to the diet of these people that you see?

Dr. LANTER. There are some who come in quite dehydrated—with weight loss. There are others that come in with various types of illnesses.

Senator DOMENICI. For this age group, compared with their counterpart age group of those who are not in these institutions, is there a noticeable diet deficiency?

Dr. LANTER. There have been, but not totally.

ONE HOSPITAL TO SERVE 17,000 PATIENTS

Assemblywoman LIPSCHUTZ. Also, I would like you to bring out the fact that the hospital you are representing is projected to become the only hospital in the area, and I would like you to talk about that.

Dr. LANTER. There are two hospital facilities in our area.

There is the possibility by the end of June of one being closed completely. Or there is the possibility if it is kept open, within the next 2 years it will be relocated about 8 or 9 miles away, and just on the other side of the city line. This would make us wholly responsible for 17,000 patients.

This will be a tremendous impact on us, and this is one of the reasons that we thought about setting up this program of reaching out, to provide the medical care. It is not only for the hotels, but we felt also the nursing homes needed this and the health related facilities—having each facility being run parallel. If the beds in these facilities are utilized and patients are moved out of these facilities, then the hospital beds can be moved. If they can be con-

trolled through an agency that is primarily concerned with the health care of the patient, and the proper utilization of the patient, there would be better use of the beds in this area.

Now, to address the question on malnutrition, we see there is enough of these individuals to realize that there is a range of services, so there is a need. There is much to be desired.

The patients in these homes and hotels represent about 3 percent of the volume, and about 25 percent of those come in by police car, or they wander in, or sometimes the family sees that there is something wrong and they bring them in.

Some are in a chaotic state, some are mentally retarded, and there is no way of finding out from the patient in many, many cases what their history is or what their diet is. Are they diabetic, are they on some kind of pills, and then we have to go out and fish for that information.

In dealing with some of these homes, it is very readily given to us. In others it is not so readily obtainable.

In other places, if you call after 5 in the afternoon, the manager has left and there is no one there except custodial help.

Other times, the patient being presented in an emergency room in a comatose condition, you have to start from ground zero to work them up.

We run into this problem in the hospital and on an in-patient basis. We run better than 100 percent occupancy, and it is tough when you have to spend this amount of time with this added burden. If there was some kind of identification on a permanent basis, it would help us.

Senator Moss. I thank you, Dr. Lanter.

We appreciate that very much.

Dr. LANTER. Thank you.

Senator Moss. I want now to turn to Detective Gary Messina of the 101st precinct. I would like you to tell us what kind of burden these homes place on the police department.

Detective MESSINA. Thank you, Mr. Chairman. With me is my precinct commander, Captain Kelly, who will present our statement, and I will assist him in answering any of your questions.

Senator Moss. Very good. We are glad to have you. You may proceed in any way you want.

STATEMENT OF CAPT. JOHN J. KELLY, 101ST PRECINCT, NEW YORK, N.Y.; ACCOMPANIED BY DETECTIVE GARY MESSINA

Captain KELLY. Thank you, Mr. Chairman.

As the doctor pointed out, many of these people wandering around become police problems and, in addition, become hospital problems.

They are sometimes in a comatose state. They do not know where they are staying and when you ask them where they stay, they will give you an address of 25 or 30 years ago; then we find the address is wrong. So we do have that problem of identifying where they stay, especially when these people are senile.

Sometimes we find them in an unconscious situation, or in an accident, and we are the precinct that Congressman Scheuer

referred to earlier in which the lady walked out on the roof in January and froze to death—literally froze to death on the roof before she was found to be missing. After that incident, the rest of our staff met with a group of concerned people—private citizens—and with Assemblywoman Lipschutz and Mr. Fried, who spoke here earlier this morning representing his group. We have gotten together sort of an ad hoc committee to mutually work out some of the security problems—some of the problems that are involved.

As you know, we are in a budgetary crisis. There is no hope of getting more manpower in the police department so we have to look for ways to conserve our time. We have gone through our records, and I find we have 67 lost adults reported from the various facilities.

So from some of the nursing homes and from some of the adult related facilities, 67 people were reported missing last year.

Patient Identification Important

Each one of these persons require an investigation by the police department involving missing persons, and a great many of the police officers—this is one of the problems that we try to approach with the various people and with the owners and administrators of the adult homes—identification problems—we should have some means of identifying these people, a picture, a brief rundown of who the patient is, where he or she is from, his blood type, any allergies he might have.

In addition to many nursing homes and health homes, we have a school for retarded children—functionally retarded—who will put this together for us.

They will make these cards and laminate them at a cost of 25 cents per card.

Now, our suggestion to the adult-home owners was that they have two of these made: One to remain in the file of the adult home in the event they report the person missing, and then we have a picture to start with; and the other one is to be given to the patient to carry on his person.

At first we had a little resistance because of the 25-cent cost, but the reasoning has been pointed out to the senior citizens; that is, since we have had this program going, we have put out an identification card [1] and we now have these people buying these on their own because they want to have this on their person to notify the hospitals and the police in case of an accident.

[1] See page 3603.

SENIOR CITIZEN IDENTIFICATION CARD

The person described on the reverse side of this card is a resident of

PRECINCT

Name

Address

City State Zip

Telephone

Blood Type Allergies

Emergency Telephone

Birthdate Soc. Sec.

We have had people in the community who are willing to spend the money to rent the camera and, I think, on March 28, we will start going into the nursing homes. We will have these as of early next month, and one of our problems will be reduced to a degree.

Senator Moss. I was going to ask, would it be possible to punch that and let them hang it on a dog tag?

Detective MESSINA. They have had the necklaces and bracelets in some of the homes and, apparently, some of the guests feel this is marking them in some way and have removed them as soon as they get out on the street.

This is why we have suggested in this particular area that we send men in and explain the benefit of carrying one of these cards.

Senator Moss. I see.

Captain KELLY. That is part of our program, and we will talk to the people and show them the benefits of using these; that it is not a concentration camp identification thing—like numbers tatooed on the hand—but that it is of a benefit to us and a benefit to them.

TOO MANY IN "LOST" CATEGORY

Senator DOMENICI. Excuse me.

Officer Kelly, the 67 people that you cannot find in the homes who are in the lost category—this does not tell me very much in terms of whether that is abnormal. Relative to what? Tell us a little bit about that.

Captain KELLY. This is the adult category. I would say maybe in the course of a year you would have four or five lost adults from other areas, other than from the various homes.

Again, that 67 represents an across the board—nursing homes and adult homes. We do not break them down and classify them.

This was another reason for calling the meeting to clarify this matter, for there was some confusion of what a nursing home is and what an adult home is. All of these labels: What services are being provided by each; who are dispensing what drugs. We did have a lot of information from the mental health people. They were very helpful to us.

Then on another day we met with the seven adult home proprietors and administrators, and came up with this plan. We made some recommendations to them regarding security; I would also like to point out, regarding the lady who froze on the roof—we did call a search procedure.

This fixes responsibility for some one in that hotel or hospital to look on the first floor, look on the roof, look in the basement, closet, T.V. room, the laundry room, corridors, patios—if they have them—and that kind of thing. The person who conducts that search, since it is documented as a search that was, in fact, conducted by someone and is not left for someone else to do—we know where to point the responsibility. It's documented who did it, and what the time was.

The reason for this is that some confusion can develop if, after 5 at night when the staff is greatly reduced, Joe thinks John did it, and then we have someone go through the scene and see what areas have been searched and have not been searched, and where to go from there.

This also was accepted by the adult-home owners. They have these now, and this procedure is now in effect as of last week.

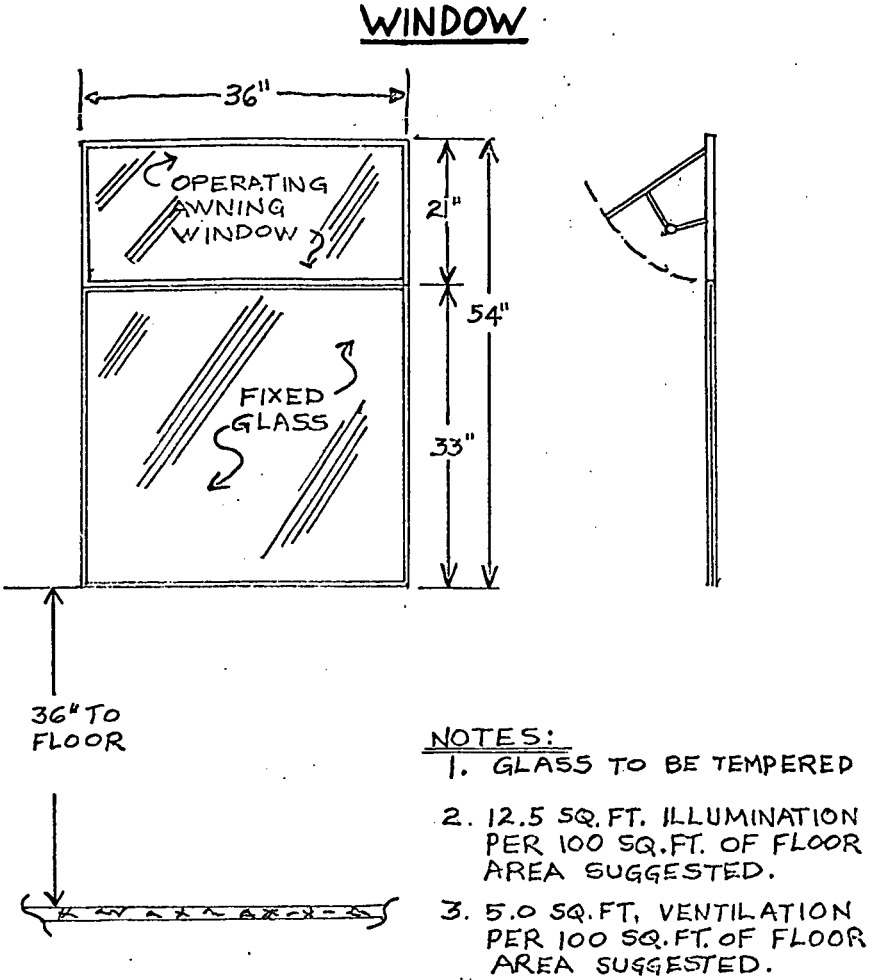
Detective MESSINA. In that location, the female was found out on the roof, and this was a health-related facility.

Also, the time lapse was over 2 hours 45 minutes between the time this individual was reported lost and the time she was found. Apparently the employees were aware of the fact that she did go to the roof area frequently. We have that report also.

Captain KELLY. Additional recommendations—some will cost money, others will not cost much, when made.

The search procedures cost nothing. We have the diagram [1] for

[1] See page 3605.



that type of window in which the patient will not be able to fall out or have an accident from.

Locks Serve Double Function

We have recommendations on locks that should be equipped where it is opened easily enough from the inside, but will keep intruders out.

You also have the problem of residents wandering outside and intruders wandering in. The security responsibility—someone has to be placed in charge of security, to check the doors to see that they are secure.

With regard to new construction being done, we have procedures that we can recommend.

Some of the homes have TV cameras and they can monitor them. We recommend that they be set up at main entrances to see the people coming out, and to see who is coming in. We understand that people are not locked in these buildings. They are guests: they can come and go as they please. But the person leaving should sign out to a specific destination, and then we would have some place to start from if they did that.

We did get resistance on that, because the owners stated that it would require an additional person on their payroll that they cannot afford.

It would be a big help as far as controlling people in and out of the building, from our point of view.

As far as people wandering in the streets, even though the person is, in fact, out on his own free will—oftentimes he is not dressed appropriately. He may have slippers on, or no coat, on a cold and rainy day.

Some of them may be the type of individual, like the woman who comes to the station almost every day and solicits cigarettes—when they find out that the cops are pretty generous—and she comes for a cigarette every morning.

We do get some slack also, and these are what help us in controlling the people.

When we talk about the psychotic patient who has to be referred back, a police officer is required to take that individual in an ambulance. This ties him up for 3 or 4 hours at a time in that kind of service.

That is all I have.

Senator Moss. Thank you very much.

Do you have anything to add to that, Detective Messina?

Alarm Systems Suggested

Detective Messina. Just to elaborate on some of the things the committee had come up with in the area of alarms. Apparently, there is nothing that says that alarms are a must in any of the types of facilities, yet they do house many people in an area. I do not want to get Mr. Fried angry at us, but it was a health related facility. To go to the situation where a female was out on the roof, there should be a large sign on the door saying that if you cannot open the door or if the door is jammed, push the panic button—a very large button—which will notify others of the problem. In this way someone could get up there to save the person out on the roof. Again, if we go into an alarm situation, this would be advantageous to us, not only to the police department, but to the community as well. Some of these people might get out to the streets at night and they themselves might become the victims.

It is not that they are endangering the community as much as they become victims of crime.

Senator Moss. You have suggested many procedures which are sensible and that would help. They should be implemented. I appreciate your help very much.

Senator DOMENICI. Are you in communication with Mr. Shapiro and his agency with reference to these suggestions?

Detective MESSINA. We have had communications with that agency relative to complaints that have been given to us by other police officers relative to these facilities. Since February 4, we have received two.

Senator DOMENICI. It would seem to me some of the things you are suggesting are properly within the jurisdiction of a State agency that controls the properties, the facilities and some minimal standards that might be incorporated on a broader scale.

We cannot do some of the things on a national level, but the kind of work you are doing is a tremendous contribution. I think you and your representatives ought to push it up the ladder, where you can, wherever it applies to minimum standards.

This is the only way to solve some of the problems, and I appreciate your telling us about them.

Assemblywoman LIPSCHUTZ. Being one of the members of the ad hoc committee who has worked this out, first of all, I do want to give a good commendation to the captain.

It was a very difficult job. It took more than 6 weeks through the cooperation of many people, all over. Since then, I have taken this report and used most of it in a bill which I placed in the hopper this past week.

It has not been assigned a number as yet, and therefore has not been committed to a committee. But hopefully it will be next week, and as soon as it has, I should think that I will be able to rally support in the State assembly. Hopefully, we will get the option of the State senators as well.

Congressman Scheuer.

PROFESSIONALISM EVIDENT

Representative SCHEUER. I think the testimony of Captain Kelly and of Detective Messina speaks for itself. I take great pride in the professionalism that the captain and the detective are showing in the 101st precinct. We have enough problems in the Rockaway's nursing homes and health related facilities. If we did not have men of this caliber in our local precinct, I just do not know what we would do. We would have a disaster instead of a service—a very difficult situation.

I want to commend them for their very thoughtful contribution.

Senator Moss. Thank you very much gentlemen. We appreciate your appearance and your testimony.

Detective MESSINA. Thank you.

Senator Moss. We now have a panel of domiciliary owners and operators.

They are made up of Dov Bercu Stoleru, owner of the Royale Manor, and Solomon Ripstein, owner and administrator of the Shalom Adult Care Home.

We will begin with Mr. Ripstein at this time.

Mr. Ripstein, tell us about the Shalom Adult Care Home.

STATEMENT OF SOLOMON RIPSTEIN, OWNER/ADMINISTRATOR, SHALOM ADULT CARE HOME, NEW YORK, N.Y.

Mr. RIPSTEIN. I am the owner and administrator of the Shalom Adult Care Home.

Mr. Lerner was also an owner. We provide the best possible care for our residents, and I myself welcome this opportunity to testify.

[Mr. Lerner did not appear to testify as requested. The committee received the following letter for the record:]

Re: Joshua Lerner.

TO WHOM IT MAY CONCERN: Mr. Lerner is my patient. He is currently under observation and treatment for both a heart condition and the after-effects of abdominal surgery.

There is drainage at the site of the surgical scar on his abdomen. He had surgery for the removal of polyps 1 year ago. This required removal of part of the large intestine.

He suffers from arteriosclerotic heart disease with angina pectoris and is unable to do anything which requires exertion. He is, for all practical purposes, confined to his house. He should avoid any emotional or physical stress.

Very truly yours,

GEORGE METZ, M.D.

Mr. RIPSTEIN. I sincerely wish you would come back, and we hope that this committee will get to the bottom of everything. We want our problems out in the open. I think Mr. Bernstein has contacted Mr. Scheuer's office in the past and has spoken to his secretary, and we have had correspondence. I also want to emphasize that we welcome any help, and we hope that the State ultimately will live up to its responsibilities to its senior citizens and to its former mental patients. Hopefully, we will see some progress.

Senator MOSS. Is this a proprietary home or is it a nonprofit home?

Mr. RIPSTEIN. It is a private home for adults.

Senator MOSS. How many people do you have?

Mr. RIPSTEIN. Approximately 117.

Senator MOSS. Are they on SSI?

Mr. RIPSTEIN. Exclusively on SSI.

Senator MOSS. What is your gross income per month?

Mr. RIPSTEIN. About $44,000 a month—somewhere in that area.

Senator MOSS. You have medical personnel in the home?

REGULAR SCHEDULING FOR PHYSICIANS

Mr. RIPSTEIN. We have doctors who come to see the residents on a regular basis, and we have optometrists, podiatrists, and we are alert to any conditions that the residents might have. If there are any problems, we also arrange for them to see specialists, urologists, or other types of specialists, and we usually bring them down to the out-patient clinic and pick them up.

Senator MOSS. Do these doctors come on a regular schedule?

Mr. RIPSTEIN. On a regular schedule, yes.

Senator Moss. They are available on-call as well?

Mr. RIPSTEIN. Not always, but usually.

Senator Moss. How many people do you have in your employment to take care of these residents?

Mr. RIPSTEIN. We have a full staffing, as demanded by the board of social welfare.

As a matter of fact, we have more than full staffing, because we recently hired a maintenance firm which takes care of our maintenance problems in the buildings. This firm has worked in nursing homes and other adult homes.

Senator DOMENICI. I have an awfully lot of questions that I would like to ask, but we will certainly run out of time.

Let me ask you, what is the monthly rate?

Mr. RIPSTEIN. $386.70.

Senator DOMENICI. Go ahead.

Mr. RIPSTEIN. For the residents, we receive $386.70, but ever since the inception of the SSI program, we have always managed to give out some money to these patients, and sometimes we receive nothing.

At first we gave them $17, and we just could not afford it. But now we give them $10.50, because we do have to give them some dignity.

Senator DOMENICI. What is the normal fee for somebody that wants to stay there full time?

Mr. RIPSTEIN. $386.70.

Senator DOMENICI. Why do you say that reluctantly?

Mr. RIPSTEIN. That is it; $386.70.

Senator DOMENICI. You have two different rates, or are they all the same?

Mr. RIPSTEIN. They are all the same.

Mr. DOMENICI. Now, if these people are on SSI, they get checks, do they not?

Mr. RIPSTEIN. Yes.

Senator DOMENICI. What is the process of handling the checks? After they turn them over to you, how do you handle them?

Mr. RIPSTEIN. We ask them to sign their checks.

Senator DOMENICI. They bring them to a certain place in the building?

Mr. RIPSTEIN. We do not line them up. We usually do everything alphabetically. It is senseless to have them line up and wait.

We deposit the checks and then afterwards they receive a refund. Anything over the $386.70 goes to the resident.

Senator DOMENICI. Do you have a contract with these people?

Mr. RIPSTEIN. Yes.

Senator DOMENICI. Did you bring one along?

Mr. RIPSTEIN. I did not, but you are free to see it.

Senator DOMENICI. I would like to have one for the record. Supply one for us, will you?

Mr. RIPSTEIN. We would be glad to. We will mail it to you.

[The contract follows:]

ADMISSION AGREEMENT

Name of resident_____

Agreement of Home for Adults	*Agreement of Resident*
1. To furnish lodging, board, linens and beddings, and such personal services as may be required for the safety, good grooming, and well-being of the resident.	1. To provide such personal clothing and effects as needed or desired by the resident.
2. To secure the services of a licensed physician of the resident's choice whenever necessary, or the services of another licensed physician if their own is not available.	2. To be responsible for physicians' fees, medications, and other treatment or aids ordered by physician.
3. To arrange for transfer of the resident to an appropriate facility when the home is no longer able to provide suitable care. Such a transfer to be arranged in agreement with the personal physician and/or responsible party.	3. To be responsible for transportation costs, hospital or nursing home charges if transfer of resident becomes necessary.

The resident or responsible party agrees to pay and the home for adults agrees to accept this payment in full consideration for above listed services.

$386.70 per month.

If the resident receives public assistance, the financial cost agreement with the local Welfare department and the resident is the following _____. Total _____.

The resident agrees to pay for the following items which, if provided, are not included in the basic weekly or monthly financial agreement_____

_____

Either party may terminate this agreement on 10 days.

_____	_____
(Signature of proprietor)	(Signature of resident or responsible person)
_____	_____
(Witness)	(Date)

Senator DOMENICI. Let me ask you, do many of your boarders give you a check for more than they owe you? Do you ever hold any money for them that belongs to them?

Mr. RIPSTEIN. No. Only if they—sometimes they will ask you to please hold some money. "I do not want to lose it," they say. We do it as a favor to them; we try not to make it a practice.

Senator DOMENICI. So you do not have a cost accounting system set up with your holding in trust for each one of your patients?

Mr. RIPSTEIN. No.

Senator DOMENICI. Let me see if I can get some yes or no answers.

Did you tell us how many people you have full time at your place to handle an average load of 117.

Mr. RIPSTEIN. I did not tell you.

Senator DOMENICI. How many is it?

Mr. RIPSTEIN. I think it is about 22 or 23, not counting rehabilitation workers from the department of mental hygiene. I think it is 22.

Senator DOMENICI. Do you have any recollection of how many of those are involved in social type work, like recreational activities?

Mr. RIPSTEIN. Yes.

Senator DOMENICI. Will you tell us?

Mr. RIPSTEIN. We have one full-time recreational therapist. We have, I think, five people assigned to us from the rehabilitation department.

They are departmental hygiene workers, and they assist the people in rehabilitation. We have sheltered workshops for the residents which are run by the department of hygiene, and there is a recreational program.

Senator DOMENICI. Do you have a program where your patients work for you part time in the delivery of services? Do you employ any of your patients part time or full time?

Mr. RIPSTEIN. No.

Senator DOMENICI. Are you aware that in some of the States they are experimenting with this?

Mr. RIPSTEIN. I am aware that sometimes residents may do some therapy work, but it is only for their own therapy. We do not take advantage of any of our residents.

Senator DOMENICI. I did not ask you that question.

Mr. RIPSTEIN. I know that.

Senator DOMENICI. In Chicago they do work, and they earn some money, and they enjoy it. They are paid under Federal law. They are paid less than the minimum wage, but they help with the dishes and they help clean up the place. This work is therapy, and people do like it.

I was not asking whether or not there is abuse, but are you familiar with it?

$7 PER WEEK FOR DOING LAUNDRY

Assemblyman STEIN. A complaint letter was received by the board of social welfare that someone was receiving $7 a week, that is, to do all the personal laundries of 124 residents.

This was verified by the board of social welfare. It is in the report to the social welfare board.

Mr. RIPSTEIN. We have aides around the clock—at least one aide around the clock—to do bathing. Most of the bathing is done during the 8-to-4 shift.

Most of the shaving is done by people in the unions. It is not done by our residents.

I do not know of any letters. We do not use our residents to do laundry. That is it.

Assemblyman STEIN. Specifically, in the report, the board of social welfare said in a particular case they give $7 a week to residents to do laundry for 124 people.

Mr. RIPSTEIN. That is ridiculous.

Assemblyman STEIN. Perhaps we should straighten out this thing here.

Senator DOMENICI. I will yield.

Mr. SCHEUER. I have no questions.

Senator Moss. Perhaps you could remain here; you may want to come back.

Assemblyman STEIN. Were there compliance hearings against the Shalom this year.

Mr. RIPSTEIN. We have been, since November 1974—we started this before—this refurbishing of our facilities. We started this to modernize our facilities and to make ourselves competitive with the other homes.

Assemblyman STEIN. But you were not in compliance?

Mr. RIPSTEIN. Excuse me? There is no hearing as far as I know, but can I say something?

Assemblyman STEIN. Sure.

Mr. RIPSTEIN. Most of the violations that we had received in 1975 had to do with decor, but we have undergone a complete remodernization. We have refurbished the building—actually the furniture—put in new furniture; completely redid the rooms and the lobby. You can see it for yourself.

Senator Moss. I wonder if you could furnish us, for the record, your last year's income and that of the owner's salary, the manager's salary, and any dividends that you pay out.

Mr. RIPSTEIN. Can I send that in to you?

Senator Moss. Yes, if you would, please.

Mr. RIPSTEIN. There is no problem.

[The information follows:]

SHALOM HOME FOR ADULTS.—STATEMENT OF PROFIT AND LOSS FOR THE YEAR ENDED DEC. 31, 1975

Income	$594, 268. 80
Expenses:	
Dietary costs	65, 968. 03
Laundry	3, 056. 16
Cleaning and rubbish	4, 239. 24
Insurance	6, 508. 59
Repairs and maintenance	14, 681. 61
Recreation and services	2, 164. 05
Telephone	6, 676. 71
Fuel	14, 638. 48
Supplies	10, 727. 48
Auto expenses	567. 63
Professional fees	3, 938. 73
Rent	222, 000. 00
Taxes	14, 955. 86
Equipment leasing	2, 571. 69
Payroll	178, 174. 92
Dues	6, 812. 00
Electric	9, 451. 70
Bank charges	438. 52
Miscellaneous expenses	169. 78
Depreciation	2, 323. 73
Total expenses	570, 064. 91
Net profit	24, 203. 89
Partners drawings	20, 213. 00
Net profit after drawings	3, 990. 89

Senator Moss. Thank you very much.

Mr. RIPSTEIN. Thank you, Mr. Chairman.

Senator Moss. We will now turn to Mr. Bercu Stoleru, or his representative, I believe.

STATEMENT OF JERRY KLEINMAN, ADMINISTRATOR, ROYALE MANOR HOME FOR ADULTS, LONG BEACH, N.Y.

Mr. KLEINMAN. Mr. Chairman, Mr. Stoleru received a telegram at 6 p.m. last night, and due to the fact that there was an incorrect ZIP code, he just received it then. No one was home to receive it, and there it was under the door. So I am here—I am the administrator and I can try to do whatever I can.

Senator Moss. All right. Mr. Kleinman, where is the Royale Manor located?

Mr. KLEINMAN. Long Beach.

Senator Moss. How long have you been connected with it?

Mr. KLEINMAN. Approximately June 1974.

Senator Moss. And how many residents do you have there?

Mr. KLEINMAN. 185 residents.

Senator Moss. And what staff do you have?

Mr. KLEINMAN Off hand, maybe 27.

Senator Moss. And are these all full time?

Mr. KLEINMAN. Yes.

Senator Moss. And do you have a flat rate?

Mr. KLEINMAN. Yes.

Senator Moss. What is your flat rate?

Mr. KLEINMAN. The rate is $386.70, which is negotiated with each resident on a contract. Each resident comes into the office, sits there, and negotiates the rates, basically.

Senator DOMENICI. You do not have a flat rate then?

Mr. KLEINMAN. We have some residents who receive more money back which seems, afterwards, that we get less money.

Senator Moss. Everything they may have comes off of the $386.70—you pay back to the resident anything over?

Mr. KLEINMAN. Yes.

Senator Moss. Do you set a trust account for these people?

Mr. KLEINMAN. Yes.

Senator Moss. As soon as the check comes in.

Mr. KLEINMAN. Yes.

Senator Moss. Do you employ any of the people there—any of the residents?

"MAKE-WORK" EMPLOYED

Mr. KLEINMAN. Yes. It is all make-work. It is a thing that we have tried to stop before. A lot of the money that is received is for make-work, and it was very difficult to stop.

The board of social welfare is aware of this. It has worked out very well, in a sense, for the residents. They are making some extra spending money and they are regulated as to how much they can work. None of this work has to be done for the facility.

One thing I can guarantee: If these residents do not work, the facility does not suffer.

All of this is make-work. This is a condition we found when we came into the facility. I will give you an example. This one woman received a small stipend, and then she was not able to do anything. We had to keep giving her the stipend. There is no way we can stop it. She has no money, and this money is in addition to whatever she receives from her check.

Senator Moss. Would you mind furnishing us with a statement of accounts [1] as I have asked Mr. Ripstein to do?

Mr. KLEINMAN. I will have to ask Mr. Stoleru. This is of the previous year?

Senator Moss. Yes; the previous year.

Mr. KLEINMAN. I would imagine so.

Senator Moss. Have you had any difficulty of people wandering away, such as the woman that we talked about earlier today?

Mr. KLEINMAN. When we find problems, we straighten it out right away. Our residents have a bracelet which states the name of the home and their room number.

Also, anytime a resident is missing, we try to report it, but they can come and go as they please from this facility.

If the resident has nowhere to go and that person is missing, we fill out a missing person's report.

I just put on the report what they are wearing and the fact that the person is wearing a bracelet, and to contact us immediately when they find them.

Senator Moss. How much does that bracelet cost to provide?

Mr. KLEINMAN. Ten cents, or something like that.

Senator Moss. A very small amount.

Mr. KLEINMAN. Yes. I believe it is 10 cents each. It is like those you find in the hospital.

Senator Moss. So that would identify them.

Mr. KLEINMAN. Yes; and again, I am in the facility almost 7 days a week, from early morning until late at night.

I know the habits of every single resident. I am very, very close to my residents, most of whom I know by their first name. That is all I can say.

Senator Moss. Assemblyman Stein.

BUSINESS RELATIONSHIP QUESTIONED

Assemblyman STEIN. Thank you, Mr. Chairman.

I noticed that you lease the building and property, which is owned by a realty corporation, which is owned by Mr. Stoleru.

On August 30, 1970, Mr. Stoleru drew up a lease for himself and his wife to lease that property and building. The question is: Is Mr. Stoleru the landlord and tenant?

Mr. KLEINMAN. I'm not sure about that. I don't think so.

Assemblyman STEIN. Would it be possible for you to get Mr. Stoleru to answer that?

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[1] Not received at time of publication. See appendix, item 3, p. 3628.

Mr. KLEINMAN. Yes.

Assemblyman STEIN. In writing?

Mr. KLEINMAN. Yes.

Assemblyman STEIN. This is the same kind of thing that we ran into in the nursing home investigations, where we have these arms-length agreements.

Mr. KLEINMAN. The point is, I believe it is arms-length here.

Assemblyman STEIN. On August 30, 1970, the annual rent was $35,000. Today, from January 31, 1975, it is around $120,000 paid to himself.

Would you not state that 340 percent increase in less than 4½ years is high?

Mr. KLEINMAN. I don't know. I am not familiar with Mr. Stoleru's financial condition.

Assemblyman STEIN. I am sorry that Mr. Stoleru is not here. Maybe you can have him answer some of these questions. I will give you a copy of this,[1] and see what you can do with it.

Mr. KLEINMAN. What difference does it make if he does that, since we are not on a cost-plus rate?

Assemblyman STEIN. First of all, I am asking the questions, even though you may be better than I am. But to me, 343 percent increase in rent is a little bit high.

Senator DOMENICI. It might make a difference as we attempt to evaluate whether or not the amount of money being paid to these homes as a direct result of a national SSI law, supplemented by the State, pays enough so you can pay this kind of rent. It may not be in the sense of a deal, in the sense of doubledealing under the previous law, where we were paying any excess that occurred in a non-arms-length transaction, but we are trying to evaluate why the resident patients are not able to get more service in this State. It is obvious that one reason is the real estate costs. They are very high here, yet the rates are flat.

SERVICES NOT COMPARABLE TO OTHER AREAS

I have been to Chicago, and $328 gets a tremendous amount of service—more service than you are giving—for the same kind of alleged facility with the same kind of management.

In one of the best homes in Chicago, they charge $335 a month, and the ratio in staff is a great deal better. All recreation is provided in-house, and all sorts of services are provided in-house.

It is very relevant as to whether or not you ought to be talking about expensive downtown buildings, or about getting out somewhere in rural areas. All that affects the profit picture. I'm not saying that it is criminal, but it is just what we want to know.

I would like to ask you, what are the biggest problems you have in operating these homes?

Mr. KLEINMAN. We would like to be able to give more service. I would like to have a larger staff. Our staff has been enlarged and we would like to increase it more. We would like to have full-time

[1] See appendix, item 3, p. 3628.

recreation. Some of these people like bingo all day long, and some like to watch a movie all day long.

I would like to have recreation for all. This is something we would like to have.

Senator DOMENICI. You are saying, as manager, the amount of money you are receiving per month does not permit you to provide the kind of service that you think the people need—is that correct?

Mr. KLEINMAN. Right. We provide the kind of service that is approved by the board's code, but I feel that I would like to do more.

Senator DOMENICI. One question about the state of health of your clients. I understand you are supposed to have, in your facility, people who are ambulatory and who do not need constant attention.

Mr. KLEINMAN. Yes.

Senator DOMENICI. Is this a serious problem, whether you can maintain a healthy group of people that do not require medical attention?

Mr. KLEINMAN. None of my residents are all nonambulatory.

I interview everybody personally, and the first question I ask: "Are you ambulatory? Can you take care of yourself?" If not, they go to a nursing home.

Senator DOMENICI. Do they get physical examinations?

Mr. KLEINMAN. Yes.

Senator DOMENICI. Who does those physicals? Is it a doctor, do you, or do you have a staff?

Mr. KLEINMAN. Every resident is examined by a doctor within 24 hours of admission to the facility.

Senator DOMENICI. What do you do with the doctor's examination when it comes back? Does it say to admit the person, or does it say not to admit him?

Mr. KLEINMAN. Based upon the original interview with the social worker, if the person has been under the doctor's care, they will tell you—documentation will tell you this. If he is a person with diabetes or if he has any infectious disease, the person receiving the examination will learn of these things.

A number of doctors provide care to facilities.

Senator DOMENICI. Thank you, Mr. Chairman.

Senator MOSS. I thank you.

We will now hear from Mr. Milton Klein.

STATEMENT OF MILTON KLEIN, NEW YORK, N.Y.

Mr. KLEIN. Thank you, Mr. Chairman.

My name is Milton Klein, and we operate four facilities in the city of New York.

I have been in the business for the past 15 years. I had been in it before—they were known as adult homes, but they were run as hotels for senior citizens.

Two of our facilities come under the grandfather clause. They are old, and two of them are newer facilities. Within the last 4 years—it must be brought to mind this morning the question of why any operator would go into this business and be losing money.

No business is put together over night. It takes us approximately 3 to 4 years to draw up plans of location then get started.

When we started building these facilities 4 years ago, no one thought, you might say—at that time our rate was $375; we were receiving pay for and by the city and the State of New York.

In the 4 years' time, there has been no increase for the operators. The SSI program in January a year ago took away the payments, and they started sending in the SSI checks.

Somehow, in all that time, we were all forgotten. No one thought that our expenses were going sky high—taxes, food, health costs, insurance, license—no matter how many meetings we had with various agencies we were promised increases, but nothing ever developed.

First, we were told we could look to a certain percentage, but our costs continued to go up—that is, the maintenance. The social service board asked for more staffing, and our costs continued to go up.

I, for one, have complied, and I am in full compliance with all regulations and with staffing. In fact, we are above staffing. I do not believe in cutting services, food, or anything, in any of our places.

Costs Increasing

Two of our new facilities—last July we were forced into a chapter 11 bankruptcy proceeding. The costs of running these facilities have gone up—the costs are tremendous.

Fortunately, I was in a position where I owned the property and also operated it. The mortgage that was taken out—the payments have to be made to the bank, and we will not take anything out after we make those payments.

An increase must be given to this industry for it to survive. The operators cannot keep on taking money out of their pockets in the amount of hundreds of thousands of dollars and to keep borrowing to keep their doors open, and to continuously keep operating.

We've got to have relief. We must have that relief to give service and to provide service to people.

Now, we know there are certain homes that may cut services and take away things from the guests. I am sure that most of the industry does not condone this action, but the mere fact three or four or maybe six homes may do this does not constitute a condemnation of the entire industry. No more than three or four or seven crooked politicians should condemn the entire political system, and that goes for us, too.

We welcome this investigation and hearing—it is about time it was held—so that the truth and, maybe, some relief will finally come out of it, to see that the elderly get what they so justifiably deserve.

Thank you.

Senator Moss. Thank you, Mr. Klein, and I agree with you. We need to find out whether or not the costs are sufficiently met and I wish you would furnish a balance sheet also.

Mr. Klein. I think you have it. You were given it this morning—the transcript[1] of our bankrupt proceedings.

Senator Moss. That is fine. That will help us and we will look at it.

Where are your four homes located?

Mr. Klein. Three in Brooklyn and one in Staten Island.

[1] Retained in committee files. See footnote, p. 3557.

If I may continue—there has been a lot of talk about people coming from mental hospitals into these facilities. I think it is only fair that the talk of these people coming from mental hospitals should be clarified.

Most of the people that are coming have been deemed to be released from the State hospitals into the homes, and most of them, by today's standards, should never have seen the inside of a mental hospital.

It was not uncommon 30 years ago to have a mother or father or child in these facilities with nothing being done for them. In the thirties after surviving the depression when hundreds and hundreds of people jumped from windows and from roofs, they suffered a lot. Thousands suffered mental breakdowns due to business and financial failure.

They wound up in these same hospitals. At that time, it was not uncommon for a husband or a wife who wanted to put a mate away to have such done by just a signature.

Nonresidents Experience Discrimination

I know in our facility we do a good and thorough screening job before we take anyone in. We go through three screening processes. Unfortunately, in the community of Staten Island, we run into the very severe community problem of the last 2 years where the community does not believe that Staten Island is a part of New York City, or the State of New York, or even of the United States. They have applied much pressure to the South Beach Hospital to withhold services for these people unless they were residents or former residents of Staten Island.

They absolutely refuse—it is a matter of public record that they will not service these people or to allow anybody to be discharged from another hospital through our Staten Island facility.

Now, I think that is an outrage. After all, the mental person is a human being also, and he does have rights. He has a rightful place when he is discharged back into the community.

Senator Moss. Well, we do thank you very much. I appreciate your discourse of what has happened in the years past. With regard to mental hospitals—and I agree with you—the fact that many are coming out does not necessarily indict them provided they are screened properly. But we know that many are being left adrift.

We regret that we are going to have to terminate this hearing because we have an airplane to catch, but we do appreciate your testimony. I think you have added a good bit to our record.

We do have two additional documents that were furnished that I will place in the record. We have a statement from Dr. McKinley, who stayed here all day, and I appreciate very much that he has given us a written statement.

This statement and that of Mr. Haugh will be made a part of the record.

[The statements follow:]

STATEMENT OF ROBERT A. McKINLEY, ACTING FIRST DEPUTY COMMISSIONER, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

I am Robert A. McKinley, acting first deputy commissioner of the New York State Department of Mental Hygiene. I feel that it is appropriate that I testify

here inasmuch as of the 17,000 people residing in proprietary homes for adults, 5,000 are former patients in State and local psychiatric centers. It is quite likely that more than these are in need of some form of psychiatric care.

To put the problem in perspective, it should be realized that there were about 33,000 patients released from State mental hygiene facilities during 1975. Of this number 1,100—or 3.3 percent—have found their way into proprietary homes for adults. Annually, over the past 10 years, about 6,000 chronic patients have been released from State centers. I mention these statistics not to minimize the problem but to point out that it should be manageable.

Until appropriate living arrangements can be made available for the mentally disabled and perhaps all persons, the problem will continue to exist. PPHA's now provide an alternative to living in a departmental institution—an alternative which many people prefer.

What Are We Doing?

(1) We are in the beginning stages of implementing a program to develop treatment plans for every discharged patient. These plans include arrangements for appropriate community care. In this effort we are working with the Board of Social Welfare and the Department of Social Services. This cooperative effort needs to continue and expand.

(2) Currently, we, along with others, do provide some treatment, though inadequate in amount, to clients residing in PPHA's. We estimate the equivalent of 120 State full-time Department of Mental Hygiene staff now provide service to clients in PPHA's. Local mental health programs and in some instances private psychiatrists in the surrounding communities also give some care. To the extent resources are available we are asking department facilities to provide more service.

(3) We have stopped our facilities from placing clients outside their own catchment areas unless assurances are given by the director from the receiving area that he can follow the patient adequately.

(4) We are studying all of our State facilities for multipurpose use with the view to develop domiciliary care programs for patients already in residence but who will require a lesser degree of care. We do not necessarily see this as a long-term solution but an intermediate step in dealing with the problem. We must now secure non-State sponsorship for these arrangements.

(5) We need more facts. In collaboration with the Board of Social Welfare, the Department of Mental Hygiene is undertaking an assessment of the needs of PPHA residents so we can plan more effectively for their care. This assessment will be completed by late spring of 1976.

What Can Be Done?

(1) Federal legislation should be enacted to permit medicaid payments to persons between the ages of 21 and 65 who are admitted to State mental hygiene facilities. The denial of medicaid effects a substantial number of our citizens in New York. About 80 percent of admissions are in this age group as are about 60 percent of the patients residing in psychiatric centers on any particular day. This could make more resources available so that patients would be more adequately prepared for community life.

(2) Presently supplemental security income recipients cannot live in residential arrangements operated by a State agency. A change in Federal law is needed to permit State sponsorship.

(3) Mandate that any federally funded mental health center must take into account this population in its annual plan. This would include a survey of this high risk group in their service area and a requirement to see that quality care is provided. This should be part of a larger program to insure that federally funded mental health centers are truly comprehensive and that they are serving the most seriously disabled.

(4) SSI recipients residing in PPHA's should receive an adequate amount of spending money as an aid to their rehabilitation so that they can participate more actively in the life of the community. Regulations should be developed to assure that this happens.

I hope some of these remarks will be helpful in moving toward a solution of some of these very complex problems. There are no easy answers, particularly since we all realize that resources will always be limited and attitudes toward those with mental impairment change slowly. I feel that the trend

toward treating most of the chronically mentally disabled in the community will continue and that it is desirable on a programmatic basis. PPHA's are not, in many instances, the preferred residential arrangement, but they will continue to be an option for some dependent persons for many years to come. People should be served in PPHA's on the basis of their need and the capacity of the home and other supporting elements to meet that need. Diagnosis of a mental illness, or any other illness, should not be the determining factor.

We will provide the committee with any data we have available and would be pleased to meet with committee staff to discuss these problems in detail.

STATEMENT OF BRIAN HAUGH, DIRECTOR, PUBLIC INFORMATION AND RESEARCH, STATEN ISLAND, N.Y., COMMUNITY CORP.

Ladies and gentlemen, my name is Brian Haugh, and I am here representing the Staten Island Community Corp. We have come to raise several questions regarding the vital issue of domiciliary care for our citizens.

Since April 1974, the Staten Island Community Corp. has been actively investigating the patterns of nursing home and domiciliary care facility ownerships. While we have focused our attention primarily on Staten Island facilities, our efforts have led to inquiries regarding related properties in other boroughs, as well.

Our interest in these institutions began 2 years ago, when Bernard Bergman began an intensified lobbying effort for his Danube Nursing Home (also known as Island View Nursing Home and Richmond Manor—Home for Adults). Bergman proposed to place Department of Mental Hygiene patients, then residents at Willowbrook Developmental Center, into his facility at an inflated annual rate. For, although his contract would call for reimbursement at a rate appropriate for a skilled nursing home, Bergman planned to deliver only domiciliary care.

It seemed to us that Bergman had a facility built as a nursing home, but capable of being licensed only as a domiciliary care facility. And, since there was a limited potential for excessive profit-making in the domiciliary care field, Bergman desired a means of increasing his profit.

The main difference in reimbursement for these facilities lies in the area of medicaid. Since a domiciliary care facility provides only "hotel" services, its residents are usually ineligible for health-related benefits such as medicaid. Even now, the real profits remain in nursing homes.

But, despite this lack of current profit potential, several areas of New York have continued to experience an increase in the number of domiciliary care facilities being constructed in their communities. Staten Island, for instance, has seen a disquieting "boom" in the number of DCF beds available in the borough. No less than five new facilities, with a combined total of more than 1,000 beds, have been constructed on Staten Island during the past 2 years.

There is, however, little need for these 1,000 domiciliary care facility beds in this borough. Quite simply, a population sufficient in number to fill these beds does not exist in Staten Island. Most of these beds, therefore, remain empty. Four domiciliary care facilities, in fact, have not even opened their doors. It is as though they are waiting for their "ship to come in"—a ship bearing medicaid reimbursements and New York State Department of Mental Hygiene contracts.

Many Department of Mental Hygiene patients have already been placed in domiciliary care facilities during the past few years. Several facilities, owned by the Klein family, have filled their beds with a number of former mental patients.

The Klein family are associated with at least six facilities, including two in Brooklyn and one in Staten Island that house former mental patients. These residents, many of whom still require some supervision and out-patient care, have found themselves in domiciliary facilities where they receive little more than bed and board.

The results of such care (or lack of care) have, on occasion, been quite tragic. At Klein's Forest Manor, located on Staten Island, there have been a number of "accidental" deaths where residents fell from windows or rooftops. These deaths have always been classified as suicides.

At Klein's Ocean Manor, in Brooklyn, two former residents were involved in an altercation last year—it resulted in murder. Obviously, these former

patients were in need of therapy and care—the kind they were not receiving in a domiciliary care facility.

Why do tragedies like these occur? The reasons are many, but the fact that these DCF's are not really community living situations is a contributing factor. The State has sought to empty its mental hygiene and retardation facilities following the exposure of conditions in places such as Willowbrook. Unfortunately, instead of developing group and foster homes for these patients, the State has chosen the easy way out—by transferring these patients from a large institution to a smaller institution. And, in mini-institutions such as DCF's, the quality of care is frequently worse than that provided directly by the State.

"PERCHED LIKE VULTURES"

The four vacant DCF's on Staten Island are in close proximity to two State facilities—Willowbrook and South Beach Psychiatric Center. It seems obvious that these buildings are perched like vultures, waiting to snatch State mental patients as they exit the larger institutions.

More disturbing, however has been the continuing efforts of some facility owners to win outright contracts with the State Department of Mental Hygiene. For instance, there is a 300-bed facility on Haven Avenue in Manhattan that has remained empty for 2 years.

Owned by the Walter Scott Co., a realty firm that has garnered the attention of several investigative reporters, including the Village Voice's Jack Newfield, the Haven Avenue facility has been considered as a residential facility for 300 Willowbrook residents. According to a Willowbrook mother who toured the facility, the owners emphasized the chandeliers and Ethan Allen furniture—but said little about available care. "They kept asking: 'Now, isn't this better than Willowbrook?'" she recalls.

Obviously, many developers are looking to the State as a source of bail-out money and contracts for facilities that can't be filled by conventional means. The question of who receives these State patients, and why they are assigned to a particular facility or chain of facilities, remains a most curious and puzzling issue. Certainly, the potential for corruption exists in such State contracts.

We are opposed to this placement of mental hygiene patients in domiciliary care facilities for another reason, as well. The Staten Island Community Corp. has always supported the deinstitutionalization of these patients and their settlement in foster homes and small-scale group homes. Frequently, we encounter neighborhood resistance to a group home's establishment—the local residents fear for their children, their property values, and themselves.

They have heard stories about the patients "running wild" at Klein's Forest Manor, and they fear that sort of atmosphere in their communities. We try to explain the difference between those unsupervised mini-institutions and a group home, but it's a difficult case to make.

Certainly, the questions regarding ownership and illegal profiteering in the DCF industry deserve the attention of this committee. Just as Bergman, Heisler, and Hollander emerged as the heads of nursing home syndicates, certain names frequently appear, in various combinations, as DCF owners.

The Klein and Scharf families, for instance, are involved in a number of facilities. Sidney Pullman, a facility developer who operates under a variety of corporate names, is also heavily involved in the industry—especially in Staten Island. There are even instances of international ownership in DCF's—Broadview Manor, a Klein-Pullman venture, included two residents of Vienna, Austria, as owners.

And, regarding the Haven Avenue facility, there have been ownership changes complicated enough to rival any Bergman property. A half-dozen listed owners (including a carpet company), all residing at the Walter Scott address, have been listed as owners during the past few years.

Considering the rather confusing nature of this industry and its questionable reliance on a State agency for patients, the domiciliary care facility business seems a most appropriate target for this Senate committee's investigation.

Senator Moss. We stand adjourned.

[Whereupon, the subcommittee was adjourned at 4 p.m.]

APPENDIX

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM CHARLES J. HYNES,[1] DEPUTY ATTORNEY GENERAL, STATE OF NEW YORK; TO STANLEY STEINGUT, SPEAKER OF THE ASSEMBLY, STATE OF NEW YORK, DATED MARCH 18, 1976

DEAR MR. STEINGUT: Three days ago, on the very day the Senate was voting upon the budget, I learned for the first time of the proposal to withhold the additional funds I requested to complete my medicaid investigation. I am addressing this letter to you in your capacity as speaker of the assembly to underscore the details of my budget request. I am convinced, based on more than a year of investigating nursing home abuses, that these funds are vital to the success of my office. I therefore request that next Monday, when the legislature votes on certain changes in the budget, you move the restoration of the deleted funds.

I requested funding for 164 additional positions: 96 auditors and 68 additional support staff, including some 30 investigators and 9 lawyers. This addition to my existing staff would provide the essential personnel to carry through to completion several main thrusts of my investigation:

(1) The audit and investigation of reimbursement claims submitted during the past 6 years by all nursing home facilities in order to recapture the funds misappropriated from the State;

(2) The determination of the extent of medicaid fraud in other public health areas;

(3) The development of a permanent fraud control mechanism to prevent any reoccurrence of medicaid abuse once my office goes out of existence.

Unless those objectives are achieved, my investigation will make but a temporary contribution to the sound management of the medicaid system and the provision of decent care for the elderly, and the funds misappropriated at their expense will be beyond our reach forever, as the Statute of Limitations runs.

It has been suggested that a substitute for my proposal would be my use of 120 of the 288 new auditors provided in the new budget for the department of health. I think this suggestion needs careful analysis and clarification. The department of health is only gaining 120 new auditors. The remaining 168 positions will be filled by patient-care survey personnel. Under legislation you passed in the 1975 session, you required the department of health to make at least two inspections annually in order to review the adequacy of care in all residential health facilities. These 168 positions presumably will carry out that obligation. They are not fiscal auditors.

In actuality, the legislature provided the department of health with 120 new auditor positions. These are not a resource we could effectively draw upon to do fraud audits covering 5 years of past reimbursement claims of nursing home operators.

This addition of 120 auditors will give the department of health a total of 204 auditors. Perhaps that figure sounds impressive, but not when it is measured against the department's obligations. Those auditors must:

(1) Audit the current year's returns of all nursing homes and health related facilities, a total of 780 institutions with 1975 medicaid expenditures of $1.25 billion. This requirement was imposed by the legislature in the 1975 session.

[1] See statement, p. 3545.

(2) Review the Blue Cross and Blue Shield audits of 360 hospitals, with 1975 medicaid expenditures of over $1 billion.

(3) Audit the construction under articles 28A and 28B of the public health law of nonprofit health care facilities—both hospitals and nursing homes. The current workload is 120 projects with a total construction cost of approximately $500 million.

(4) Audit all other facilities, such as home health care agencies, and clinics, under the department of health's jurisdiction—more than 400 facilities with 1975 medicaid expenditures of some $500 million.

(5) Address the problems of some 700 medicaid mills, currently operating without any effective supervision.

This is a staggering task that will easily consume all health department audit personnel, both existing and newly budgeted.

OFFICE CONDUCTS SOPHISTICATED AUDITS

Moreover, the proposal to use health staff in my investigations bears no relation to the way my office functions. My office conducts sophisticated fraud audits, which take my staff behind nursing home books to scrutinize vendor dealings and to identify the nature of and participants in potentially corrupt transactions. I must have my own audit staff, trained and skilled in sophisticated fraud audit techniques. Equally indispensable are the legal, investigative, and support personnel who do the field work and develop materials for prosecution.

This request has been carefully structured. It grows out of the experience of my office in more than a year of investigation and prosecution, where I found the common thread among nursing home operations to be a sweeping pattern of improper claims for reimbursement.

It comports fully with the desire of Governor Carey to identify and deal swiftly with misuse of medicaid funds in other health areas, as part of his long term goal of reforming health care management in New York State.

Finally, it was based on my own personal belief that these abuses, which undermine high standards of patient care, must never be allowed to reoccur; that the sequel to this office shall not be another round of scandals once the public expressions of concern have faded. Only the development of an effective and permanent fraud audit unit to supplement the day-to-day work of the department of health can guarantee this.

The size of this budget request is modest, particularly in the context of the size of a $3.2 billion medicaid program. I envision that if this budget request is approved my work can be completed by the spring of 1978, and the diversion of medicaid funds from patient care eliminated.

My proposal offers immediate and concrete fiscal benefits to the State, far in excess of its cost. My audit of nursing homes' past claims would identify a minimum of $70 million in overpayments for recovery and return to local, State, and Federal governments. These millions are to be lost if my request is denied.

The identification of overstated costs in past returns will play a real role in controlling spiralling medicaid costs. Once overstated, many costs remain permanently in a nursing home's rate base, falsely inflating expense ceilings, depreciation allowances and equity returns. Identifying and correcting cost overstatements will insure that future medicaid reimbursement is limited to the amount actually expended on patient care, and reduce the rate of growth of medicaid payments to nursing home operators.

These conclusions are not based upon speculation. Rather, they are founded upon analysis of the findings of our audits to date. My auditors have already identified more than $13 million in overpayments which will be available for recovery by the State. I have received actual restitution, in hand, of $237,000; moreover, additional restitution is to be made in several other cases.

I have extensively detailed my first year's experience and the considerations which led me to make this request for additional staff in my first annual report to the Governor. I have enclosed a copy of this report for your information.

The issue before you here is the extent of our commitment to reform the sagging medicaid system and to provide top quality care for the elderly. Failure

to restore these funds to my investigation would be an unmistakable signal that the State's commitment to qualify medical care for the aging is limited and tentative, as my investigation would then have to be.

I view my duty in light of the goals set out by Governor Carey at the time of my appointment: to fight to change a system that has left thousands of our older citizens to live out their lives in misery; to see that those who have exploited and mistreated our elderly for gain must feel the full force of an outraged people; to insure that institutions built to serve the elderly are scrutinized and reshaped. I have submitted this budget request pursuant to that duty and to carry out successfully the obligations it imposes.

Sincerely,

CHARLES J. HYNES.

ITEM 2. LETTER AND ENCLOSURES FROM CAPT. JOHN J. KELLY,[1] NEW YORK CITY POLICE DEPARTMENT; TO SENATOR FRANK E. MOSS, DATED APRIL 12, 1976

DEAR SIR: Enclosed please find a copy of a report on security conditions in homes that house senior citizens.

This report was dated February 4, 1976.

Very truly yours,

JOHN J. KELLY, *Captain.*

[Enclosures]

POLICE DEPARTMENT,
New York, N.Y., February 4, 1976.

From: Commanding Officer, 101 Precinct
To: Commanding Officer, Queens Area
Subject: Recommendations Re: Security at homes for senior citizens.

1. In response to an incident in which an 82-year-old female was found frozen to death on the roof of a "Health Related Facility," the undersigned directed the 101 precinct crime prevention and community affairs specialists to research problems at senior citizen's facilities.

2. An ad hoc committee was formed, and on February 4, 1976, a meeting of that committee was held in the office of the 101 precinct commander.

3. The attached report contains recommendations formulated by said committee which will be made to the operators and administrators of nursing homes, health related facilities, and adult homes within the 101st precinct.

4. I call your attention to paragraph No. 7 and suggest that the recommendations made in this report be forwarded to the crime prevention section and the legal bureau for consideration of formulation of such legislation.

JOHN J. KELLY, *Captain.*

[Enclosures]

POLICE DEPARTMENT,
New York, N.Y., February 4, 1976.

From: Commanding Officer, 101 Precinct
To: Commanding Officer, Queens Area
Subject: Nursing homes, health related facilities, and adult homes within the confines of the 101 precinct.

1. On January 17, 1976, at a health related facility located within the confines of the 101 Precinct, a resident exited from the roof door, undetected, and was later found dead on the roof. The administrator of this facility stated that he had checked the door alarm that evening before leaving, and it was in good working order. Further investigation indicates that in the year 1975, 67 people were reported lost from nursing homes, health related facilities, and adult homes located within the confines of the 101 Precinct. These were individuals lost over a period of 24 hours, and our reports do not indicate how many others are lost for a lesser time and do not come under the heading of "Missing Persons." Of the 67 reported lost, 30 were from the location where the female was found dead on the roof.

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[1] See statement, p. 3601.

2. In an attempt to correct existing conditions and prevent further occurrences, Captain John J. Kelly, commanding officer, 101 Precinct, directed his staff to draw together the expertise of certain selected individuals in the community and solicit their help and suggestions. This ad hoc committee consisted of the following individuals:

Mr. Bernard Feuer, nursing home administrator;
Mr. Herbert Rothman, health related facility administrator;
Ms. Anne Wyden, South Shore Rockaway Mental Health Service;
Mr. Antonio Blanco, director, South Shore Mental Health Services;
Mr. Gerald Fried, State Association of Homes for Adults;
Mrs. Gerdi Lipshutz, community liaison, Rockaway Health Council;
Mrs. Pearl Appelman, mayors office, Neighborhood services;
Detective Gary Messina, crime prevention specialist, 101 Precinct; and
Detective Frank Favilla, community relations specialist, 101 Precinct.

3. Generally, these institutions are divided into three categories: Nursing homes; health related facilities; adult, or proprietary homes.

Information relative to these institutions is as follows:

A. Nursing homes:

1. Regulated—New York State Department of Health.
2. Registered nurse—on premises 24 hours per day (one per "X" number of patients).
3. Controlled drugs—dispensed by authorized personnel.
4. Administrator—licensed by the State.
5. Service—complete medical care for injured; mentally retarded; etc.

B. Health related facilities:

1. Regulated—New York State Department of Health.
2. Registered nurse—on premises 40 hours per week, Monday through Friday (one).
3. Controlled drugs—can be possessed by resident, at the discretion of the administrator.
4. Administrator—licensed by the State.
5. Service—supervisory care for ambulatory residents.

C. Adult—or proprietary:

1. Regulated—New York State Board of Social Welfare.
2. Registered nurse—not required on premises.
3. Controlled drugs—held by administrator and brought to the guest at meal time. Not dispensed by a registered nurse or practical nurse.
4. Administrator—not licensed.
5. Service—food, shelter, custodial care, recreation.

4. There are no existing laws or regulations that mandate:

A. Bed checks.
B. Alarm installations.
C. Camera surveillance.
D. Search procedures.
E. Security responsibility.

5. All the above indicates a lack of laws or regulations that are specific in the areas pertaining to drug control, building security, and the safety of the individual patient, resident, or guest. Rules that merely state "The safety of the patient, resident, or guest will be the responsibility of the administrator" are vague and are not generally enforceable. Many administrators have provided security techniques and controls on their own; however, some have been remiss in the matter.

6. Security suggestions:

(a) *Bed checks.*—We suggest bed checks to be conducted by the outgoing and incoming shift, and recorded on a form. Responsibility will then be placed on an individual. We also recommend an additional bed check at 0400 hours. We feel that this is necessary because if an individual does leave one of these facilities unnoticed, the lack of pedestrian traffic on the street will lessen chances that he or she will be observed and reported to the police.

(b) *Alarms.*—We suggest a "proprietary alarm" installation. All exterior doors and doors that lead to sensitive areas should be equipped with alarms that terminate at either a central point at the nursing station, or at another point within the premises. The alarms should be equipped with two reset

switches. One will be at the desk and one at the point of origin. This will force a visual check of the door and area, and prevent the turning off of the alarm without the knowledge of the person at the desk (zoned panel, light indicator, and audio).

Panic alarms should be installed on the roof, terraces, etc. If an individual was accidentally locked out or could not open the door, they could press the panic alarm—which would ring at the desk.

(c) *Surveillance cameras.*—We suggest the installation of closed circuit television cameras with monitors at the control desk to enable constant viewing of selected areas.

(d) *Search procedure.*—We suggest a search procedure form to be instituted. This form will be an itemized search procedure which will list all areas to be searched; who searched them; and, if necessary, the times the police were notified and responded. [See below.]

(e) *Photo identification.*—We suggest the issuing of identification cards to all residents. The cards will have a photo affixed and list address and medical peculiarities. We also suggest a duplicate card to be filed at the location in a resident photograph file, and given to the responding police when a person is reported lost. (Card annexed hereto [See p. 3603.].)

(f) *Windows.*—We suggest all windows to be installed no lower than 3 feet from the floor and constructed in two sections. The lower section to be of tempered glass and of solid construction. The upper section would operate from below by means of a crank and would open out (awning windows). This type of window would provide the necessary amount of illumination and ventilation, deterring burglaries, and accidental falls from windows by residents. (Diagram enclosed [See p. 3605]).

(g) *Locks.*—All exterior doors should be equipped with antipanic locks that prevent entry from the outside without the use of a key, but allows quick emergency egress.

(h) *Security responsibility.*—One individual in the institution should be designated "security coordinator." This person will be responsible for monitoring the internal security of the building, carrying out all mandated security measures, provide security programs unique to the location, and maintain records. Members so designated could be afforded the opportunity to attend the security management course conducted by the New York City Police Department Academy.

(i) *New construction.*—Security procedures and equipment be given major consideration when new facilities are contemplated. Initial installation of such equipment would provide for maximum security at less cost. Providing better security will enhance the image of these facilities and provide greater protection to the residents, and the community.

7. It is further recommended that this department consider the feasibility of initiating security standards for all facilities in which aged or disabled persons reside, or are being treated. These standards would require legislation similar to the regulations promulgated by the New York City Fire Department.

JOHN J. KELLY, *Captain.*

[SEAL]

MISSING PERSON SEARCH PROCEDURE

In an attempt to provide greater security and safety for residents of nursing homes, health related facilities and adult homes, within the confines of the 101 precinct, the following is a suggested systematic search procedure that could be followed:

Date of report_____ Time of report_____

Name of missing person_____ _____
((*Last name*) (*First name*)

Person discovering absence_____ _____
((*Last name*) (*First name*)

Date of discovery_____ Time_____

SEARCH AREAS

Time search was started_____

Basement:	*Search conducted by*
Boiler room	
Closets	
Stairways	
_____	_____
_____	_____

1st floor:	
Stairwells	
Closets	
Public rooms	
TV room	
Toilets	
Kitchen	
Laundry	
_____	_____
_____	_____

2d floor:	
Stairwells	
Closets	
Terraces	
Public rooms	
Toilets	
_____	_____
_____	_____

3d floor:	*Search conducted by*
Stairwells	
Closets	
Terraces	
Public rooms	
Toilets	
_____	_____
_____	_____

4th floor:	
Stairwells	
Closets	
Terraces	
Public rooms	
Toilets	
_____	_____
_____	_____

Roof:	
Court yard	
Patio	
_____	_____
_____	_____

Name of supervisor in charge_____ _____
(*Last name*) (*First name*)

Signature of supervisor_____

Police notified by whom_____ _____
(*Last name*) (*First name*)

Date police notified_____ Time notified_____

Name of police officer responding_____

Rank_____ Shield No._____

ITEM 3. LETTER AND ENCLOSURES FROM JULIUS J. ROSEN, NEW YORK ATTORNEY; TO SENATOR FRANK E. MOSS, DATED MARCH 31, 1976

DEAR SENATOR MOSS: You will recall that at the conclusion of the hearing of subject subcommittee in New York City on Friday, March 19, 1976, Mr. Stein requested Mr. Kleinman, the administrator of Royale Manor Home for Adults, to have Mr. Dov Bercu Stoleru, the certified operator of the Royale, and also two other adult homes, respond to certain questions set forth and marked on the typewritten sheet which was given to Mr. Kleinman. The subcommittee also asked if Mr. Kleinman could have Mr. Dov Bercu Stoleru submit a financial statement of his operations.

Mr. Dov Bercu Stoleru submitted to our office to forward in his behalf for your subcommittee, responses to those questions. I enclose herewith such responses together with the sheet on which the questions were propounded.

I trust this is the information you require.

Very truly yours,

JULIUS J. ROSEN.

[Enclosures]

QUESTIONS SUBMITTED TO DOV BERCU STOLERU BY NEW YORK ASSEMBLYMAN ANDREW STEIN. MR. BERCU STOLERU'S ANSWERS FOLLOW EACH QUESTION

Question. Mr. Bercu, the building and property that the Paradise Manor stands on is owned by the Gerax Realty Corp. Is that true?

Answer. The building and property constituting Paradise Manor Home for Adults is owned by Gerax Realty Corp.

Question. I noticed that from the lease of August 1, 1974, the Gerax Realty Corp. has the same address as the Paradise Manor. What is the reason for that?

Answer. Since the lease from Gerax to Paradise Manor Home for Adults was a strenuously negotiated arms-length lease, and since none of the partners of the lessee have any connection with or control over Gerax, we can only conjecture that the reason for Gerax having the same address as Paradise Manor is because prior to our leasing this facility, Gerax leased to its own principals who were the certificated operators of Paradise Manor and they merely failed to correct the address when the then-certificated operators were replaced by the new lesses.

Question. Do you personally know any of the partners of the Gerax Realty Corp.? Partners: Jeno Berger, Louis Buchler, Jeno Friedman, Simon Friedman, Bernat Reisman, Armin Reisman? How have you known them?

Answer. I know all of the partners of Gerax Realty Corp. named in your question. However, I know them as former operators and owners of the real estate constituting Paradise Manor. They have never been partners of mine in any business transactions and my dealings with them have been as fellow operators of NNHA's and as lessors with lessees in an arms-length negotiated transaction.

Question. I noticed that from the lease of the building and property that the Ila Adult Home stands on is owned by the 325 West Realty and that 325 West Realty is owned by you. Is that not correct? On August 30, 1970, you drew up a lease for yourself and your wife to lease the property and building. That is, you are both the landlord and the tenant. Does the 325 West Realty Co. buy and sell other real estate (probably not)? Then the sole purpose of this realty company is to lease the property to you? Do you get any benefits from this type of transaction? (Tax deductions?)

Answer. 325 West Broadway Realty Corp. is a wholly owned subsidiary of 401 Boardwalk Corp. which is entirely owned by my wife and myself. Therefore, we do indirectly own and control 325 West Broadway Realty Corp. (sometimes called "325"). 325 does not buy or sell other properties. We would point out to you that the reason a lease was made to my wife and myself for the Ila is because the board of social welfare does not permit a corporation to operate a PPHA. They were fully aware of the fact that this was not an arms-length lease. The purpose of this lease was exclusively to comply with the requirements of the board of social welfare at the time an application was made to certificate our operation of the Ila. The only benefits we received from the transaction indicated was a substantial loss since, as will be explained in the answer to No. 13 below, we did not consider the necessary carrying charges of the property in preparing this non-arms-length lease whose sole function was to comply with the requirements of the board of social welfare. 325 was not formed for the purpose of leasing the Ila to my wife and myself. Instead, it was formed for the purpose of purchasing the real estate and the hotel business in 1969. It was not until over one year later that application was made for certification and at that time the $35,000 lease was executed.

Question. In your August 30, 1970, lease, your annual rent paid to yourself was $35,000. Today, taken from your January 21, 1975, application for an operating certificate, your annual rent is $120,000 paid to yourself. Wouldn't you say that a 34 percent rent increase in less than 4½ years is exorbitant, to say the least?

Answer. The annual rental of $35,000 in the 1970 lease did not include costs of interest, taxes and amortization of the first and second mortgages which alone amount to over $60,000. Between the time of that lease and the new lease which provides a $120,000 rental, the property was sold in an "arms length" transaction and the carrying charges alone are approximately $95,000 to $100,000. There are now obligations of taxes, interest and amortization to the current owners which come close to the new rental. The implication of your question No. 13 is not only erroneous but it is not based on any legitimate and correct facts. We point out to you as was done by our administrator, Mr. Kleinman, that we have every right, legally and morally, to cover all costs and even make a legitimate return on our real estate investment. We are not required to disclose our financial situation to either you or the Board of Social Welfare but we have always done so voluntarily.

With regard to the submission of financial statements, our accountants have advised that due to pressure of year end statements they will be unable to furnish us with same until some time after April 15, 1976. Upon receipt of the statements, we will be pleased to furnish you with a copy of same.

Respectfully submitted,

DOV BERCU STOLERU, *Partner.*

ITEM 4. LETTER FROM ROBERT A. McKINLEY, M.D., ACTING FIRST DEPUTY COMMISSIONER, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE; TO SENATOR FRANK E. MOSS, DATED MARCH 23, 1976

DEAR SENATOR MOSS: I would like to send along some additional comments which I would have made in response to questioning had time allowed me to speak at the PPHA hearing last Friday. It was a privilege to be there and to hear about some positive steps that were being taken, especially by the police in Long Beach and the Peninsula Hospital in Far Rockaway.

The saturation of areas with health and welfare facilities has indeed been a big problem and one would hope to see this better controlled by having all of them come under the purvue of the health planning agencies.

We are attempting to provide alternatives to the PPHA's but it is a fact that many patients who have had an emotional or menal illness are candidates for admission to them and certainly have the right to be considered along with those who may be suffering from other chronic diseases such as diabetes mellitus, arthritis, and heart trouble. As was mentioned, work is being done to develop community residences (capacity no more than 40) and hostels with capacity of 10 to 20. We were pleased to note that federally funded mental health centers can now secure construction money for hostel development and this effort should be expanded. Money for leasing might perhaps be even more appropriate. It would be advantageous if these mechanisms could be expanded to those areas not covered by mental health centers.

The problem, age old and at times made worse by ill advised placement efforts, of community resistance to the mentally ill in their midst is ever present and not easily countered. The provision of space in public housing for patients returning should also be considered.

The thing to remember in all of this is that the discharged mental patients do not form a homogenous class but are as different as the diabetic in coma and the diabetic able to play professional football.

Sincerely,

ROBERT A. McKINLEY, M.D.

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MEDICARE AND MEDICAID FRAUDS

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 4—WASHINGTON, D.C.

FEBRUARY 16, 1976

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Medicare and Medicaid Frauds:
Part 1. Washington, D.C., September 26, 1975.
Part 2. Washington, D.C., November 13, 1975.
Part 3. Washington, D.C., December 5, 1975.
Part 4. Washington, D.C., February 16, 1976.
(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

MEDICARE AND MEDICAID FRAUDS

MONDAY, FEBRUARY 16, 1976

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 318 Russell Building, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss, Percy, and Domenici.

Also present: William E. Oriol, staff director; Val J. Halamandaris, associate counsel; William A. Recktenwald, David L. Holton, and William Halamandaris, investigators; John Guy Miller, minority staff director; Margaret S. Fayé, minority professional staff; Patricia G. Oriol, chief clerk; Eugene Cummings, printing assistant; and Dona Daniel, assistant clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The subcommittee will please come to order.

We would like to welcome you here this morning as the Subcommittee on Long-Term Care continues its hearings into various aspects of medicare and medicaid fraud and abuse.

At our September 26 hearing, Mr. Edmond Morgan, president of the Illinois Clinical Laboratory Association, testified that he feared the criminal element was muscling into the ownership of clinical laboratories in his State.

He added that $1 out of every $6 in medicaid payments to clinical laboratories was fraudulent. He cited the most frequent abuses among certain quarters of his profession as: (1) performing additional tests not ordered by a doctor; (2) claiming lab tests were performed manually when they were performed by automated machines; (3) billing twice for the same services by falsifying dates; (4) reporting the completion of procedures when the clinic does not have the equipment to perform the tasks.

I asked the staff of the Committee on Aging to make a full investigation into this matter. The investigation focused on the States of Illinois, New Jersey, California, Pennsylvania, and New York. This report, "Fraud and Abuse Among Clinical Laboratories," is the result of an intensive 6-month staff effort.

The report concludes that a small number of clinical laboratories control the bulk of medicaid payments. In New York, 17 labs control 70 percent of the medicaid business. In New Jersey, 12 labs control nearly 60 percent of medicaid payments. In Illinois, 26 labs control over 90 percent of the medicaid business.

Kickbacks Necessary To Secure Business

The report concludes that, at least in the States which come under investigation, kickbacks are widespread among labs specializing in medicaid business. In fact, it appears to be necessary to give a kickback in order to secure the business of physicians or clinics who specialize in the treatment of welfare patients.

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total the lab received for performing tests for medicaid patients. Kickbacks took several forms, including cash, furnishing supplies, business machines, care, or other gratuities, as well as paying part of a physician's payroll expenses. Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a $10,000 fine and a year in jail upon conviction is not being enforced.

When I was confronted with an early draft of this report I was shocked by the conclusions that the staff reached in their work with Chicago's Better Government Association. I decided to go to that city and see things for myself, accompanied by Senator Pete V. Domenici, of New Mexico.

I saw the proliferation of so-called medical clinics spreading like mushrooms all over Chicago.

I saw their glaring signs beckoning medicaid patients to utilize health care services.

I visited a postage-stamp-size clinical laboratory which billed medicaid for almost $200,000 last year. There was little in the way of equipment and no lab technicians in evidence. While the owner assured us as to the quality of the work performed, I heard from the owner himself that he chose to send his wife's blood test to another laboratory.

I visited the sparkling new laboratory of Illinois Masonic Hospital and saw its sophisticated new machines—only to learn that the hospital could not obtain much medicaid lab business because of its refusal to offer kickbacks.

Tests Not Ordered by Physician

I interviewed a physician who received over $100,000 from medicaid last year. I asked him to check nine lab invoices presented to medicaid for payment by D. J. Clinical Laboratory of Chicago against his records. The doctor told us that he had not ordered 55 percent of the $259 total in lab tests for which D. J. had billed the Illinois medicaid program on these nine invoices. This same doctor told us that he received a rebate of $1,000 per month from the laboratory in exchange for sending them all this medicaid business. The kickback was disguised as rent for a 6- by 8-foot room in the physician's office. The doctor's rent for the entire suite was $300 a month, and yet he received $1,000 per month for the "rental" of a 6 by 8 room.

Finally, I interviewed a man who owns two medical clinics which received about $300,000 in medicaid payments last year.

This man admitted sending all of the lab business to one company in Chicago. He told us he received a rebate of 50 percent of the amount medicaid paid for laboratory tests which physicians in his clinics ordered for welfare patients.

As a result the work of the staff and the BGA, as well as my own personal investigations, I am even more convinced that the medicaid program is rampant with fraud and abuse.

I renew my pledge to root out those who abuse the system in whatever quarter they may lie. It is my belief that eliminating fraud, abuse, waste, and inefficiency in the Federal health care programs may make it possible for us to move toward that balanced Federal budget that we all desire.

And it will, no doubt, improve the quality of health service to the poor and aged.

The Senator from Illinois, Senator Percy, is the ranking Republican member of this subcommittee. He has engaged in all of these efforts, he has done tremendous detailed work, and I am pleased that he is here this morning. I will ask him if he has an opening statement.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Thank you very much, Mr. Chairman.

I would like to first comment on the rather unusual alliance that has been formed between this Senate subcommittee, a civic organization—the Better Government Association—and the media.

This is a technique that has been developed over a long period of very careful work.

The Better Government Association formed its Operation Watchdog almost a decade and a half ago. I had the privilege of serving as its founder and first chairman.

The Better Government Association at first only screened candidates for political office. We felt at that time there was need for an oversight operation that would look at what government was actually doing at the State and local level in Illinois. I know that there were charges at that time that the forestry department was padded with city workers who were not working. There were strong denials from the city of Chicago.

The simple techniques of having a camera go out and follow these crews to see where they were at what time, how they were using State or city equipment, if it was for their own personal usage, to see the amount of working time they were putting in—revealed the whole story once and for all. Someone said a picture is better than a thousand words. There was no disputing the facts that the camera revealed. Since then, various techniques have been used to simply provide public disclosure to put the spotlight on abuses.

EXPOSURE NECESSARY IN COMBATING FRAUD

We cannot investigate every single thing, but what we can do is spot check enough things so that with the help of the media, who have been extraordinarily cooperative, we can reveal things that will cause a cleanup. I think what has actually been done in nursing homes has been as a result of the exposure that the work of this

committee has given to regulations that were not adequate and regulations that were not being enforced. So I think that this new effort, carefully planned ahead of time by the subcommittee staff, under Val Halamandaris' direction, has proved remarkably successful.

There is no question but that there is a terrific ripoff of the public purse here. It is engaged in by professions that should be above that. They have a code of ethics that should be accepted. But the exploiters have moved in to take advantage of Federal programs in such a way that I do not see how, Mr. Chairman, it is going to be possible for this country to even act on national health insurance.

I think that what we are doing is simply demonstrating that we do not have the capability or the linkage between Government and the private sector that would enable us to move into a program the size of national health insurance. Only if we correct some of these abuses can this be anticipated.

We have here a program that should be administered carefully. The ones we investigated in the clinic setup in Rogers Park that was revealed on "60 Minutes" last night are in an area just a few blocks from where I spent my entire childhood.

The neighborhood in Rogers Park is now densely populated by the elderly. To have these people exploited, and the public exploited in this way, is reprehensible.

As our report indicated, in practical terms, it is possible for any medical testing laboratory, which is so inclined, to bill medicaid for a patient that a doctor has seen, for blood never drawn, for tests never performed, at a rate exceeding costs of four times—and twice the prevailing charge for private paying patients—with the nearly absolute assurance they will not be caught and prosecuted; that is, until today.

I think we have changed all that. Certainly the State of Illinois has been moving very agressively in recent periods, and within recent weeks. There has been an admission by State officials that this investigation has caused them to perform in a way we expected the States to be doing all along.

We do not have Federal enforcement agencies out there; we do not have Federal enforcement officers. We depend on the States to do this, and it is not just the State of Illinois that has not been doing it, it is many, many other States.

Nationwide Pattern Indicated

What we are revealing today is a pattern, not just in Illinois, or peculiar or unique to Illinois, it is a pattern that possibly can be developed, and has been developed in many, many other States. The purposes of these hearings is to alert the country once again that this particular aspect of the care of elderly patients is going to be in the spotlight and that these kinds of practices are going to be stamped out.

Just as I am pleased to report that we are making considerable progress now in nursing homes and in correcting the abuses in this area, which this subcommittee, under your leadership, Mr. Chairman, found some time ago, so too I feel that in this particular area, the

one revealed in the study released today, we can and will make progress. We warmly welcome the active participation of the distinguished Senator from New Mexico, Senator Domenici. He has gone with our chairman to see for himself in Chicago some of these abuses, and can report firsthand. The reports that were made to the Nation last night are not exaggerated; they are factual accounts of the ripoff occurring in this particular activity.

Senator Moss. Thank you, Senator, especially for pointing out that we need law enforcement. Our report has already been filed with the Justice Department here in Washington, and it has been sent also to the U.S. attorney and the State attorney in Illinois. We hope that they will now undertake prosecution for those who are guilty of violating the law.

I am pleased to have the Senator from New Mexico, my colleague, Senator Domenici, here, and I will ask him if he has any opening comments. He was in Chicago when I was there.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. Thank you, Mr. Chairman. If I appear to be tired, or if my voice sounds tired, it is only because I just got in on what we call the red-eye special, Senator Percy—that means I leave Albuquerque at 2:10 in the morning. I love to spend time in your great city of Chicago, but not at 4 in the morning, and not for 2 hours to wait for another plane. I was, however, pleased to visit the city of Chicago and tour some of the facilities during this recess.

I have a rather lengthy statement that enumerates, Mr. Chairman, the attention that was focused by this committee on the abuses in nursing homes, and I firmly believe that what we are doing today will cause the same kind of reforms in medicare and medicaid.

I think those hearings have served a very valuable purpose. We know those hearings have led to large numbers of indictments and, more indirectly, to expanded nursing home investigations in other States.

Preliminary investigations by the staff of this committee have indicated that fraud and abuse seems to be everywhere. Medicaid in particular has been a "sitting duck." In my opinion, neither HEW nor the States have been equipped to meet this problem, and recently, HEW had less than 10 investigators. The majority of the States have neither audited a single provider for medicaid fraud nor referred any cases of fraud to HEW and the Department of Justice.

I understand, however, in the city of Chicago—perhaps you covered this, Senator Percy—our recent probe is the result of some local investigations, and apparently it will yield some further attack on this problem at the State level.

VISIT LEAVES LASTING IMPACT

What I am saying today, however, is that abuse and fraud in certain programs do not seem to be new for most of the people in this room. We have heard the stories with growing frequency. However, all of the talking in the world cannot equal the impact of one visit-

I recently had an opportunity to visit one of the poorer areas in Chicago, and what I saw troubled me greatly.

I saw the proliferation of medical clinics in dilapidated buildings all over the poverty area, where pornography shops now house more lucrative enterprises. Fancy signs attract the poor and elderly with promise of free care. The care may be free to the poor and aged who have medicaid cards, but it is not free to you and me and the other taxpayers of this country.

This year we will spend some $15 billion on this kind of care, and I for one am in favor of doing all we must. But I certainly am not in favor of what I saw there and what, I speculate, is the real tip of the iceberg.

I am disturbed by many aspects of the problem. For instance, the owner of a so-called medicaid mill may be renting an office space in a building. The building itself may be owned by another corporation, in which the clinic operator has an interest.

The second possible problem is that many clinics are not even owned by physicians, but rather by private entrepreneurs. The recent evidence is that businessmen not only share in the profits of the medical practice, but they also pressure the doctor into taking unnecessary tests to increase clinic revenues.

Yet another factor disturbs me. Most of the physicians working in the clinics are from foreign countries. Many do not have deep ties to the United States, or to any particular city. Many have centers in the clinic as a way to make some money in a hurry and return to their home country. In other cases, the overriding ambition is to open a medicaid clinic or mill of their own as soon as possible.

I am afraid many of these physicians are carrying the mistaken notion that kickbacks in medicaid are the norm of medical practice in the United States.

I am sure that many of them do not even know they are breaking the law when they request or receive a kickback. The possibility for kickbacks in these medicaid mills is endless.

Generally, one person rents the clinic for, let us say, $300 a month, and then subleases a tiny part of this space to a pharmacist who pays him $1,000 a month in rental. The payment is disguised as rent. It is certainly more than that, and I regret to say the example I have just given is not hypothetical.

We visited just such a place, with just such a rental arrangement in the city of Chicago. Senator Percy, when you were there the people operating at that late date last week were not reluctant to give us this kind of information. A person rented a store building for $300 a month. He remodeled it, and then he got $2,600 a month rent from people that served in that clinic as the captives of the basic doctor that operated.

"Ping-Ponging" Becoming Growing Practice

But there is yet another practice that is very offensive that is beginning to be called "ping-ponging," which describes the procedure where the welfare recipient will be seen by all of the practitioners in a clinic irrespective of need.

Typically, a patient will be seen, or at least medicaid will be billed for such visit, by the general practitioner, the podiatrist, the dentist, the optometrist, and the chiropractor—all in one visit on 1 day.

It is apparent to me that something must be done immediately to head off the uncontrolled proliferation of these medicaid mills. After my visit to Chicago, I can understand why some experts project that $1 out of every $5 we spend for health care under medicare and medicaid is ripped off.

Furthermore, I don't think we should stop with efforts to reform medicaid mills. I think the problem of factoring companies requires our immediate attention. A factoring company is a brokerage. Physicians who have large outstanding accounts that are not paid promptly sell these for cash, and I wonder if these factoring procedures are going without any specific laws that govern our small companies, like loan institutions. If they are governed in some States, I wonder why we should be part of a system which is so out of touch with our times that anything like 10 to 15 percent of the money we thought was going to services goes to a factoring entrepreneur. I think this is rampant in the city of Chicago, and whether this committee or the State itself looks into it, it deserves more than just quick attention.

I would also like to mention clinical laboratories. I don't believe I will ever forget the visit to a tiny lab in the back of one of these medicaid mills. This lab does about $200,000 in business from medicaid. You would think with that dollar volume the lab would be buzzing with technicians. It was, in fact, as quiet as a church. There was a distinct lack of sophisticated laboratory equipment. It looked like a rundown high school chemistry lab.

I must say, I would have serious doubts about the quality of the work performed by the laboratory. I wonder if they billed for the tests not authorized by physicians as we found with respect to other labs. I wonder if they are claiming lab tests performed manually when, in fact, they were subcontracted and performed more cheaply by machine at some nearby laboratory. I wonder about the full extent of rebates and kickbacks. Did the lab owner pay them to his suppliers? Did he pay kickbacks to physicians, and nursing homes?

I wonder if the laboratory ever uses the "sink test." That consists of pouring the specimen down the sink and then writing down some meaningless numbers which are sent to the ordering physician. We heard of this being done.

I wonder what percentage of the tests in this facility were inaccurate and what were the consequences to the totally helpless people waiting expectantly for life-or-death news from the laboratory.

Programs Needed, Despite Problems

I wonder why neither the State nor HEW was around to check up on these schemes that I have witnessed. May I suggest at this point that perhaps large spending programs involving both the State and the Federal Governments are not ever going to be efficiently administered? Too many problems, such as enforcement, fall between the

cracks of bureaucracy. Yet the programs are needed. Perhaps medicaid should be run entirely by the Federal Government. In return, the Federal Government should relinquish its control over other programs best handled by the State alone.

I know the Senators here this morning share my concern about this particular scandal. I think that it is time we knew the answers to some of these questions.

I think it is time that the Congress stepped in and ended this gold rush in the area of health care of the poor and aged. As our report says, it is time to stop the hemorrhage of Federal funds.

I plan to do everything that I can to bring about some improvement in the present sorry state of affairs. I want to see for myself how medicare and medicaid are working at the street level. I invite the members of this subcommittee to join me. It appears that we have much to do and we must begin at once if we are ever to control the massive and wholesale fraud that feeds upon the public dollar.

I thank you, Mr. Chairman.

Senator Moss. I thank you very much for your very good work on this committee, and especially your visit to Chicago, Senator Domenici.

As you may recall, we observed in many places what the Senator from Illinois referred to, that the medicaid—or public—charge for a particular lab procedure is often double the price that is charged a private patient. The conclusion is that we are paying twice as much as we should for lab services.

Not only are costs inflated, oftentimes bills were submitted for work not performed. The system encourages this because the doctor sends his slip to the laboratory saying what he wants, and the laboratory fills out another one and sends it to the State for payment. It does not necessarily follow that the two forms are identical. The physician has no way of checking which tests have been billed to the State in his name.

Outstanding Investigative Work

Well, we are very pleased with the investigative work done by the staff in this area of Chicago, Ill., but I do want to emphasize that, although our focus was Chicago, this is by no means the only place where we find fraud and abuse. We will hear later this morning about at least one other State which has had similar problems. I would like to compliment our staff for a very fine investigation, which was carried out by Val Halamandaris, the associate counsel of the Senate Special Committee on Aging, and William Recktenwald, Mr. David Holton, and Mr. Bill Halamandaris, who are investigators. They worked in conjunction with investigators from the Better Government Association of Chicago, to which Senator Percy referred.

I am going to ask Mr. Halamandaris and Mr. Recktenwald to come to the table with J. Terrence Brunner, Douglas Longhini, and Geralyn Delaney.

Val J. Halamandaris is the associate counsel, Senate Special Committee on Aging; William Recktenwald is an investigator for the

Senate Special Committee on Aging; J. Terrence Brunner is executive director, Better Government Association, Chicago, Ill.; Douglas Longhini is an investigator, and Geralyn Delaney is a staff secretary, also with the Better Government Association, Chicago, Ill.

As was pointed out, the Better Government Association is a private, nonprofit voluntary association that was formed in Chicago 52 years ago. We have worked with them several times in the past 6 years.

In this case they were of great service to us; they carried much of the load in this investigation.

Now, we welcome all of you before the subcommittee and, Mr. Halamandaris, I think you should proceed. You will probably want to refer the matter to various members of the panel as you report to us what you found in Chicago.

STATEMENT OF VAL J. HALAMANDARIS, ASSOCIATE COUNSEL, SENATE SPECIAL COMMITTEE ON AGING

Mr. HALAMANDARIS. Thank you, Mr. Chairman, Senators. I must say it is a little bit different sitting on this side of the table, rather than being at your elbow.

I think we have a rather important purpose here today. We want to put into the record all the facts and specifics of the fraud investigation that we have undertaken in the State of Illinois and elsewhere.

You gentlemen have very eloquently indicated the parameters of our investigation and conclusions that we reached. I would like it understood that our purpose is to provide specifics, names, places, and dates. With your permission, Mr. Chairman, I would like to supply at this time a key to our staff report. We did not use names in our staff report, preferring to provide them here this morning, under oath. With your permission, Mr. Chairman, I would like us to be sworn.

Senator Moss. I believe that is an excellent idea, since there may be controversial matters.

Will you all stand and raise your right hand? Do you all solemnly swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

[All witnesses affirmed in the positive.]

Mr. HALAMANDARIS. Mr. Chairman, in the course of our investigation, we examined more than two dozen clinical laboratories in the State of Illinois. We visited some 50 medical clinics, and we interviewed more than 50 physicians in the State of Illinois.

In addition, we also examined whatever evidence we could find in the clinical laboratories in every other State. There are three or four States that have conducted intensive investigations, including the State of New Jersey. It was in this connection that we contacted Mr. Holstein, the executive director of the commission of investigation, Trenton, N.J., who is here today, and who will provide testimony to this committee.

In short, we pulled together all of the information we could find on fraud and abuse among clinical laboratories, and I would like to state our conclusion for you.

"Few Labs Control Most Medicaid Business"

First of all, comparatively few labs control most of the medicaid business in the United States. In New York, 16 labs controlled 70 percent of the medicaid business. In New Jersey a dozen labs controlled nearly 60 percent of medicaid funds. In Illinois, 26 labs control over 90 percent of medicaid funds paid to clinical laboratories. In Wisconsin, 12 labs control the bulk of the business.

Our second conclusion: Competition for medicaid accounts is fierce. It seems that the only way to obtain a medicaid account is to offer a kickback. If you do not provide a kickback, you cannot get services. The greater the kickback offer, the more likely the lab will be to obtain medicaid business.

Three: The average kickback is about 30 percent. This is about the figure we projected for kickbacks between pharmacies and nursing homes in the exhaustive study we completed 2 years ago. Kickbacks can take any form from cash, gifts, supplies, long-term credit arrangements, to the furnishing of supplies and business equipment. Most commonly, the technique used is the "rental" of a small amount of space in a medical center or the payment of part of the physician's overhead or payroll expenses.

The root of the problem is the overgenerous fee schedules for clinical lab services. The fee schedules were established in 1967 when medicaid went into effect and most tests were performed manually.

Since that time, there have been rather major advances in terms of technology for clinical laboratories, and yet the fee schedule has not been changed to take advantage of their technology. Whatever cost savings have accrued—and there have been a lot—simply have not been passed on to consumers. Instead, they have been used for promotion devices or marketing or physician inducements.

In short, they are used for kickbacks.

In order to maximize their ability to succeed in the kickback game, we found that labs have learned ways to increase their income from medicaid. The predominant way of increasing income in order to offer more kickbacks is simply to charge for tests not authorized by the physician.

That is the easiest way. There are other ways, of course, such as billing for component parts of what is a panel of tests. For example, there is a series of tests called SMA–12, and the law and regulations require they be billed as a panel at one set amount. Typically the charge of that panel of tests might be $15; however, for component parts of this series billed separately, the reimbursement for the same 12 tests can go up to $100 or more.

Senator Moss. As I understand it, many of these tests are run by machine and the labs bill separately for component parts, which amounts to claiming the tests were performed by hand.

Mr. Halamandaris. Right.

Senator Moss. They bill each one separately, even though the tests are performed as a panel.

"Mechanical" Tests Billed Separately

Mr. Halamandaris. Exactly, Mr. Chairman, and, as you know, pretending tests are being performed by hand when in actuality they

were performed by machine is another device by which you can increase the amount of medicaid money that you have coming in, to be able to pay out in kickbacks.

We estimated, by conservative estimate, that at least $45 million out of the $213 million in medicare and medicaid payments to clinical laboratories is either fraudulent or unnecessary. This is a conservative estimate because a reasonable case can be made that about 50 percent of current payments are inappropriate. I cite New Jersey's experience where fee schedules were reduced by 40 percent as well as New York's analysis that lab payments could be cut in half by incorporating the principle of regional laboratory programs.

Studies in these States reached the conclusion that the amount of money paid for medicaid, clinical laboratory services could exactly be cut in half. This was also the conclusion we reached in our Illinois investigation. We believe Illinois could cut their current fee schedule by more than 50 percent; or if you want to put it another way, that the State is overpaying labs by 116 percent.

Restating again, if the State of Illinois were paying for lab services performed for its medicaid patients at the same rate that private patients pay for these same lab services, then Illinois would save about half the money it now spends.

A couple of more points:

As you know, in 1972 Congress enacted the specific statute which prohibits kickbacks, making the offer or receipt of money or other considerations illegal, and punishable by a $10,000 fine, 1 year in jail, or both.

When our report concerning kickbacks between nursing homes and pharmacists was published a year ago, Mr. Chairman, we concluded that the statute was not being enforced. It was one of our major recommendations that the Department of HEW and the Department of Justice should begin enforcing the law with respect to kickbacks.

Only One Indictment Issued to Date

I am sorry to say there has only been one case that has ever been brought under the 1972 statute, and that is the indictment issued by the Honorable Sam Skinner, U.S. attorney for the northern district of Illinois, about 2 weeks ago.

Senator Domenici. Do you have the language of that so-called kickback statute in front of you?

Mr. Halamandaris. Yes, sir, we do; and if you have a copy of the report,* it is on page 10.

Senator Domenici. Thank you. You do not have to read it.

Mr. Halamandaris. Yes, sir. It is explicit. In practical terms, what this all means is that any laboratory that is so inclined can bill medicaid for tests for patients the doctors have never seen, for blood that is never drawn, for tests never performed, at a rate exceeding four times costs, and twice the prevailing rate to private patients, and in so doing violate laws and regulations of general and specific application with nearly absolute assurance that they will not be caught and prosecuted.

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*See S. Rept. 94–944, *Fraud and Abuse Among Clinical Laboratories.*

That is the end of my formal statement, Mr. Chairman.

At this time I would like to introduce Mr. William Recktenwald, who is seated on my immediate right.

Mr. Recktenwald is the chief investigator of the Better Government Association in Chicago. As you stated we have been working together with the BGA for the last 6 or 7 years, and we have the greatest respect for the BGA, particularly for Mr. Recktenwald and for his boss, J. Terrence Brunner, who is also seated here today. We have been fortunate to have Mr. Recktenwald on a leave of absence and working with us for the past 6 months.

I would like to have Bill tell you how he got into this investigation of clinical labs.

STATEMENT OF WILLIAM RECKTENWALD, INVESTIGATOR, SENATE SPECIAL COMMITTEE ON AGING

Mr. RECKTENWALD. Thank you, and good morning, Senators. After our hearing on September 26, Mr. Chairman, we were contacted by Herbert Meyer, a physician in general practice on the south side of Chicago. Some 80 percent of his patients are elderly. More than 90 percent qualify under medicare or medicaid.

On October 14, 1975, at approximately 1:20 p.m., I was present in his office when he was visited by a man who identified himself as Riaz Khan, a sales representative for Westlawn Clinical Laboratory. In the first 6 months of fiscal year 1976, this laboratory received $448,369.50 from the Illinois Department of Public Aid in medicaid funds. I was seated in a closet adjacent to Dr. Meyer's office. From that position I was able to overhear the conversation between Mr. Khan and Dr. Meyer. Mr. Khan offered Dr. Meyer a return of 30 percent of each month's gross billings submitted to the Illinois Department of Public Aid. He said this kickback could take several forms, it could be paid either as a rental to the physician or disguised as payment toward the salary of one of Dr. Meyer's employees.

The following is taken from a sworn statement I prepared at that time [reading]:

Mr. KHAN. It's good to see you, Dr. Meyer. I'm glad you are considering our services.

Dr. MEYER. Well I can't make anything definite until I talk with my lawyer who won't be back until next week. (Dr. Meyer then asked some questions about how soon the work would be completed and how many pick-ups per day were made.)

Will you go over your incentive plans you mentioned to me last time again?

Mr. KHAN. Yes, it's 30 percent—there are several ways to handle it. We can pay your rent or cover your overhead.

Dr. MEYER. Well, my rent here is not very high.

Mr. KHAN. Don't worry about a thing. There are a number of ways this can be handled. We can pay your rent or cover part of your overhead or cash. My chief can give you all the details. I would like to set up a meeting with the two of you.

Dr. MEYER. Well, anything I get, anything coming in here goes on the books.

Mr. KHAN. Don't worry, this is all legal. There are loopholes to every law. We do this with doctors and clinics all over town.

Dr. MEYER. Who else do you handle this for?

Mr. KHAN. Northtown Clinic (and mentioned several others). In three clinics alone we have almost 24 doctors plus about 15 other individual doctors.

Dr. MEYER. Now this 30 percent, is that of gross or net?

Mr. KHAN. It's 30 percent of all your public aid business.

Dr. MEYER. What about medicare? I have many patients on medicare.
Mr. KHAN. I'm not sure about that. My chief could give you details about that and about private work.
Dr. MEYER. Do you bill public aid directly on these things?
Mr. KHAN. Yes; we handle all billing.
Dr. MEYER. I've got to check this with my lawyer before I go ahead.
Mr. KHAN. This has been cleared with our lawyer and everything is perfectly legal.
Dr. MEYER. What is your lawyer's name?
Mr. KHAN. It is a Mr. (F. N. U.) Greenberg.
Dr. MEYER. Let me show you the rest of our operation here. (Both left room)

I exited the closet and met the doctor and Mr. Khan in a different room. The doctor asked Khan if he had met me and Khan said, "No." The doctor said: "Stanley, meet Mr. Khan, who represents a medical laboratory." I asked him if he did any work for dentists and he said, "No." [Continues reading:]

Mr. RECKTENWALD. Herb, is this the fellow you were telling me about last week?
Dr. MEYER. Yes.
Mr. RECKTENWALD. Well, I hope you get things made clear (motioning to Khan), Herb thought you were offering him some type of kickback.
Mr. KHAN. Oh no, just help with your overhead.

Khan said goodbye and started to leave. I said I was going across the street to get cigarettes and left at the same time. Outside the building I spoke with Khan.

We have a photo * here taken by one of the BGA investigators. That is Mr. Khan on the right [indicating]. [Continues reading:]

Mr. RECKTENWALD. You know, you really had Dr. Meyer worried; he thought he might get in some trouble if he got involved with your rebate program.
Mr. KHAN. There is nothing wrong with it, nothing illegal. We just pay part of his overhead, part of the rent, or however he would like it, it just works out to 30 percent of his public aid business. Everyone does it. There is nothing wrong with it. See, when he takes samples and things here, that is wear and use of his office, so we just pay him back by helping with the overhead.

MEETING ARRANGED

With Dr. Meyer's cooperation, and at the suggestion of Mr. Khan, a meeting was arranged on October 20, 1975, with Mr. Trivedi, one of Mr. Khan's superiors in the clinical lab. Present with Dr. Meyer was William Hood,** who was introduced as a replacement for Dr. Meyer's regular attorney who was said to be out of town. Mr. Hood is an attorney who, until December 1975, served as an investigator with Chicago's Better Government Association. He had served as an investigator—consultant—with the Senate Committee on Aging since March of 1971.

Under questioning from Hood, Mr. Trivedi confirmed the offer extended by his associate, Mr. Khan. Trivedi said the arrangement would allow the doctor to get back from the lab 25 to 30 percent of the gross monthly medicaid billing sent to the lab. Mr. Trivedi concluded: "My personal feeling is, that the best way is for us to pay your rent or to pay an employee. It works simplest that way."

Mr. Khan, who was also present at this meeting, expressed amazement, as did Mr. Trivedi, that Meyer had any doubts about the legality of procedures they proposed. They said he was the first doctor who had ever raised any questions with them about this.

*See p. 422.
**See affidavit, p. 513.

—Photo by James Huenink, BGA

Mr. Riaz Khan (right), sales representative, Westlawn Clinical Laboratory, Chicago, Ill.,

Senator PERCY. I think that is one of the concerns I have. You are never able to police something 100 percent. But when you work with a profession which presumably has ethics, then I must ask how widespread is the knowledge among doctors that this practice goes on? How many cases were turned over to the Illinois State Medical Society or turned over to the district attorney, the Attorney General, for investigation?

What goes on here? Do they just silently acquiesce with it and do nothing about it?

Mr. RECKTENWALD. Senator, these statements, together with the number of physicians allegedly involved in a similar practice, the fact that no one apparently had ever questioned the legality of the practice, led the committee staff to again question how widespread the practice of offering kickbacks was in the Illinois medicaid program.

Moreover, the flat insistence by Mr. Khan and Mr. Trivedi as to the legality of this practice caused the staff to recheck the pertinent medicare and medicaid statutes relating to kickbacks. The law is explicit. The law is reprinted on page 10 of the staff report. The identical language can be found in both medicare and medicaid.

In addition to this specific provision, there are other applicable fraud provisions in the United States Code.

CLINIC OPENED BY INVESTIGATORS

Satisfied that the practice was clearly illegal, committee investigators set out to find an answer to an essential question: How common was the practice? An extensive discussion among the staff of the committee led to the conclusion that the best way to test the extent of such practices would be to simulate the actions that would be taken by an independent physician beginning a practice specializing in public aid—welfare—patients. To this purpose, it was decided that a storefront clinic would be opened in an appropriate area. Only from the perspective of the practitioner, at street level, could the committee gain information on the mechanics of these highly questionable operations. And only through understanding the mechanics of the operation could effective corrective legislation be proposed.

A decision was made to go ahead with this plan in conjunction with the Better Government Association—BGA—of Chicago, Ill., a nonprofit, nonpartisan civic organization which has cooperated with the committee for more than 6 years in a number of areas of investigation. Subsequently, due to considerations of time and money, the BGA assumed primary responsibility for setting up and operating the storefront clinic with committee staff present only as observers. Two Illinois physicians cooperated with investigators to the extent of allowing their names to be used.

A small storefront was rented at 1520 West Morse in the Rogers Park area of Chicago. Mr. Holton has a photo* here of the storefront. This neighborhood has the highest proportion of aged in any area in Chicago, and possibly one of the highest in the Nation. A

*See p. 424.

The storefront clinic, located at 1520 W. Morse Ave., Chicago, Ill.—Photo by George Quinn, *Chicago Tribune*

sign announcing the opening of the clinic was placed in the window. A number was listed with the statement: "Professional inquiries invited." Mr. Douglas Longhini, a BGA investigator, posed as a business representative of the two doctors. He is with us today accompanied by Mr. J. Terrence Brunner, executive director of the BGA, and Geralyn Delaney. He will explain what transpired in that storefront clinic.

Senator Moss. Mr. Brunner, please go ahead and carry on the story.

Mr. BRUNNER. Mr. Chairman, BGA Investigator Doug Longhini was present for every meeting; also present was Mrs. Delaney, our secretary who transcribed the conversations in shorthand, and she is also present today.

Senator Moss. Why didn't you just set up a tape recorder?

Mr. BRUNNER. Senator, the Illinois eavesdropping statute prohibits the taping of any conversation without the consent of all parties. We were very careful throughout the investigation never to violate any Federal or State statutes. As an alternative to taping, we had Mrs. Delaney sitting right there across the table from the lab representatives taking everything down in shorthand and then transcribing her notes immediately afterwards.

Senator PERCY. Were they not a little nervous when you were taking this down in shorthand?

Mrs. DELANEY. I was a little worried that they might be, that they might wonder why I was taking all of this down in shorthand, but they did not seem to be.

Senator Moss. They did not complain about it, and you were able to transcribe it later, so anything you tell us under oath is what you transcribed?

Mrs. DELANEY. Yes.

Senator Moss. You may proceed, Mr. Longhini.

STATEMENT OF DOUGLAS LONGHINI, INVESTIGATOR, BETTER GOVERNMENT ASSOCIATION, CHICAGO, ILL.; ACCOMPANIED BY TERRENCE BRUNNER, EXECUTIVE DIRECTOR, AND GERALYN DELANEY, SECRETARY

Mr. LONGHINI. Thank you, Senator.

In December 1975, the Better Government Association, CBS "60 Minutes," and the Chicago Tribune obtained the use of a $400-a-month storefront office in Chicago's Rogers Park community. Located on Chicago's northeast side, Rogers Park is a predominantly white, Jewish and Catholic neighborhood with a substantial elderly population.

The sign we placed in the storefront window advertised that a medical clinical would soon open at that location. Also, in early December, I telephoned representatives of 15 Chicago-based clinical laboratories. I told each lab that I represented two Illinois physicians who were opening a medical clinic in Rogers Park. I informed each that the new clinic would require laboratory services, and I invited each lab to send a representative to the medical clinic to discuss the availability of their services.

Over a 3-week period, I spoke to representatives and owners of 13 different clinical laboratories. After each interview I wrote detailed affidavits of each conversation,* and on January 6, 1976, the conversations were filmed and recorded by CBS's "60 Minutes."

ELEVEN OF THIRTEEN LABS OFFERED KICKBACKS

Of the 13 laboratories I spoke to, 11 labs offered the doctors a kickback or rebate on the dollar amount of laboratory business referred

*See appendix 2, p. 490.

by the medical clinic to the lab. Through additional interviews outside of our clinic in Rogers Park, the BGA found a total of 13 independent clinical laboratories giving kickbacks to doctors and medical clinics. These 13 laboratories alone account for 65 percent of Illinois' medicaid payments to clinical laboratories in 1975.

The kickbacks were all based on a percentage of medicaid billings for a week's or a month's laboratory tests referred by the doctors to the labs. The kickbacks were expressed in terms of percentages of the volume of business given to these laboratories. These percentages varied from 15, 25, 40, to as high as 50 percent of a week's or a month's total medicaid billings for lab tests.

Although these percentages of kickbacks varied, the method of payment was consistent from lab to lab. Each of the laboratories giving kickbacks also offered to rent space at our storefront offices in Rogers Park. The laboratories only required enough space to accommodate a laboratory technician to draw blood. This space could literally be 2 square feet—enough space for a blood-drawing chair—or one small room within the clinic.

The laboratories explained that the rent they would pay the medical clinic for this small space had no relationship to the amount of space used by the lab technician. The rent, as the laboratories proposed it, would be based solely on the volume of laboratory business referred to the labs. The actual rent would be calculated by multiplying an agreed-upon fixed percentage by the volume of business the individual laboratory received during a week or a month. "It is just our way of saying thank you," one lab owner said.

If the volume of medicaid laboratory business was $4,000 a month at our clinic in Rogers Park, and the fixed percentage was 50 percent—two laboratories offered kickbacks of 50 percent: United Medical Labs and Northside Clinical Labs—then that month's rent paid by the clinical laboratory to the doctors would be $2,000.

This could be $2,000 a month—$24,000 a year—for 2 square feet of space. Again, the whole storefront rented for approximately $400 a month. But as Ernest Villanueva of Ridgeland Medical Laboratory pointed out: "I don't have to know how much rent you are paying for the medical clinic."

The laboratory representatives said that the amount of rented space—the number of square feet actually utilized—would not increase if the volume of business increased. However, the amount of rent paid by the laboratories would increase as long as business did. Mr. Robinson of Chicago Medical Laboratory said: "The rent is adjusted to whatever the volume is." Robinson advised me not to worry about the amount of space the laboratory would rent at the medical clinic. Robinson told me, "It's just a box"—referring to the rented space—"and you don't worry about a box. What you're interested in is the money coming out of that box every month."

Although the laboratories would send the medical clinic weekly or monthly rent checks through the mails, some of the laboratories would not, initially, sign legal leases or subleases with the medical clinic. Robinson of Chicago Medical Laboratory felt that, "Leases are used only if you have a good thing going."

However, most of the laboratories offering kickbacks suggested or agreed to signing a legal lease or sublease. Mr. Simos, owner of Claremont Laboratory, said that a rebate based on a percentage of the volume of medicaid business was "dirty business; the doctors would get clobbered"—apparently if Government officials investigated. Mr. Simos assured me, however, that: "As soon as the State sees a rental agreement, they stop questioning the doctors." Simos offered our clinic a 30-percent kickback disguised as rent.

The rental scheme appeared to many laboratory representatives to be their private loophole to avoid charges of kickbacks to medical clinics. For example, William Footlick, owner of Division Medical Laboratory, said our clinic could receive between $5,000 and $6,000 a month from Division for the rental of one blood drawing chair. When I asked Footlick if this was a rebate on the volume of business, he said: "A rose, is a rose, is a rose. I look at it as a rental." Footlick had earlier assured me that "I"—Division Labs—"am able to be looked at * * * by the FBI; this is not frowned upon. It is a percentage as a starting base"—from which to establish the initial rent.

Senator PERCY. How did the doctors handle this on this income tax return?

Mr. LONGHINI. I was told by the laboratory representative that he handled this as business income.

Senator PERCY. As income?

Mr. LONGHINI. Yes, that it would be declared.

Senator PERCY. No questions, to your knowledge, have ever been raised as to why you would have income sometimes exceeding the amount of the basic lease?

Mr. LONGHINI. They were not worried about that.

Senator DOMENICI. Could I ask you a question regarding payment of percentages? Does the clinic pay this amount, whether they get paid or not? Do they pay it regularly, or do they pay when they get paid?

Mr. LONGHINI. They pay it regularly.

Senator DOMENICI. On invoice amount, rather than amount received?

Mr. LONGHINI. Yes, on invoice amount.

Senator MOSS. Was there any discussion which invoice would be controlling—the one the doctor sent to the lab or the one the lab sent on?

Mr. LONGHINI. The one the lab sent out to the State to be paid. I do not think they expected an invoice from the doctors. They just directly billed the State.

The laboratories offering to lease space at the medical clinic said that they would reevaluate the lease every month, or 3 months or 6 months. Footlick of Division Laboratories said: "We pay a flat rental and determine that rental on the first month's volume. The rental must stay as a fixed amount; but rent is reviewed every 3 to 4 months." Mr. Simos of Claremont Laboratory said that he would renegotiate the lease every month. And finally, Nemie LaPena of Northside Clinical Laboratory said—we have a picture:* "I don't

*See p. 429.

know how legal"—it is—"but rental agreement could say that we are giving you back 45 percent of the volume of the medical tests ordered." LaPena told me that Northside presently maintained this type of sublease with a number of medical clinics.

Clinic Is Dropped if Volume Stays Down

There can be pressures applied when it is time to reevaluate the lease. According to Judy Pedgrift, a representative of United Medical Laboratory: "If a clinic's volume goes down any month, I call up the clinic and tell them they had better get the volume up the next month. If the volume stays down, we have to drop the clinic."

Simos of Claremont Laboratory told me that he would like to have our medical clinic see between 15 to 20 patients a day, and order two or three tests per patient. Simos left a clear impression that two or three laboratory tests per patient was the minimum. Simos gave me this advice, "What the hell, go ahead and order 10 tests"—for a patient—"just go ahead. The State pays for it."

The stress on volume can invite the medical clinics and doctors to milk one sector of the community as much as possible and ignore other people in need of competent medical services. Riaz Khan, a representative of West Lawn Medical Laboratory, urged this business tack.

Khan said: "The secret to the success of a medical clinic is in promotion." Khan asked me if there were any black neighborhoods near our clinic in Rogers Park. I said there was a relatively small black neighborhood about five blocks north of the clinic. Khan said: "Well, that is where you should promote; the money is where the blacks are. There isn't any money in these old people"—referring to Rogers Park elderly population. "Old people are dried up. There's not much blood you can draw out of old people."

Thank you.

Mr. Halamandaris. Mr. Chairman, if I could be allowed to continue for a few more minutes, I would like to tell you what we did next. We had found some 13 or 14 laboratories we knew offered kickbacks. We then went to the controller's office and constructed a profile of all the physicians who used those particular laboratories.

We then had a reasonable idea that the 100-some doctors we found using these labs received kickbacks.

At the same time, we integrated into our list the names of Illinois physicians who made more than $100,000 from medicaid last year. We then selected about 50 physicians for interview.

On the morning of January 7, the investigators from the Special Committee on Aging and the Better Government Association began visiting physicians all over the city of Chicago.

On that day alone we interviewed about 25 physicians. Our search for the physicians led us to the clinics that Senator Domenici described. Some might have once been taverns, others were once pornography stores, but now signs heralded free medical care for the fortunate with medicaid cards.

Senator Domenici. The sign also states: "We accept green cards."

Mr. Halamandaris. Yes, and the signs are so vivid they fairly grab you off the street.

—Photo by Carlos Contreras, BGA

Mr. LaPena said, "You'll make lots of money . . ."

Senator Moss. And the green cards is the medicaid cards?

Mr. HALAMANDARIS. Exactly. Although the card might be different colors in different States. To begin with, we had the idea that a lot of physicians were ripping off the system, so we confronted some of them, including a physician named Jose Hilao.

PHYSICIAN ON SALARY BY CLINIC OWNER

Dr. Hilao threw us a curve. He indicated he did not know anything about kickbacks. He said he was on salary, and he worked for somebody, and he referred the committee staff to Mr. Robert C. Parro, who owns two clinics in the city of Chicago. We visited Mr.

Parro and he was very candid. He told us two clinics received about $300,000 of medicaid funds the previous year from the department of public aid. He candidly admitted he was receiving a rebate from the laboratory; that he now uses the Park-Dewatt Laboratory; and that his present rebate arrangement amounted to 50 percent of the amount his clinic charged medicaid for lab services on behalf of medicaid beneficiaries.

He added that he was troubled by this arrangement in that some might think it illegal.

The other point he made is that he did not go to the Park-Dewatt Laboratory out of greed, but that they had the best program in town.

Mr. Chairman, you visited with Mr. Parro, and I am sure you recall his admission that the laboratory he had been using, the Northside Medical Laboratory, in fact, offered him a kickback of 55 percent, which he turned down, because he was unhappy with the quality of their services.

Senator Moss. Yes, I recall he said that.

Mr. HALAMANDARIS. The man was very open and concerned about the practice. The point he made was that the law should be clarified. In his view, the statute is not explicit enough.

Speaking as an investigator, as a lawyer, I think it is very specific. Later, we interviewed a clinic administrator, Mr. Roy Oliver, the gentleman we have identified in the report as Mr. F.

Senator PERCY. May I ask—if we have a key to the report, why was it necessary to print the report with "G, H, Y," and so on? As long as you have a key, why could you not print the names?

Mr. HALAMANDARIS. The decision was made that we should not use names until we testified under oath, and only after the particular parties who would be named could be notified. We have done that. The chairman sent a registered letter to all of the parties involved, indicating their names might be mentioned, telling them that they might want to have somebody here to listen to the testimony, that they are entitled to appear to answer our charges today at this same hearing, and that they are entitled to have counsel appear with them.

Senator PERCY. This procedure you adopted is a good procedure, and certainly provides an opportunity for the laboratories and the individuals named in the allegations and against whom charges are made to answer them. It might be well for you to determine now whether there is anyone who has appeared, who is in the room today, who is named in the report, and who has received notification from this subcommittee, to see whether or not it is their intention or desire to testify today. We can then determine how long the committee will be holding this session.

OPPORTUNITY GIVEN TO DEFEND AGAINST ALLEGATIONS

First, I would say the statute is explicit. I would like to read the and we will then ask if anyone who has been named in here in any way would care to come forward. It is in order to avoid the problem that you alluded to, Senator, that we decided to go this route, to make sure everyone was appropriately notified with time to come here if they wanted to come here.

Mr. HALAMANDARIS. I would like to supply for the record the experience we had together, Senator Domenici and Senator Moss, in visiting Dr. C.

Dr. C's name is Julio Lara-Valle, and we visited Dr. Lara-Valle at his establishment, which was a converted tavern that he made into a medical clinic, for which he is paying a rent of $300 a month. The doctor is receiving a rent of $1,000 a month for a closet-size room in this clinic.

Mr. Chairman, you remember this as well as I do. Why don't you tell us of your views. You went in, and you can verify this.

Senator Moss. Yes. This is one more experience that I had personally, and Senator Domenici was there in this crowded little place, several people waiting to see the doctor. We talked to the doctor awhile, and he took us back to see the room that he was subleasing. A young girl was in there. There was a blood-drawing chair, another chair, and a small table that was not even 3 feet square. Finally, there was a little cabinet with some needles and syringes in it. That is all there was there. The entire room might have been 4 by 6 feet.

She could hardly turn around in this space that was there, but the doctor received $1,000 a month in "rental" for this little room.

When we asked Dr. Lara-Valle about it, he tried to justify it as legitimate rental. He said the $1,000 helped defray some of the cost of remodeling. He was also receiving $1,000 a month from a pharmacy that was subleasing space in his clinic.

Mr. HALAMANDARIS. The lab that paid him the money was the D. J Medical Laboratory of Chicago, and I understand the company is now no longer in business. However, the doctor told us that in the interim he had secured a similar arrangement from another laboratory.

Senator Moss. He said, "D. J. flew."

Mr. HALAMANDARIS. Yes. He did not complete the idiom. He said "flew," instead of "flew the coop."

I would like to turn to Mr. Recktenwald who will help place things into perspective.

Senator PERCY. Mr. Halamandaris, before you turn it over to Mr. Recktenwald, I would like to again put on notice those who might be in the room, representing any of these labs or clinics, that criminal actions may have been committed. I think the people who believe that there is no criminal action here are rather naive. I have here the Internal Revenue Code that would seem to be very clear in its intent and purpose. Will you describe for us what you mean by a kickback?

Mr. HALAMANDARIS. I would like to answer the question in two parts.

STATUTE EXPLICIT ON DEFINITION

First, I would say the statute is explicit. I would like to read the two lines from the statute. This will answer the first part of your question, and then I would like to respond in detail to the notion that these payments are not kickbacks but are really fair rentals.

First of all, what the statute says is that whoever furnishes items or services to an individual in the medicaid program, who offers,

solicits, receives any kickback or bribe in connection with furnishing services, or making payments, rebates, or any fee charge with individuals, for furnishing such services shall be guilty of a misdemeanor.

Senator PERCY. Will you read the last sentence, describing what a kickback is, to be certain that the use of the term "kickback" you have been using is in accordance with the Internal Revenue Code description?

This is the Internal Revenue Service Code 162(c), subparagraph 3. "For purposes of this paragraph, a kickback includes payment and consideration of the referral of a client or customer."

Now, does that describe what you have all been talking about as a kickback?

Mr. HALAMANDARIS. Exactly.

Senator PERCY. And that fits it?

Mr. HALAMANDARIS. Yes.

Senator PERCY. So the code refers to it, and the Congress wrote this into the code in 1970 at suggestion of the Senate Finance Committee staff. It was done anticipating this possible situation. The code is very, very clear, and I think, and I suggest, Mr. Chairman, that we refer this entire testimony to the Internal Revenue Service and request they investigate whether or not these labs have been taking kickbacks as business deductions, and, therefore, might be in criminal violation of the Internal Revenue Code. That is why I ask the question: How do you suppose they are handling these on the income tax? Are the clinics handling it as income? Are the labs handling it as a business expense?

Mr. HALAMANDARIS. Good question.

Senator Moss. This will be referred to the Internal Revenue Service. We have referred it to the Department of Justice already, but we will specifically send it to the IRS as well.

"KICKBACK" DEFINED

Mr. HALAMANDARIS. I would like to make the second point, and Senator Domenici had discussion with me on this very point. The question is: When is it legitimate rent, and when is it a kickback, and how do you tell the difference between the two? That is the legal issue we are addressing. The Senator from New Mexico echoed my belief when he said if it is a flat fee, and reasonable, and it does not change from month to month, the labs may have a reasonable argument that this is a rent; however, if the flat fee rental is renegotiated frequently, then it is entirely a kickback.

Second, if the rent fluctuates from day to day, week to week, with the volume of business they send medicaid, then obviously it is a kickback.

It is a kickback if the amount of money paid, cash or other considerations, just happens to equal a set percentage of medicaid business, that is, if it just happens to equal 30 percent of your payments, then to me that is a kickback. If the payment is a precondition of getting a physician's account, then it is a kickback.

It is a kickback if it is undisclosed. It is a kickback if the space is small or unused, that is, if the space is one foot square in the middle of a hallway.

To me it is a kickback if the space is never used by the laboratory; more important, if the rent that is paid is inappropriate or excessive as compared with the cost of rental of space in that geographical area and similar real estate values.

Senator Moss. You have addressed yourself to this rental technique but there are, of course, other ways of paying kickbacks; such as paying part of the overhead, paying for the doctor's employees, supplies, equipment, and things of that sort.

Mr. HALAMANDARIS. Yes.

Senator DOMENICI. Mr. Chairman, I might just add a few words on the last statement. I certainly, at this point, do not agree that just because the rent would be fixed, that it would be legal, and that it would not be a kickback.

Senator PERCY. If there is no relationship to space.

Senator DOMENICI. Precisely. It seems to me we are on the tip of an iceberg, which is far bigger than just labs. Everyone of these little clinics has a pharmacy in it; a little tiny cubbyhole. One told us that he paid $1,000 a month rent even though he only served the doctor there—that is one full-time doctor. I think that we will find this is as broad as there are kinds of services that can be rendered in one of these clinics. I would assume that you would find it in the delivery of frames for glasses and shoes from podiatrists—we saw advertisements for a podiatrist. That region of your State, Senator Percy, will have the best feet in the United States. They approved podiatrists, and they had an ad on the wall with brochures how you could take care of your feet, because podiatry is not bound by some of the rules as the medical people are. Six different brochures were available for the people to take home so they would know how to get their feet checked.

That would require another service. I am sure they sell them something.

ONE PHARMACIST DISSATISFIED

One pharmacist, he would not tell us, but he was delighted to see a representative of the U.S. Congress. He said the whole pharmacy business is changed by this setup. "I do not like what I am in," he said:

> I happen to be here because the typical pharmacy does not work any more. You have to be inside one of these little places, and you just serve these doctors. I do not like what I am, but it is the only place I can make a living at this point.

We asked, "What rent do you pay?" On that question, he said, "It is my business." As I recall, however, with regard to the other pharmacists, I think your last statement is relevant, Senator Percy, with reference to income tax violation—violation of the IRS Code. One pharmacist is paying $1,000. That has gotten to be big business.

He just works for pharmaceutical companies. That company owns 11 of those little leases, and he is the pharmacist in charge.

It would be interesting to see what that owner of 11 pharmacies in all of these little clinics gets.

What other kind of relations do they have? Their "business" is all predicated upon what I perceive as a whole new subculture for the delivery of medical care and drugs and services to the poor people under medicaid and the medicare program.

Mr. HALAMANDARIS. I have a personal observation. We are constantly confronted with some pharmacists, or other provider telling us, as staff members of this committee, or telling the Senators, that the kickbacks and fraud are rampant. We have often been in the position of persuading this provider to come forward and tell the Senate what is going on so we could learn first-hand about fraud and abuse. We then could be able to make the necessary changes in the laws. Despite our coaxing, we are constantly confronted with people who are greatly reluctant to talk, because they will probably lose the accounts they now have and probably will be ostracized by the members of their own profession.

Nevertheless, we have insisted in the past that people come forward to testify. But the people named as receiving kickbacks have not been prosecuted. Nothing has happened. We published this in a beautiful little report on nursing home kickback 2 years ago, and we sent the specific cases of abuse to the attorneys general in 4 or 5 different States. However there were no prosecutions brought. This is a syndrome we have seen so often. Someone testifies before the Senate committee, and the next thing that we know we have some association's representative, who comes up here and says: (1) "we are all against crime, but I am happy to tell you, we do not have much of it in our profession," (2) "these are isolated instances; they do not represent the general pattern of the industry," (3) "they are made by representatives who do not know what they are talking about."

"PROBLEM HAS REACHED THE CRISIS STAGE"

The importance of our investigation and testimony today is that we have demonstrated, once and for all, that fraud is rampant, and it is blatant. Providers came off the street offering us money, so we can put to rest any misgivings we had about the extent of this problem. The problem has reached the crisis stage with wide implications for all of us as taxpayers and as users of medical services in the United States.

Senator PERCY. You really have to go to those parts that are actually fraudulent, that are of criminal violations, and that is just a tip of the iceberg that is perhaps characteristic of our society.

We saw, for instance, what I consider to be illegal—but how do you catch them—the practice among nursing homes of a group going in and buying the nursing home, and then setting up a corporation just to own it and renting it at an exorbitant rent to the operators of the nursing home. It is the same people; they just have two heads, and they have an income or two, and it is difficult to detect.

The other areas where they are selling services to these people, whether it is head to foot, and so forth—I was struck this weekend by talking with a constituent, who had recently moved from a

Scandinavian country. I said: "How do you like this country?" and he said:

I thought America was a healthy country—a healthy people—but I have been looking at television. It is unbelievable. You have more aches and pains, ailments; and you have more things that you can take for them. It must talk people into feeling ill, to just sit there, hour after hour, and see all of the things that go wrong with you.

I imagine, if you start pushing foot care, you can boom that business. There is money to be made, just as they say in this report in Rogers Park. There is money to be made among the old people, particularly if you are old and a member of a minority group. Those are the groups these vultures move in on and exploit. We have a part of our society that we have a real obligation to do something about and focus in on.

Senator DOMENICI. Specifically, with regard to Mr. G, in your report—I was told about him, but did not meet him. It is clear he is not a medical doctor.

Mr. HALAMANDARIS. That is correct.

Senator DOMENICI. It is clear he owns a medical clinic in the usual sense of ownership.

Mr. HALAMANDARIS. Correct. He has registered that ownership with the city of Chicago.

Senator DOMENICI. It is clear he receives, as owner, some substantial portion of what the Government pays as medicaid that is related to the amount of professional services rendered in those clinics.

Mr. HALAMANDARIS. That is my understanding.

Senator DOMENICI. Is there anything in our law that makes that illegal? Is there anything in our law that says we cannot pay an entrepreneur for delivery of what a doctor is supposed to deliver? We never intended that. Is it illegal or not?

Mr. HALAMANDARIS. I do not know that there is any specific statute. The canons and ethics of the American Medical Society do prohibit it.

Senator DOMENICI. He is not a doctor. He is not bound by the canons. They cannot expel him.

SOME PHYSICIANS VICTIMS OF ENTREPRENEURS

Mr. HALAMANDARIS. Yes, I am aware of that problem. We found this again and again. Many foreign physicians were employed by laymen who, to some degree, took advantage of them. These entrepreneurs are in this business to make money. They push these poor doctors to order tests that are not necessary in order to increase the amount of money coming into the clinics which they own.

To me, this is a reprehensible practice.

Senator PERCY. Do you want to identify the Robert Taylor Medical Center? This is one of the largest public housing projects in this country—just block after block of high-rise public housing. I presume Mr. Robert C. Parro operates in a medical center, in or near those public housing buildings.

Mr. HALAMANDARIS. Yes, Mr. Parro is the owner. He has a clinic in this area. I forget the exact address, but it is on Chicago's south side.

Senator PERCY. The south side?

Mr. HALAMANDARIS. Yes.

Senator PERCY. And he has another clinic called the Professional Medical Center. Where is it located?

Mr. HALAMANDARIS. On 51st Street. I do not have the exact address in front of me.

I would like to shift for a brief moment, from the subject of kickbacks to the question of the quality of services performed, and to some of the ways in which laboratories increase the amount of medicaid reimbursement, making kickback more possible. I am talking about such things as billing for tests which the physicians have not authorized.

I would like to turn it over to my colleague, Mr. Bill Recktenwald, who has some charts and presentations.

Mr. RECKTENWALD. One of the things we determined, was the fact that there were two pricelists. These labs would charge one amount to private patients and a higher amount to those in the medicaid programs for the same service.

Now, this practice violates HEW regulations that require all bills submitted to medicaid to be the usual and customary charges for these services.

HEW regulations further state if there are two pricelists, the lower of the two will be charged and used as the basis for reimbursement.

DOUBLE PRICE LISTS

The BGA examined more than $10,000 worth of paid bills for 14 selected tests. These 14 tests are ones which we knew had two prices. This information came from salesmen visiting the Morse Avenue Clinic. In order to arrive at $10,000 in paid bills for these 14 selected tests, considerably more than $10,000 worth of bills were examined.* Mr. Bostick of the Library of Congress has prepared some charts for our use. As you can see, D. J. Laboratory was paid by the State $9,274 for certain tests that would have cost a private person only $3,514.50—a 164-percent overcharge to the State.

The Northside Clinical Laboratory was paid $10,749 for tests which would have cost the private sector only $4,864—a 121-percent overcharge to the Government.

The Norsom Medical Reference Lab, which has some 60 nursing homes as their clients, was paid $10,696 for tests which would have cost the private sector only $4,978.50, or a 115-percent overcharge to the Government.

The Illinois Medical Laboratory was paid $12,997 for tests for which private patients would have paid $6,190, or an overcharge to the Government of 110 percent.

The United Medical Laboratories, Inc., which is an Illinois corporation, was paid $12,575 for tests which would have cost the private sector $6,495, or a 94-percent overcharge.

Senator MOSS. Do every one of these have two pricelists—the private and the medicaid?

*See chart, p. 437.

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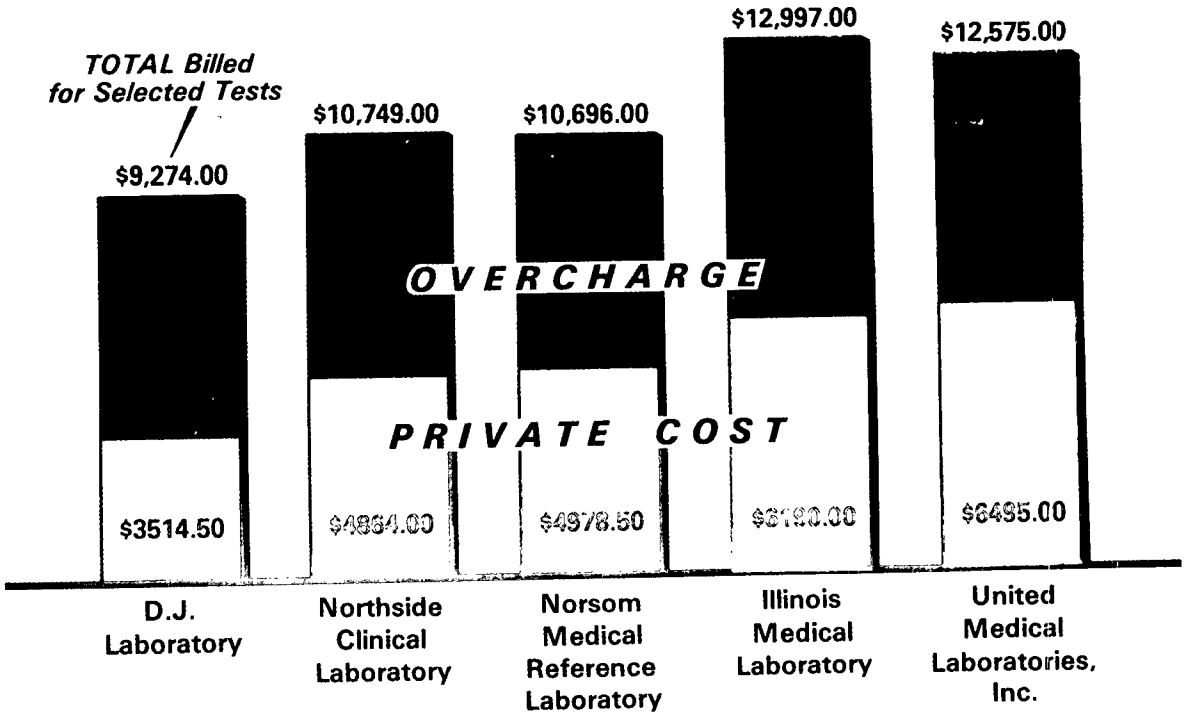
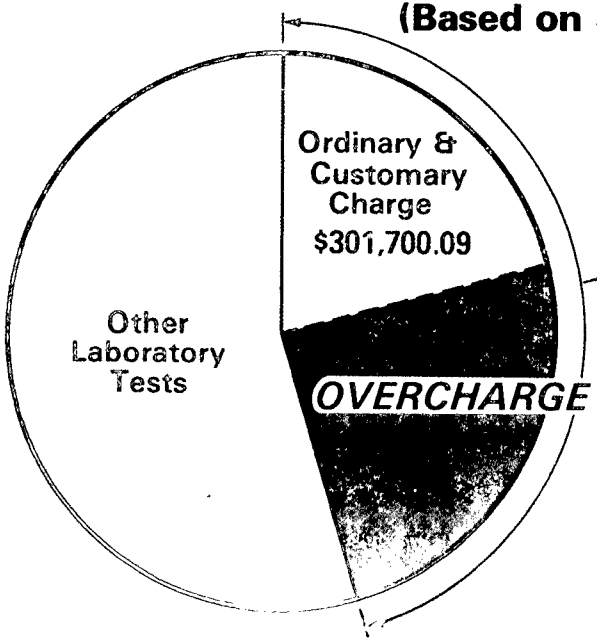
Overcharge to Medicaid for Selected Laboratory Tests



PROJECTION OF OVERCHARGES OF FIVE CLINICAL LABORATORIES

(Based on 8 Percent Sample)



Selected Laboratory Tests
$655,869.76
(45.5%)

$1,441,472.08 (Paid by Medicaid for the first 6 months of F.Y. '76)

Mr. RECKTENWALD. Yes, sir, most of them do. The bulk of the information about double pricelists was gained by Mr. Longhini and Mrs. Delaney in the Morse Avenue Clinic. They would be told about the double pricelists by the laboratory representatives.

During the first 6 months of fiscal 1976, these five laboratories were paid some $1,441,000.

From the information gained in the examination of these selected tests, it is our projection, based on an 8-percent sample—which is a very large sample—that the State of Illinois has overpaid $354,000-some-odd to these laboratories just for these selected procedures. Again, we are talking of only these five laboratories for a 6-month period. It is a very large piece of the pie that we have overpaid these people.[1]

Now, in still another area of fraud—laboratories charging medicaid for tests not ordered by physicians—we pulled some 20 bills at random submitted by D. J. Laboratory on behalf of Dr. Bascon. We have these bills on charts.[2] These are actual bills.

Senator MOSS. These are facsimiles of the bills themselves.

Mr. RECKTENWALD. Yes; Xerox copies.

Perhaps, Mr. Chairman, if you want to go over and look at them closely—it is difficult to get them blown up.

Senator MOSS. I just wanted to see how they are laid out. They are all on a regular form.

Mr. RECKTENWALD. Yes; if you will notice the date of service on that particular bill,[3] the date of service on the left-hand column——

Senator MOSS. Yes, February 5.

DOCTOR NEVER SAW PATIENT ON STATED DATE

Mr. RECKTENWALD. According to the doctor's record, that patient never visited the doctor until February 17. It would be difficult for the doctor to draw blood on a patient who never visited the doctor.

Out of these cases, the doctor had no record of having any patient visit him anywhere near the time when the alleged service was given.

In one case, they had no record of a patient with that name. In two cases, the first visit to the doctor was after the alleged date of service. Then in many of the cases, the doctor found that he had not, in fact, requested these tests, nor had he received any results.

Senator PERCY. I wonder if Senator Domenici could mention publicly the possibility which he mentioned to me, that in some of these cases where it says no tests requested, it may reflect a change of attitude by the doctor now that the heat is on.

Senator DOMENICI. I saw a couple of these, and there is no doubt in my mind to begin with, that the labs can, and probably are, adding tests that are not ordered by the doctors; however, I think that there is another possibility that the doctor, by the time he starts interrogating, begins to get kind of queezy and scared about this whole process. He went through a file that we cannot even understand, and said, "I did not order these three."

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[1] See chart, p. 438.
[2] See appendix 1, p. 469.
[3] See p. 476.

I think they could have developed an attitude of being scared of the whole process, and they will fudge on the short side, and pin it on somebody else. I think that is a possibility, although we will never be able to find out, because the doctor's name is on each of these. From what I saw, there is no way you could distinguish the point of time and the laboratory tests, either written in or checked in. It is always the same kind of script; it is pretty hard to tell.

You could just see him flip through, and say, "I did not order these four." I think it is a possibility—it is a real possibility that——

Senator PERCY. In your judgment, is it a possibility?

Mr. RECKTENWALD. Senator, on these particular bills, the doctor made a very careful examination. He first checked the patient chart to see the date on which he saw the patient—this also notes what exams or tests that he had requested—then he checked the patient files to see what results he had received from the laboratory. Then, as a third check, the doctor kept a book in which he entered the date, name of patient, and type of test requested for every lab test. So at least on these 20 bills, chosen at random, we have not one or two, but actually three different cross-checks.

There are also other strange things about the tests. For example, when the doctors' records show that only a urine sample was taken and the lab bills for blood tests. Out of the 20 bills, only 1, No. 15,* had all the tests billed for been requested by the doctor.

The total amount that was billed to medicaid, just on these 20 tests, was $855; the amount that was actually referred by the physician was only $119, leaving $766 of extra charges that were just added on.

Senator PERCY. Were you able to determine that the established quota of two or three tests per person was pretty well maintained? Was there any greater frequency of the number of tests to medicaid patients as opposed to those patients who had to pay the bill themselves?

MEDICAID MORE LUCRATIVE THAN MEDICARE

Mr. RECKTENWALD. During one of the conversations that Mr. Trivedi and Dr. Meyer had during the investigation, Trivedi suggested that medicare patients not be given tests. "Don't test those people. There is no money to be made on medicare. The money is to be made on medicaid." That is what I overheard Trivedi say.

Dr. Meyer said that may be good business, but certainly not good medical practice.

Senator PERCY. Did you discover a disparity in the number of tests based simply on the ability to get paid for these tests?

Mr. RECKTENWALD. You can see in some of these bills, in their eagerness to make money from the State, that they had actually listed CBC—complete blood count—twice on the same bill.

It gives me the impression that someone was just writing things down—taking test names out of the blue.

*See p. 483.

Mr. BRUNNER. Senator, the random sample that Mr. Recktenwald is talking about is not just an isolated incident. Working with the subcommittee staff, we went out in teams to visit clinics.

I was on a team that visited a clinic in Bridgeport where Mayor Daley lives. It was a very well organized clinic. The doctors had everything computerized. Their records were excellent. The doctors very carefully looked at the bills we gave them and in many instances, after checking them against patient records, they said, "No, I did not order these tests run."

One doctor had the best looking records I had ever seen, and we found instance after instance of laboratory tests billed for that were never ordered by the doctor. This is in the area on the southwest side of the city of Chicago, a white area as opposed to the black area that Mr. Recktenwald was talking about. I think the conclusion you might draw is that the practice is very widespread.

Mr. RECKTENWALD. Some of the inappropriate tests ordered like EKG's, with interpretation, for people diagnosed as having arthritis, and sickle cell tests being ordered for middle-aged white adults. This leads us to believe that people were just writing in test names, and that these tests were never requested, they were never made, and results never given.

Senator PERCY. I would like to have you amplify, and perhaps our chairman would be interested in this matter. We, many times, have maintained that we are not trying to set up a Federal bureaucracy to oversee these programs. We delegate this to the States, and we pay the costs. The States have a great responsibility to carry this out.

Now, can you indicate whether, say, in the State of Illinois, any State agency ever did routinely have the kind of audit that would determine whether or not the bills are valid bills, whether they actually were submitted for services that had been rendered?

Has there been any audit of that kind that you know of?

NEWLY ASSIGNED INVESTIGATORS

Mr. RECKTENWALD. There are about 50 public aid investigators that have been assigned to check the medical laboratories in Illinois.

Senator MOSS. Just recently assigned?

Mr. RECKTENWALD. Yes, sir.

Senator PERCY. How many were there before?

Mr. RECKTENWALD. To my knowledge, none, sir.

Senator PERCY. So this is a recent flurry of activity, since the investigation has been carried on.

We are pleased that they have responded, but I cannot help but ask the question: Why was it not done before?

Is there any incentive for the State to properly audit, so long as they are being reimbursed by the Federal Government anyway? Is there a State cost involved?

Mr. HALAMANDARIS. On the contrary, Senator, there is little cost to the State.

As you know, Congress, in its infinite generosity, decided in 1972 that the Federal Government would pick up 75 percent of the cost

of moving each State into the computer age. So if you are a director of a health department or welfare department, you know that the Federal Government will pay 75 percent of the costs of installing and operating computer systems. The Federal Government also pays 100 percent of the cost of making State inspections, which relates to the quality of health services. Senator Moss has a bill pending that would provide 100 percent Federal funds for that purpose and to help States accomplish annual audits.

There are 50 percent matching funds available now for auditors. As we learned in New York, we recover anywhere from $6 to $15 for every $1 invested in the salary of auditors so there should be an incentive for the States to set up surveillance units.

Senator Moss. But States do have to monitor the medicaid program to insure there is no fraud or abuse.

Mr. HALAMANDARIS. Yes, the State has a vested interest in doing so and indeed, they are required to do so under the medicaid regulations.

Senator Moss. You recall, when we heard testimony relating to the fraud squad in Michigan—they were doing some auditing and follow-through, providing a good example for every State in the Union.

Mr. HALAMANDARIS. The fraud squad is really a superb group. The official name is Post-Payments Surveillance in Michigan, and their computer system is cranked up to the point where they pay 97 percent of the bills within 30 days, and the computer automatically catches any sort of suspicious practices. They have a group of investigators that follow and visit people suspected of ripping off the system, and they have recruited a fantastic amount of money. For every dollar they have invested, the surveillance—the fraud squad—has recovered $6.

I think there is a precedent that other States ought to follow there.

Mr. BRUNNER. With respect to Senator Percy's question regarding the program in Illinois, the BGA delved into the State's effort to combat fraud prior to this investigation, and the State of Illinois had roughly 100 welfare inspectors.

INSPECTORS NOT CONSCIENTIOUS

Now, before Mr. Recktenwald came to work for the Senate, he had investigated those inspectors to find out what they did. Mr. Recktenwald's investigation found that many of them were retired Chicago policemen. Many have never bothered to even come to work, except to sign in. Very often, they spent the day shopping, or working in another job, and those roughly 100 investigators only filed 200 cases against individuals who should not have been on the welfare roles. Illinois' fraud inspection was a complete misuse, at least in my judgment, of the people who were on the staff to do investigative work. They were concentrating on individual cases of welfare recipients as opposed to concentrating on large scale welfare fraud. One of the conclusions of this investigation is that much money in Illinois—we estimate some $3 million of $11 million in this lab area—is being ripped off. This $3 million could help an awfully lot of people and make health care delivery more efficient.

Dollars that you are appropriating for health care in Illinois are not getting to people who need help. Very often, as you know, Sen-

ator, the suggestion has been made by the Illinois Department of Public Aid that there is no real welfare fraud, and only a small number of offenders. Yet these labs that we investigated—about thirteen labs that do a $6.19 million business—are a fair sample.

We are talking about 65 percent of the lab business, so the fraud we encountered is anything but an isolated instance.

Senator PERCY. Were these retired policemen? Were they supplementing their income? Were you able to determine if they were political workers as well?

Mr. BRUNNER. I think there was no doubt those people had political clout and got jobs on public aid because of their expertise as Chicago policemen.

I think in my experience, you just cannot go about this sort of thing that we are talking about, catching people doing what we are talking about, with people who have this sort of background. You need accountants, you need lawyers, you need people who have expertise, in order to find these sort of crimes.

Since IDPA took over this program in January 1975, as opposed to the county running it. Mr. Trainor has gone out of his way to try to remove these people and get people who are qualified to do this sort of work. I think there is a realization on his part that it has to be done, and certainly the program is much better than it was before.

Mr. Trainor has told us, and he told Mike Wallace on "60 Minutes," and as John Simon who wrote the report testified before you, there was no fraud inspection program in the Illinois Department of Public Aid until the fall of 1974.

John Simon told me as recently as last week that the investigators he found in the department of public aid, when he went there, were unable to find their rear end with both hands. That is what Mr. Simon said about the investigators that he found in the Illinois Department of Public Aid.

FULL COOPERATION NEEDED

I have a lot of respect for him. I worked with him in the Department of Justice. He knows how to conduct fraud investigation and I think he did his best under the circumstances. But certainly you cannot approach these problems without full cooperation from State government.

Senator PERCY. Could Mr. Recktenwald comment on the political activities of the personnel that were paid, as investigators? They apparently did not really work for the Public Aid Department.

Mr. RECKTENWALD. What we are talking about, Senator, is an investigation which took place in spring and summer of 1974.

It turned up evidence that Cook County public aid investigators, who are supposed to track down welfare cheaters, are themselves cheating the public.

Loafing and inefficiency on the Cook County staff resulted in operational costs three times higher than the court fines finally recovered. In 1972, 73 public aid investigators managed to find only 222 prosecutable cases out of nearly 1 million welfare recipients in Cook County.

The Bureau of Special—public aid—Investigations in Springfield, with a nine-man staff, referred more cases a month for litigation than the Cook County unit did with 73 men. The Springfield bureau is responsible for investigating welfare fraud in every county in Illinois except Cook.

Many of the Cook County investigators were spending their working hours taking leisurely lunch breaks or running personal errands.

On one occasion, BGA staff members saw a public aid investigator head for home at 10:30 a.m. He remained there most of the day, after visiting a bank and a grocery store. Investigators are paid to work until 4:30 p.m.

Another investigator was seen driving 1 hour each way in order to eat his lunch at home. Members of the Cook County unit are allowed 45 minutes for lunch.

Senator PERCY. What was the source of funds being used to pay these investigators?

Mr. RECKTENWALD. This is when they merged the county welfare department with the State.

Senator PERCY. Could the staff determine for us what the source of those funds would be?

Mr. RECKTENWALD. Yes.

Senator PERCY. We know the way the game is played in Chicago. Workers are held to very high standards of performance on election day, but what happens to the public aid patients? What happens to the fraud and all of that? Is it none of their business?

This is a very callous operation. I certainly am pleased to get your reports that this has been discovered and that was the situation you found, and that they are doing something about it.

Senator Moss. Is there any licensing or inspection system of the laboratory equipment itself?

LUNCH, BLOOD SAMPLES SHARE REFRIGERATOR

I am thinking about the lab where you opened the refrigerator and there were blood samples and a bottle of milk, and a sandwich—all of this together—and it sort of made me feel I would not want to get my lab work done there.

Senator PERCY. You would not want to get your sandwich there either.

Mr. RECKTENWALD. Senator Moss, as you know, we discovered that one lab owner was sending his wife's blood sample out to another laboratory. There is a licensing regulation for the clinical laboratories. I believe that in Illinois they are licensed by the State department of registration and education, and that they do have periodic inspections. There is a requirement that the lab owner or supervisor be a medical doctor, that he has certain expertise in biochemistry, but they have perhaps only one inspection a year.

Senator Moss. They must not have very rigid inspections to permit these little holes in the wall to operate and, as I said in my opening statement, we visited the laboratory over at the Illinois Masonic Hospital, just blocks away, but they can't get any medicaid business.

Mr. RECKTENWALD. Even the labs that you and Senator Domenici visited, I am sure, would be sparkling clean on inspection day.

Oftentimes in Illinois people know when the routine annual inspection is coming, and they are prepared.

Mr. HALAMANDARIS. I think we are getting close to wrapping things up, but I would like to explain this item here.

At the present time, there are many laboratories that charged $25 for so-called combined SMA–12, and also for determining the albumin-globulin ratio. That sounds complicated, but it is really not.

When the SMA–12 is run, they charge $15 as posted, and all that is necessary is to take this little computer and pull the tab until the two readings are in line, and you have the index. [Illustrating] I just earned $10. The State of Illinois, in its wisdom, is paying $10 for this procedure, and a lot of other States are too. This helps make the point that the fee schedules in some States are really antiquated.

Mr. Holstein in his statement suggests they are in the horse-and-buggy era with lab fees. Most of them were promulgated in 1965 and 1967 and 1970, when medicare was first coming into operation.

These fee schedules do not take into consideration the new technology, which makes it possible to perform tests for 7 cents or less.

Let me give an example. The cost of performing a simple urinalysis is 7 cents to 25 cents. What is involved is taking a little piece of paper, sticking it in the urine, and reading it, that is, comparing it to a color chart. That process costs 25 cents, let us say.

A private patient in Illinois pays about $3 for this test. However, the State of Illinois, more specifically medicaid, is charged $10 by some labs and more for this simple procedure.

I do not know why Uncle Sam has to get clipped. I do not know why we have to assume that money which is paid—paid in Federal funds—like medicare and medicaid belongs to nobody and is up for grabs. To illustrate the point, let's talk about the cost of a urinalysis. In Illinois, the cost to do it is 25 cents; private patients are charged $3; and in medicaid, the Government is charged $10.

AMA VIEWS SOUGHT

Senator DOMENICI. Mr. Chairman, I must leave. Could the staff give us one additional item which we might all be interested in? Would you furnish us with the American Medical Association's rules regarding the ethics that pertain to the subjects which we have been discussing? I think it is very important that we consider sending them some of this record so that there is no claim that we have not asked them to do their share.

I think in the area of rebates, in the area of kickbacks, in the area of fee splitting, there are some rather precise rules and regulations that govern the majority of medical doctors. Those who deliver the services—I do not think much of what we have found here is condoned by most doctors, or even would be ethical at all in the bona fide medical profession. I would like to have that information, with some analysis by the staff, so we could look at it, Mr. Chairman.

Senator Moss. We would be glad to do that.

Senator PERCY. I think that would be very valuable, and you might also go one step further, and determine what the AMA—in this case, the Illinois State Medical Society—feels its responsibility is.

There is no group that is less governed than the AMA, and there is no practice being carried on that calls for more intervention than this.

Certainly the members of the board of directors of the Illinois Medical Society that I know would just be as appalled as we are at these activities.

Here is a profession that has every reason to want to see these practices and abuses stamped out. They know that it is a small proportion of their total profession, but it is there, and it has got to be rooted out.

To amplify on what their responsibility is or should be: Once the ethics have been established, do you know if they have any self-policing within the profession?

Mr. HALAMANDARIS. In fairness, I should say Mr. Roger White, the executive director of the Illinois Medical Society, had contacted the staff in late October and met with Mr. Recktenwald and myself.

He was very helpful and very cooperative. He indicated from the beginning that these practices have existed, they were widespread, that a number of physicians were taking advantage of the system, but they wanted to do everything possible to eradicate fraud and abuse. I wanted to put that on the record.

Senator PERCY. I am delighted to hear that. I would not be surprised at all—once they see a problem, they usually jump right on it.

Senator MOSS. Now that the report is completed though, we can send that to him and ask for a response in writing from their governing body.

Mr. HALAMANDARIS. With your permission, Mr. Chairman, I would like to ask the Better Government Association to submit for the record the sworn affidavits they made concerning what took place at the storefront clinic, the people that came in, the conversations that took place, the solicitations that were made, et cetera, and have them printed as part of the hearing record.

Senator MOSS. You can do that; fine.

Mr. BRUNNER. We have those records.*

Senator PERCY. I have just a couple of questions. Can you give us some idea as to what portion, what percentage of independent clinical labs are engaged in the questionable, if not illegal, practices you have been assessing here today?

SMALL PERCENT CONTROL BULK OF MEDICAID BUSINESS

Mr. HALAMANDARIS. The percentage would be small. I would say, if we have 3,000 independent clinical laboratories in this country, about 150 would control the bulk of the medicaid business. That would be my estimate.

Senator PERCY. But of those that control the bulk, what proportion do you think are engaged in these fraudulent practices?

Mr. HALAMANDARIS. In my opening statement, I made a pretty flat statement that you apparently must give a kickback to get the account, and it is my impression that laboratories which garner large

*See appendix 2, p. 490.

amounts of medicaid funds must be offering a kickback. I am sure there are exceptions, but this is my basic assumption. For the most part it appears that if you have got medicaid money coming in, you are giving a kickback.

Senator Moss. Could I intervene? In my visit to the Masonic Hospital laboratory, the director there was pointing out that they had unused facilities.

They could have run another shift—a whole shift of people—and these facilities were not being used up to the maximum by any means. Yet they got very little—almost no medicaid business. Although the administrator was rather carefully choosing his words, he indicated that a major reason was because they had no kickback or inducement system.

Senator PERCY. That is why they are not getting the business.

Senator Moss. Yes.

Senator PERCY. How is it that these phony rates can be established? They are not based on costs. It seems that they have this tremendous leeway, that they charge these vast amounts, mainly paid by Uncle Sam. How can it be that the fee gets established and is paid? Cannot an audit by a competent Government agency determine there is no relationship between costs and charges?

Mr. HALAMANDARIS. We have something called the HEW Audit Agency. They conducted only about 200 medicaid audits since the beginning of the medicaid program. From our records and our analysis, the agency did only one audit of the clinical laboratories since the medicaid program began in 1967 to the present. The one audit of laboratories concerned the State of Illinois. It was released in 1974.

That audit is referred to in our staff report. There has been very little attention paid to the matter. As I noted, the fee schedules have not been evaluated by the States or by the Federal Government for years.

I would suggest very strongly that it is time that this were done. Perhaps the impetus might a letter from the two of you to Secretary Mathews of HEW, suggesting that we need to take a look at these fee schedules.

California has 28 separate fee schedules for clinical laboratories, if that is not confusing enough.

Senator PERCY. I would suggest, Mr. Chairman, that this be done either through Secretary Mathews or we might send a letter ourselves directly to the Governors of every State.

MILLIONS OF DOLLARS COULD BE SAVED

They are all working under tremendous pressure on budgets, and here they are paying 50 percent on costs. Here is an area where they can pick up millions of dollars just by simply enforcing a law, as it now exists.

If you can use the term "loophole" that exists in the law, is it your judgment, Mr. Halamandaris, that the loopholes have been plugged by the Federal Government? We do have an Internal Revenue Code adequate to cover this, but are we not enforcing it?

Mr. HALAMANDARIS. Yes. As I stated, the kickback statutes are explicit. There are Federal and State laws that apply. There are IRS

provisions. There are even general fraud statutes that apply. They could not be any more explicit. But none of these laws are being enforced.

Senator Moss. Well, we thank you very much for this report and for your testimony. Especially, I wish to commend the Better Government Association for their fine work and in aiding our committee staff so well in this matter.

In fact, it was indicated that, because of the funding problems, the Better Government Association, along with CBS, did pick up the costs—the rental, and whatever else was needed—to get the storefront set up. I want to express my appreciation and thanks to them.

It is a chilling report, and its implications are vast. The report is certainly welcome because it will enable us to get at fraud and abuse in medicare and medicaid. We thank you all very much.

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

Senator Moss. Now, I want to give an opportunity to anyone who is named in our report, or any lab representative who desires to address the committee. If they want to refute the charges made, they have that opportunity now. The labs will be sent a copy of this transcript to which they may respond in writing.

Is there anyone that would like to come forward now?

Mr. FULLER. Mr. Chairman, I am not one of the persons that you have referred to here, but I am Garret Fuller, attorney here in Washington, representing the organization that has been known for many years as United Medical Laboratories. They are based in Portland, Oreg. It is not the United Medical Laboratory, the one that is referred to here, that was referred to last night on the "60 Minutes" show. I would like the record to show that, with your permission.

Senator Moss. It certainly will be, and I am glad you have come forward to make that clear; we do not want the two companies to be confused.

I think Mr. Recktenwald did clarify the record and I am glad you are here to underscore that the lab referred to earlier is not United Medical Laboratories which are based in Portland, Oreg.

Mr. FULLER. That is correct.

Senator Moss. Thank you very much.

Mr. FULLER. Thank you.

NO REBUTTALS TO ALLEGATIONS

Senator PERCY. I think the record should show, Mr. Chairman, that a full opportunity was provided. We offered to provide this forum to anyone against whom allegations have been made, either on the "60 Minutes" show last night, or in the news media, or in the comments made today. No one has come forward to testify on his own behalf, or on behalf of any of the organizations they represent.

I thank you very much, Mr. Chairman, for establishing that.

Senator Moss. Thank you.

Mr. FULLER. Thank you, Mr. Chairman.

Senator Moss. Now we have two very good witnesses to hear yet, and we will shift the locale from Illinois to New Jersey.

Senator PERCY. I am happy to have it shifted, Mr. Chairman.

Senator Moss. I saw you smile.

Mr. Frank L. Holstein, executive director, Commission of Investigation, Trenton, N.J., and Mr. Anthony Dickson, counsel, Commission of Investigation, Trenton, N.J.

Will those gentlemen please come forward?

STATEMENT OF FRANK L. HOLSTEIN, EXECUTIVE DIRECTOR, COMMISSION OF INVESTIGATION, TRENTON, N.J.; ACCOMPANIED BY ANTHONY DICKSON, COUNSEL

Mr. HOLSTEIN. Mr. Chairman, I am Frank L. Holstein, executive director of the New Jersey State Commission of Investigation.

With me, as you mentioned, is Mr. Anthony Dickson, also of our commission of investigation.

Senator Moss. We are pleased to have you before the committee, and we looked forward to your testimony.

You may proceed.

Mr. HOLSTEIN. Mr. Chairman, members of the committee, on behalf of the New Jersey State Commission of Investigation—SCI—I would like to thank you for this opportunity to appear before you and testify about the commission's investigation of independent clinical laboratories receiving moneys under the medicaid program. We believe we can be of particular assistance in this area because, to our knowledge, we were pioneers in undertaking such an in-depth probe into the practices and procedures of independent clinical laboratories and in exposing the abusive methods by which some of those laboratories can literally bilk the medicaid program for high profits which flow directly to the laboratory owners and, via them, also to some of the doctors supplying those laboratories with medicaid-funded test business.

Perhaps more importantly, our investigation demonstrated that the shortcomings and loopholes which had developed in the New Jersey Medicaid program presented a virtual open door to those laboratory owners to profiteer at the taxpayers' expense. Therefore, I will be putting considerable emphasis in my remarks today on how the lessons learned in our investigation have pinpointed the areas of controls and surveillance capabilities which must be improved to prevent further abuses.

NEW JERSEY PROBE NEARING COMPLETION

By way of background, let me state briefly how this particular investigation of independent clinical laboratories and the ensuing public hearings were developed by the New Jersey SCI. Early in 1975, the commission began an evaluation probe of the entire medicaid program in New Jersey, a probe which was mandated to us by request of the Governor. The SCI proceeded to set up three investigative teams to look into the three principal medicaid areas: nursing homes, hospitals, and purveyors of services other than nursing homes and hospitals. It was the last of these three major areas which covered the flow of medicaid dollars to independent clinical laboratories, doctors, pharmacists, and others. Having held several interim public

actions during this overall investigation of medicaid, we are nearing completion of that probe and hope to make a final report and recommendations to the Governor in the months ahead.

As to the other purveyors-of-services phase of our medicaid investigation, one of the earliest signs detected by us as to possible abusive practices related to the operations of some independent clinical laboratories. With the cooperation of the New Jersey State Medicaid Division, it was quickly determined that 12 of the 184 independent clinical laboratories in New Jersey were receiving more than half of the $2.2 million in medicaid funds flowing annually to all of those laboratories. Attachment A* to this statement lists medicaid reimbursement to those 12 laboratories. Additionally, data obtained from that division's bureau of surveillance indicated patterns of apparent irregularities in the practices of those laboratories which were doing an inordinate amount of medicaid-funded business. Accordingly, an in-depth investigation of those laboratories was immediately authorized by the commission.

The practices and procedures of independent clinical laboratories have quite technical aspects which can present confusing complexities to a layman without expertise in this particular field. It should be remembered these laboratories perform a wide variety of tests, the results of which are used in the diagnosis, treatment, and prevention of disease. Fortunately, the commission was able to enlist the cooperation of the New Jersey State Health Department which assigned personnel with expertise in the clinical laboratory area to assist the SCI in this investigation.

The expert personnel made field inspections of the laboratories, analyzed many hundreds of pertinent documents, and then provided the SCI with comprehensive written and oral reports. On this solid foundation, the SCI then used its investigative expertise and its full subpena and witness immunity powers to develop facts about abuses of the medicaid program in the following principal areas:

Subcontracting Reaps Large Profits

(1) The reaping of windfall profits by some small and largely unautomated independent clinical laboratories which marked up by as much as 300 percent or more the cost of tests performed on a subcontract or referral basis by large, automated laboratories and then collected the markups from medicaid. The facts gleaned in this area as well as other areas discussed below were instrumental in documenting that the New Jersey medicaid fee schedule for reimbursing independent clinical laboratories was much too high and in need of revision downward.

(2) Numerous instances where some independent clinical laboratories were able to overbill medicaid for certain tests and even render false test claims, without these practices being detected at either the prepayment or postpayment processing levels.

(3) Rebate or kickback type practices whereby some laboratories either returned a set percentage of medicaid test fees to some of the doctors referring business to those laboratories or indulged in some

*See p. 467.

other financial-inducement-type payments to the doctors under the guise of paying for "rented space" or "office salaries" in the doctors' offices.

The transcripts of our public hearings have been made available to the committee. They contain numerous specific instances of the type of abuses summarized above. Those transcripts contain sworn testimony and reference to substantial documentary evidence which detail how specific laboratories, middlemen, and doctors engaged in the abuses of the system. That same extensive factual picture in the transcripts demonstrates that the abuses were not sparse but rather general and quite widespread in nature. Relying on those transcripts as the full and complete record of our investigation, I will review only some sample instances of various abuses in this statement, so that members of this Senate committee will have a capsule picture of how medicaid can be specifically bilked by independent clinical laboratories.

In the area of huge markups by some of the laboratories, it should be noted that in New Jersey, medicaid establishes a maximum fee level at which it will reimburse independent clinical laboratories for the tests performed.

We have submitted as an exhibit to the staff of this committee a schedule of these maximum reimbursement levels of certain tests.*

In one particular instance, we addressed ourselves as did this committee staff, to the SMA–12 test.

We showed a relatively small unautomated laboratory which was paid a maximum of $12.50 by medicaid for allegedly performing an SMA–12 test.

We uncovered a relevant document and we demonstrated that in actuality the test was never performed by this small laboratory, but was referred to a larger automated laboratory, specifically the Center for Laboratory Medicine, Inc.

This highly automated lab billed the small lab only $3.50.

Excess Payments Should Be Eliminated

Naturally, of course, the smaller lab turned around and billed medicaid $12 for basically doing nothing but providing a delivery van, and it was our suggestion, Senator, that serious consideration be given to cutting out the excess profits of the middleman.

There was absolutely nothing at that time in New Jersey medicaid plans or rules and regulations to preclude this particular kind of price gouging tactic, so you had an instance here where the State system almost constituted an open invitation for middlemen and smart money entrepreneurs to move into this particular area, and to exploit the system to a maximum profit in the manner I just described.

Also, relevant to this area of overbilling, our hearings demonstrated frequent practice by some of the laboratories of taking a single test, which produce the multiple component part results, such as the SMA–12 test. Mr. Chairman, I think you described that very well earlier this morning; we like to call that our a la carte, so that

*See attachment B, p. 467.

really you can get the whole meal, so to speak, for one very low price. But the labs were very good in the razzle-dazzle of overbilling, and would break down basically a very simple chemical and mechanical process, and charge on an a la carte basis, sometimes tripling and quadrupling the total bill in that way.

As to a specific example, the director of the Park Medical Laboratory in New Jersey conceded under questioning at hearings in New Jersey that his relatively small and unautomated laboratory did indulge in the overbilling practice of collecting for medicaid for the component parts of the multiple results tests including, in one instance, where they took seven parts of an SMA–12 test, which was performed by this Park Medical Laboratory by a big automatic lab for a mere $3.40. By this a la carte billing that we have described, he was able to bill medicaid a total of $58, by the technique that you have heard earlier this morning that you have referred to.

Obviously, that is almost five times the maximum permissible reimbursement for SMA–12 tests, and also, of course, very disturbing, Senators, that the medicaid system in New Jersey was not structured in a way to have the kind of fine filters and screens to select out this kind of semifradulent overbilling and protect the taxpayer's dollars. Since the time of our hearing and the inception of the work of this Senate subcommittee, there have been changes in the regulations that make it explicit that this is a "no-no" in the medicaid program.

There was also very significant and troubling exploits and abuses of the system in another way. This is documented as a specific example of how this Park Medical Laboratory, and some other laboratories, billed and received from medicaid $15 for each German measles test, which is known as the Rubella test. But in fact and in truth, the test had not been performed by this small and independent laboratory.

Lab Charges for "Free" Testing

The fact of the matter was that the tests had been performed free of charge for the Park Medical Laboratory by the New Jersey State Department of Health, because the New Jersey State Department of Health runs a public laboratory wherein it does testing for certain kinds of contagious and public health type diseases, and German measles is one of them. Some of the smart money boys in New Jersey in the laboratory business were sending their tests to the State owned and operated lab, where it had been done for free, and then, of course, they had turned around and billed medicaid for it.

The officials or, rather, representatives of this laboratory conceded at our hearings that this is a regular practice, so this is not an isolated example.

In the third and final area of our work—to wit, rebate or kickback type payments—we heard testimony from laboratories who do not indulge in these practices. We are referring to testimony from businessmen, physicians, and technicians who have formed and put into operations the large, very professional, and highly automated laboratories in New Jersey.

For instance, Dr. Paul Brown, who is the head of MetPath, Inc., operates a very large and highly automated laboratory, which made

it straight, and his staff of salesmen and employees were under strict orders and policy directives not to take kickbacks, not to offer kickbacks, and not to offer rebates.

As a very tragic result of this very straight policy by this laboratory, they simply were not able to get medicaid business from many of the large medicaid mills.

The testimony from Dr. Brown was that the kinds of inducements and kickbacks that some of the unscrupulous labs entered into were in several forms. First, there were the cash payments, which were euphemistically referred to as "greens," which are made by the laboratories, either directly to the doctors, or indirectly to the doctor via an office manager or nurse.

A second technique by some of these slippery operators was providing of personnel to the doctors by the laboratories, and the paying of the salaries of those personnel by the laboratories for work allegedly performed in the doctor's office.

Third, the rent of the space, such as a closet in the doctor's office or shelf in the refrigerator, and you have heard ample testimony about that here this morning.

Fourth, the providing to the doctors of goods and services such as surgical supplies or miscellaneous items such as cigars and cigarettes, or even some expensive equipment for free—is another form of inducement to get the doctor to send the lab work to a particular lab.

However, the testimony of the operators and managers of some of the ethical laboratories—some of the very sophisticated laboratories—was that they would not offer these inducements.

Now, the tragedy of that, as I respectfully see it and subject to your judgment, Senator, is that these highly automated labs, first of all, could have passed along to the taxpayers of New Jersey the benefits of technological cost saving techniques.

Technology Should Help Consumers Save

I think, Senator Percy, you will agree that one of the great points of pride in America is that we have been able to pioneer technological advances in many fields in this country, and one of the great benefits of those advances has been the ability to pass along cost savings to consumers and taxpayers because of more efficient and modern methods. So here we have a sad situation where a lab is very competent, professionally managed, and very advanced technological equipment could have been used. It would have been able to do the medicaid work for a very low price but, because it would not knuckle under to those shakedowns, it was not providing the very necessary cost savings in services.

Senator Percy. Is this lab—MetPath, Inc.—a proprietary lab?

Mr. Holstein. Yes, sir.

Senator Percy. I have difficulty in understanding why the ordinary business procedures do not operate here.

I can remember times in my own corporate experience when we had the supplier come in and say: "I cannot get business; there must be something wrong down there." Sometimes we would discover there was something wrong, and they were the ones that really brought it

to our attention. We did not depend on the police department to do this. We depended on competition in the field to figure out that even though the quality of the product is high, when you cannot get the business there must be something wrong.

Why did they not complain before you contacted them, and bring it to the attention of the district attorney, or whoever it may be? Why did they not say that there are fraudulent practices in our industry, and we want them rooted out? We want to do business the way it should be.

Mr. HOLSTEIN. That is an excellent point, Senator.

One of the discoveries we made was that in the early formulation of the medicaid program in New Jersey, some of these men were standing up in public proceedings and trying to be heard. But they were not heard; they were not listened to.

Why, and what the motivation was for not listening to them, I don't know.

Senator MOSS. In earlier hearings, the pharmaceutical associations said some of this was going on, and that is one of the reasons our investigation got focused. There are some men in each profession that try to clean up fraud and abuse. They should be credited for their good work.

Mr. HOLSTEIN. We have been impressed, of course. I am sure you Senators know the frustration of hearing details and accounts of rather abusive practices, but I am sure you will agree that one of the very pleasant parts of our work is that you do hear on occasion from men of integrity and professional excellence in the medical profession. So there are the good and the bad.

Senator MOSS. Is there any evidence in here of organized crime being involved? We keep hearing little overtones from our investigations on nursing home problems.

POSSIBILITY OF ORGANIZED CRIME INVOLVEMENT

Mr. HOLSTEIN. I would want to carefully select my words. I would want to avoid inflammatory conclusions where perhaps evidence is not of the kind or substance that you gentlemen, I am sure, would want, before I made such conclusions.

Let us say that there are some that do—that have the possibility of organized crime involvement, and I make that statement on a rather limited basis.

We did have a situation in New Jersey during the time of the investigation hearings where a particular middleman—salesman—between some of these unscrupulous physicians and these laboratories, which were engaged in the practices I have described—where this particular middleman did claim and invoke the privilege against self-incrimination.

The New Jersey State Commissioner of Investigation concluded that he can give relevant material evidence concerning these abusive and illegal practices, and so he was granted immunity from the use of this testimony, and he was then compelled to testify.

This person refused to testify even then. He stood moot; he remained silent. The State commissioner of investigation was com-

pelled to secure an order of contempt from the superior court—which order was obtained, sir.

The witness was then ordered by the court to answer our questions. The witness again refused and stood moot. The witness was then incarcerated some 4 or 5 days for his refusal.

I think you will agree that it was highly unique, in a field such as laboratories and doctors, that a witness would be so recalcitrant as to go to jail rather than answer the questions.

Finally, after 4 or 5 days of incarceration in one of the local county jails in New Jersey, in late June or early July and in non-air-conditioned facilities, the witness had a change of heart and did testify.

In his testimony before the commission, he, of course, described these relationships and unethical practices which we have heard of this morning concerning kickbacks, rebates, over billing, and so forth; however, we also made inquiry of him as to why he was so adamant in his original refusal to testify.

I again caution that here is the testimony of only one man—this middleman. It is unsupported; it is merely an indication of a possible danger in the shadows.

Portion of Ear Used in Threat

It is not a foundation that is strong enough but, very simply, this person testified that he received a very clear threat from some very shady characters he had never met before. He was shown, and they were shown, as part of their threat, portions of an ear. So you have the classical and very melodramatic threat that he must remain silent. It was allegedly delivered on behalf of those who did not want certain financial relationships uncovered.

Now again, I respectfully guard against talking too much from this one man's testimony, but we did receive that.

Senator Moss. But this is one single instance that you are aware of?

Mr. Holstein. Yes, sir.

Senator Percy. And we certainly know that there are markups of this kind. Persuasion is an element of salesmanship. They move in rather rapidly. The potential is very much there.

Mr. Holstein. That is correct, Senator.

Of course, as you have heard before, there were many efforts made to cover up rebates and kickbacks and to justify them in very nice euphemistic terms. You gentlemen have heard descriptions of these efforts.

Oftentimes it was said that the kickbacks were merely payments of salary, for services, or rental of space actually made available; however, the kickback story was finally told like it really is at our hearing by James Dimitrion, the supervisor of the Fairlawn Clinical and Sytology Laboratory.

Inside Mr. Dimitrion's laboratory—and, by the way, this laboratory did more medicaid business than any other medicaid lab in New Jersey—you could see that its gross revenue went very markedly up on the scale of revenues, and it doubled and tripled from 1 year

to the next. That doubling and tripling coincided with its employment of this very same salesman, who I just mentioned had invoked the privilege against self-incrimination before the commission; however, Mr. Dimitrion, the supervisor of the lab, was also given immunity to testify to the regular practice of giving kickbacks.

I think the most important question, though, is the adequacy of the maximum fee schedule.

I think our hearings demonstrated as well as the work of this committee that the New Jersey fee schedule, even when it was adopted in 1970, was keyed to a horse-and-buggy era of manual laboratory testing.

There was a lot of fat there in the fee schedules because of failure to respond to modern advances in technology, and the fat financed these mammoth, maximum kickbacks.

The basic stress of our recommendation, and I think you gentlemen respectfully have felt the same way here this morning, was that rather than having the middleman salesman get the benefits of these huge markups, let's eliminate the fat from the fee schedule and, therefore, allow the taxpayer to benefit with the savings.

The New York medicaid division reduced its maximum fee schedule for independent laboratories by 40 percent after the SCI hearings.

We suggested that a special panel be formed of persons with expertise in modern technological advances so a new fee schedule could be formulated to take into account modern technology.

During our investigation, the New Jersey medicaid division, which administers the medicaid program, undertook a substantial revision of the medicaid manual.

Tightening of Provisions Recommended

We have recommended that there should be simultaneous and thorough tightening of the provisions of both the fee schedules and the manual, so that there are more explicit definitions of various test requirements and their component parts.

We found that the language of the State fee schedule and manual required improvements were vague. As you gentlemen well know, there is always the implication to interpret and to construe to the detriment of the taxpayer, so we recommended that there be more provisions prohibiting certain practices.

It certainly is true that on the Federal level the Federal legislation prohibiting these kinds of growing kickbacks and rebates is very explicit; however, in New Jersey, up until the very recent time, there was no explicit prohibition, so you had the strange situation where, at the Federal level, it was clearly against the law to obtain or to give kickbacks, but there was the New Jersey regulation or the statute clearly providing for it. If I could be so presumptuous, Senator, I would say the one thing the Congress might consider, now and in the future, is that when it starts to involve itself in one of these 50–50 type partnership arrangements with a State in a health care situation, that the Congress may want to consider requiring from the State that the State also enact certain very explicit regulations and statutes barring such practices as condition of membership

in the program. I think this would enable State prosecutors, attorneys, and other investigative agencies to have the legal weaponry to address themselves to some of these abuses privately.

I think it is necessary to run to Washington for prosecution or for investigations, but it also would be desirable that it is done on the State level.

I think putting aside the question of illegality, it is the potential arm to the quality of laboratory work that most concerns us in a rebate situation.

In addition to rebate and financial kickback arrangements, we had uncovered situations where actually doctors had part ownership interest in laboratories.

Of course, when Mr. Dickson and I first began to work in the laboratory field, we visualized a laboratory as a big shiny, modern, clean, very dazzling operation. Of course, some of these are thankful that they are that way; however, the principle laboratories in New Jersey that are engaged in the medicaid business constituted a shock to our idealized vision of what a laboratory was. Very tragically, many of them were not operated in accordance with good sanitary conditions. In fact, this principle that they are very big—the kind of laboratory that I referred before, the Fairlawn Sytology Laboratory—did the most medicaid business of all labs in New Jersey. It was operated out of a basement. For instance, in the manual dipstick test, certain dipsticks would be used, and then used again, and again, and again, for multiple specimens, thereby contaminating each specimen.

Mr .HALAMANDARIS. Am I correct that the dipstick test costs less than a penny?

SHODDY TESTING PRACTICE SAVES PENNIES

Mr. HOLSTEIN. I would say about a penny and, of course, you put the finger right on the candle. To save a few pennies, they were using the same dipstick to maximize the profit, and removing any possibility of a fair and accurate test.

The most scary and most dangerous aspects, in addition to this, is that some of these tests involved specimens where contamination was certain to be present and would be highly contagious. This laboratory is being operated out of its basement in the middle of a residential neighborhood and these specimens are then thrown out in the garbage can. Modern technology has developed some very good machinery in which to put such specimens so that they are burned up or otherwise dealt with, so that any possibility of contamination is neutralized.

Senator PERCY. You said you were shocked as an investigator, but you have no medical background, have you?

Mr. HOLSTEIN. No, sir.

Senator PERCY. It shocked you when you saw these conditions?

Mr. HOLSTEIN. Yes.

Senator PERCY. Here was a service being performed for doctors and payments were being made. Did the doctors not investigate the labs from which they got their tests to make certain that the operation should be supported?

Mr. HOLSTEIN. Senator, you just put the finger on the point I was trying to make and I got off the track. I thank you.

That is what really upset us. Obviously, the physicians—those who get a kickback from the laboratory or who have a part proprietary interest in the laboratory—have little or no motivation to go to that lab and to take a look to see if the quality of the testing and the conditions are good or bad. Their eyes are focused on the "greens" and, therefore, the doctors tends to become unmotivated to check up on the quality.

Senator PERCY. This again is the pattern we found in the nursing homes—a lack of concern. They just do not give a damn about what kind of care is given.

They are after the buck; the faster the buck, the better. Apparently this is the case here with some doctors and some clinical labs.

Senator Moss. Did you find any linkup between these laboratories and the nursing homes—specimens coming in from there?

Mr. HOLSTEIN. We are hesitant to comment on that, because our investigative work in that area is in the process, rather than completed. I would rather not make a reckless assertion without our being able to complete it.

Senator Moss. We will allow you to complete it, just so you tell us later.

Mr. HOLSTEIN. Fine, sir.

LAB EXPERTISE SHOULD BE REQUIRED

I think another very important contribution the Congress might make is in the area of the kind of personnel the State medical administration must have.

Obviously, after months and months of work, Mr. Dickson and I have a little bit of understanding of what an SMA–12 is, although I still do not get it right. I am sure your staff has concurred that some of the technology or chemistry, and so forth, is difficult to understand, but it is absolutely imperative that the personnel staff of the State medicaid program includes people with expertise in the laboratory field.

They ought to go out and hire some lab technicians. We found they were not employed in New Jersey—not one person who had that kind of background or expertise. So these razzle-dazzle confidence-types of billing practices went right by the laymen who were kind of supposedly present to filter out the overbilling and the fraud.

We may be conversant in it now, having heard the testimony on it, but it is important that every State administration have this kind of personnel. That is one recommendation we felt very strongly about.

Senator Moss. That is a good one.

Mr. HOLSTEIN. There must also be a sufficient number of personnel, of course. Numbers are important just so that you can have good quality control in the State apparatus.

As you know, many States use fiscal intermediaries: that is, they use insurance companies as the first level to filter, so that when that

bill comes in from the doctor or the lab, it often goes to an insurance company, which acts as a fiscal intermediary under contract with the State.

That intermediary is supposed to make the original pay or no pay decision on the claim form that comes in from the lab or the doctor.

Now, whether the State apparatus is doing it through State employees or whether you are using a fiscal intermediary—that is, an insurance company—in either event, I, respectfully think the Congress might want to give attention to stipulating what constitutes a good surveillance program.

Requirements Should Be Enumerated

I think you might want to think about this in the future, if there is additional health care legislation, so that the Congress, with its expertise, could say: "Now listen here, you folks in New Jersey, Illinois, and New York, if you are going to have a State medicaid program and we are going to give you 50 percent of the funds, here is what you have to have: you have to have a computer and we will lend you some computer experts who will tell you how to set this up; you have to have some people who are expert in laboratory work and nursing home work; and you have to have some people who should be good hard-shot-type investigators in accounts."

I do not mean to build another huge bureaucracy by this suggestion, but you have to plan on who is going to be your cops, when you institute the new system, because you sure as heck are going to have your robbers. I think that is an area where the Congress can be of assistance.

Thank you very much.

Senator Moss. Thank you for a very good presentation Mr. Holstein.

The need for inspection and expertise in fraud detection certainly comes through very clearly. Even if you have a computer, and you have clerks that can interpret its printouts, you have to have somebody that knows enough about programs and procedures to understand what has to be done.

Mr. Holstein. That is right. That is exactly right.

Senator Moss. Have you noticed an increase in the number of laboratory procedures ordered with this increase in malpractice suits and premiums we are hearing so much about? Have doctors widely increased the numbers of tests they are asking for?

Mr. Holstein. Mr. Dickson, would you like to respond?

Mr. Dickson. Senator Moss, many members have come before the commission and testified as a reaction to malpractice, and large amounts of malpractice tests are ordered by physicians.

Whether or not it is a malpractice discovery, I am not prepared to say at this point; but certainly the term is used.

Senator Moss. I have heard that allegation, and that is the reason why I posed the question.

Mr. Dickson. We do not have that type of a feel for it as yet.

Senator Moss. When did New Jersey reduce its fee schedule by 40 percent?

Mr. HOLSTEIN. Sometime in the summer or fall.

Mr. DICKSON. The fees were reduced by the same medical division immediately upon the conclusion of our hearings. They would have been announced in July and, I believe, effective sometime in early September this past year.

Senator MOSS. Did this make any appreciable difference in the use of the services? Have labs gone out of business because the fees dropped?

Mr. HOLSTEIN. There was a great cry raised when the fee reduction was first announced, that many small labs would be forced out of the business.

NO DECREASE IN PARTICIPATION

We were informed by physicians, as recently as last Friday, that there has been no decrease in the numbers of labs involved in the program.

Senator PERCY. At the bottom of page 3, you talk about reaping of windfall profits, and so forth. Are markups of this size one of the reasons why medical costs are going up so high?

We know that malpractice insurance is forcing hospital bed rates up, but if the lack of surveillance in certain areas is like this, if people are reluctant to really question something of a sacrosanct nature like a clinical test or analysis, then we must conclude that individuals are not questioning what they get for very high fees. Can you not bring down the costs of medical care if you squeeze out these exorbitant profit margins and unnecessary markups?

Mr. HOLSTEIN. I think that is very well put, Senator. It is clear with proper attention paid, for instance, by the Senate Committee on Aging, that that kind of goal can be reached.

It does require a constant vigilance, because the unscrupulous entrepreneurs are, of course—they wish to take advantage of these opportunities. I think with oversight in this, you will be able to reduce the cost of health care.

Senator PERCY. I would like to ask you a question, because I feel certain that after seeing "60 Minutes" last night, a lot of people might say: "Well, that is Illinois; that is Cook County. That is not the way it is here in my State." Yet on page 4 of your prepared testimony, you say that rebates or kickback-type practices involve inducement-type payments to doctors under the guise of paying for rented space, or office salaries, in the doctor's offices. These are absolutely the same phrases technique, and methods used in Illinois.

My observation is, what happens in Illinois appears to be happening in New Jersey—the same identical pattern. Do you think this is a national pattern, that probably we would find this in as many States as we might go in, at least in the large industrial States that have very, very high concentrations of people receiving this type of service?

Mr. HOLSTEIN. I have no doubt of what you stated is correct, Senator.

I think it is a problem throughout our highly industrialized States. Basically, I think that if they have the kind of techniques that could

be used to exploit the system in one State, or New Jersey and Illinois, they can be used anyplace.

I think it is fair to presume that men and women will certainly follow the profit motive whenever government programs allow them to exploit the system.

Senator Moss. I have said that news travels fast. If they can do it in one place, they will do it in another.

Senator PERCY. That is right. It may well be as we found in nursing homes, that they were syndicated and then sold on Wall Street. It became a national pattern.

There is money to be made on the old and the poor, and so, too, there is money to be made in this field.

REDUCING PROFITS MAY BE DETERRENT

On page 8, you very wisely recommend that we have to prevent the outrageous ripoff of taxpayers' health care programs, and to bring fees down as low as possible in relation to advancing technology with respect to independent clinical laboratories and similar industries.

If we take the big or exorbitant profits out, will we automatically squeeze out all of the malpractice going on?

Mr. HOLSTEIN. I think so.

Senator Moss. Or you would take the incentive out.

Mr. HOLSTEIN. That is well put, Senator. I agree with that.

Senator Moss. On the top of page 4, it was the fat in the fee schedule that financed the markups, the overbilling practices, and the 25- to 30-percent kickbacks.

Here we are not talking about a service that has a lot of research and development behind it, where there are a lot of possible failures which build up costs. So there is no real reason to charge those exorbitant rates; is that right?

Mr. HOLSTEIN. That is correct, Senator. Ironically, the witnesses who testified from some of the large, inefficient, automated laboratories said the most important component of this overhead was not the cost of doing the test, which were a minimum cost because of automation, but the major cost is filling out the medicaid forms and then transporting the test results back to the physician.

It can be done very efficiently and very professionally if the system promotes that kind of care.

Senator PERCY. Finally, I would like to make a suggestion to States that are now investigating this area. As I look at attachment A,* it is possible to see that the Park Medical Laboratory increased from $35,565 in 1972 to $164,849 in 1974, and then increased to $205,852 in 1975.

Could you explain what happens here? That is quite a dramatic increase in business compared to the drop from $35,000 to $346 between 1972 and 1973. Could you explain what happened here? Why such a dramatic dropoff in business, unless they closed up for that year? Maybe they were closed, and then suddenly they are back flourishing.

*See p. 467.

I never saw a business that grew that fast after a precipitous downdrop. That is better than the photographic business with its cycles.

Mr. DICKSON. Senator, we have correlated the earnings of these laboratories with the appearance of the entrepreneur—salesman—on the scene.

It is these moneymen—with different means available to them to secure business. That is the answer to it.

STATES SHOULD CHECK MEDICAID RECORDS

Senator PERCY. My suggestion to every State in the Union that wants to cut their own costs and to cut down their medicaid payments, would be to just pull out of their files an annual report or record of the medicaid payments to clinical laboratories and see where the trend goes. If they see one fairly stabilized, maybe there is not much of a problem. Perhaps it would be wrong to imply that if all of them would have a dramatic increase, that this means they are engaging in these practices. But your judgment is it would be a very good thing for them to look at it?

Mr. DICKSON. Yes, sir.

Senator MOSS. I would say the States would be negligent and derelict if they did not do that.

Mr. HOLSTEIN. Evidence has been provided to you by the State of Illinois, and now the State of New Jersey, to take a good hard look to see how you can correct the malpractices.

Senator MOSS. It is obvious that some people can easily move in and really rip off the system. Medicaid, which was a noble concept when it started, has degenerated into something riddled with fraud and abuse.

Mr. HOLSTEIN. I agree with the chairman. The testimony has been extraordinarily valuable, and it would not have been complete if we did not have the highlights on Illinois.

Senator MOSS. I certainly agree with that.

I do thank you gentlemen very much.

Counsel has a question for you.

Mr. HALAMANDARIS. One last question. We discovered that a lab owner that Senator Moss visited was sending specimens from Chicago to Columbus, Ohio. He admitted to us that he was doing this, and I ask you, what precautions could he take of the specimens to insure that they were preserved? Do you see the problem I am suggesting?

Mr. DICKSON. Yes, I see it. We have seen it in New Jersey, but we were not so concerned with sending specimens out of one State and into another as much as we were in sending them from the city of Newark to, perhaps, a laboratory in the city of Patterson. The transportation was made in something of a styrofoam container.

Certainly the quality of testing done on these specimens is subject to certain conditions.

Senator MOSS. Thank you very much. I do commend you for this fine testimony. We will make your statement and its attachments a part of the record in full, so we will not lose any of it when the transcript is printed.

Thank you very much.
Mr. HOLSTEIN. Thank you, Mr. Chairman.
[The prepared statement of Mr. Holstein follows:]

PREPARED STATEMENT OF FRANK L. HOLSTEIN

Mr. Chairman and members of the committee, on behalf of the New Jersey State Commission of Investigation—S.C.I.—I would like to thank you for this opportunity to appear before you and testify about the commission's investigation of independent clinical laboratories receiving monies under the medicaid program. We believe we can be of particular assistance in this area because, to our knowledge, we were pioneers in undertaking such an in-depth probe into the practices and procedures of independent clinical laboratories and in exposing the abusive methods by which some of those laboratories can literally bilk the medicaid program for high profits which flow directly to the laboratory owners and, via them, also to some of the doctors supplying those laboratories with medicaid-funded test business.

Perhaps more importantly, our investigation demonstrated that the shortcomings and loopholes which had developed in the New Jersey medicaid program presented a virtual open door to those laboratory owners to profiteer at the taxpayers' expense. Therefore, I will be putting considerable emphasis in my remarks today on how the lessons learned in our investigation have pinpointed the areas of controls and surveillance capabilities which must be improved to prevent further abuses.

By way of background, let me state briefly how this particular investigation of independent clinical laboratories and the ensuing public hearings were developed by the New Jersey SCI. Early in 1975, the commission began an evaluation probe of the entire medicaid program in New Jersey, a probe which was mandated to us by request of the Governor. The SCI proceeded to set up three investigative teams to look into the three principal medicaid areas—nursing homes, hospitals, and purveyors of services other than nursing homes and hospitals. It was the last of these three major areas which covered the flow of medicaid dollars to independent clinical laboratories, doctors, pharmacists, and others. Having held several interim public actions during this overall investigation of medicaid, we are nearing completion of that probe and hope to make a final report and recommendations to the Governor in the months ahead.

As to the other-purveyors-of-services phase of our medicaid investigation, one of the earliest signs detected by us as to possible abusive practices related to the operations of some independent clinical laboratories. With the cooperation of the New Jersey State Medicaid Division, it was quickly determined that 12 of the 184 independent clinical laboratories in New Jersey were receiving more than half of the $2.2 million in medicaid funds flowing annually to all of those laboratories. Attachment A to this statement lists medicaid reimbursements to those 12 laboratories. Additionally, data obtained from that division's bureau of surveillance indicated patterns of apparent irregularities in the practices of those laboratories which were doing an inordinate amount of medicaid-funded business. Accordingly, an in-depth investigation of those laboratories was immediately authorized by the commission.

EXPERTISE NECESSARY IN INVESTIGATION

The practices and procedures of independent clinical laboratories have quite technical aspects which can present confusing complexities to a layman without expertise in this particular field. It should be remembered these laboratories perform a wide variety of tests, the results of which are used in the diagnosis, treatment, and prevention of disease. Fortunately, the commission was able to enlist the cooperation of the New Jersey State Health Department which assigned personnel with expertise in the clinical laboratory area to assist the SCI in this investigation.

The expert personnel made field inspections of the laboratories, analyzed many hundreds of pertinent documents and then provided the SCI with comprehensive written and oral reports. On this solid foundation, the SCI then used its investigation expertise and its full subpena and witness immunity powers to develop facts about abuses of the medicaid program in the following principal areas:

(1) The reaping of windfall profits by some small and largely unautomated independent clinical laboratories which marked up by as much as 300 percent or more the cost of tests performed on a subcontract or referral basis by large, automated laboratories and then collected the markups from medicaid. The facts gleaned in this area as well as other areas discussed below were instrumental in documenting that the New Jersey medicaid fee schedule for reimbursing independent clinical laboratories was much too high and in need of revision downward.

(2) Numerous instances where some independent clinical laboratories were able to overbill medicaid for certain tests and even render false test claims, without these practices being detected at either the prepayment or postpayment processing levels.

(3) Rebate or kickback-type practices whereby some laboratories either returned a set percentage of medicaid test fees to some of the doctors referring business to those laboratories or indulged in some other financial-inducement-type payments to the doctors under the guise of paying for "rented space" or "office salaries" in the doctors' offices.

The transcripts of our public hearings have been made available to this committee. They contain numerous, specific instances of the type of abuses summarized above. Those transcripts contain sworn testimony and reference to substantial documentary evidence which detail how specific laboratories, middlemen, and doctors engaged in the abuses of the system. That same extensive factual picture in the transcripts demonstrates that the abuses were not sparse but rather general and quite widespread in nature. Relying on those transcripts as the full and complete record of our investigation. I will review only some sample instances of various abuses in this statement, so that members of this Senate committee will have a capsule picture of how medicaid can be specifically bilked by independent clinical laboratories.

In the area of huge markups by some of the laboratories, it should be noted that in New Jersey, medicaid establishes a maximum fee level at which it will reimburse independent clinical laboratories for the tests performed. Attachment B to this statement shows that maximum reimbursement level for certain tests as of the time our investigation was being carried out. The specific, sample markup instance I will now review involves a blood chemistry analysis test performed by a device known as an SMA–12. This device reports almost instantly on the status of as many as 12 blood chemistries in any given test sample.

In this sample instance, we showed that a relatively small, unautomated laboratory, Physicians Laboratory Service, Inc., was paid the maximum of $12.50 by medicaid for allegedly performing an SMA–12 test. But by reference to appropriate documents, we showed that in actuality that test was performed on a referral basis for Physicians Laboratory by the larger, automated Center for Laboratory Medicine, Inc., which, in this instance, billed Physicians Laboratory only $3.50 for the SMA–12 test. What's more, there was nothing at that time in the New Jersey State medicaid manual of rules and regulations covering independent clinical laboratories to preclude this price-gouging tactic.

Multiple Tests Billed Separately

In the area of overbilling, our hearings demonstrated the frequent practice by some of the laboratories of taking a single test which produces multiple, component-part results, such as the chemistries by an SMA–12, and billing for each component part as if it were a separate test. As to a specific sample, Edward Gibney, director of the Park Medical Laboratory, conceded under questioning at our hearings that his relatively small, unautomated laboratory did indulge in the overbilling practice of collecting from medicaid for the component parts of multiple results tests including one instance were seven parts of an EMA–12 test, performed for Park Medical by an automated laboratory at a cost of $3.40, were billed to medicaid for a total of $58. That is almost five times the maximum permissible reimbursement of $12.50 for an SMA–12 test. And again, at the time of our investigation, the State medicaid manual contained no specific prohibition against this overbilling practice.

As to false billing, the hearings documented a specific example, among others, of how the same Park Medical Laboratory billed and received from medicaid $15 for a German measles test known as rubella titer, when, in fact, that test

had been performed free of charge for Park Medical by the New Jersey State Department of Health. The same Mr. Gibney conceded further at our hearings that it would be fair to state that during 1974 alone, there were 197 instances where Park Medical billed medicaid for rubella titer tests performed free of charge by the state. And again, there was no specific restriction in the medicaid manual at that time against this abuse of the system.

In the third area of rebate or kickback-type payments, we heard testimony from several heads of laboratories who do not indulge in those practices—that their laboratories, as a result, received only minuscule amounts of medicaid-funded business. Dr. Paul A. Brown, head of MetPath Inc., a very large and highly automated laboratory which played it straight, testified his staff has found four basic kickback techniques are being used to induce doctors to refer medicaid-funded business to independent clinical laboratories. They are, in his words:

(1) Cash payments known as "greens" which are made by the laboratories either directly to the doctors or indirectly to them via their nurses.

(2) The providing of personnel to the doctors by the laboratories and the paying of the salaries of those personnel by the laboratories for work allegedly performed in the doctors' offices.

(3) The renting of space, such as a closet, in the doctors' offices, with the "rent" often being determined as a percentage of the amount of medicaid-funded test work referred to the laboratories by the doctors.

(4) The providing to the doctors of goods and services, such as surgical supplies or miscellaneous items such as cigars and cigarettes.

The testimony of the heads of some of the laboratories indulging in financial-type inducement payments to doctors provided resounding support for Dr. Brown's testimony. For example, Saul Fuchs, director of Physicians Laboratory Service, Inc., conceded under questioning that he paid 20 percent to some doctors of what he received from medicaid for test business referred to his laboratories by those doctors. He contended the rebate payments were for the drawing of blood samples and the filling out of medicaid forms in the doctors' offices. He also conceded that he "rented" space for $150 per month in the office of another doctor who referred medicaid business to his laboratory.

Robert Kupchak, president of North Hudson Clinical Laboratories, Inc., testified he paid 25 percent of his medicaid-funded business to his laboratory. He contended these payments were for "services rendered" by the doctors in processing the specimens referred to his laboratory.

The kickback story was finally told like it really is at our hearings by James Dimitrion, supervisor of the Fairlawn Clinical and Cytology Laboratory. Mr. Dimitrion, testifying under the compulsion of a grant of witness immunity, testified to instance after instance where he agreed to kick back a specific percentage of his medicaid reimbursements to doctors supplying his laboratory with medicaid-funded test business. The initial negotiations for Fairlawn's kickback arrangements were conducted by Harry Hirshman, Fairlawn's middleman-salesman. And Fairlawn's business boomed. Mr. Dimitrion testified that 90 percent of the laboratory's business came from doctors with whom Fairlawn had arrangements to kick back 25 to 35 percent of medicaid reimbursements. He testified further that a kickback was a kickback whether it was a cash percentage or under the guises of services rendered in the doctors' offices or of payment of salaries for personnel in the doctors' offices.

Fee Schedules Should Be Updated

I now address myself to the all-important question of how do you prevent such outrageous ripoffs of a taxpayer-supported health care program for the impoverished. First of all, the State-set fee schedule for reimbursing independent clinical laboratories must be kept as low as possible in relation to advancing technology in the independent clinical laboratory industry. Our hearings demonstrated that the New Jersey fee schedule was, even when it was adopted in 1970, keyed to an already passing horse-and-buggy era of manual laboratory testing. It was the fat in the fee schedule that financed the mammoth markups, the overbilling practices, and the 25 or 30 percent kickbacks to the doctors.

After our hearings, the New Jersey Medicaid Division reduced the maximum fee schedule for independent clinical laboratories by 40 percent. Our suggestion that a special panel be formed to devise a new fee schedule geared to the industry's technology has been followed. Maximum fee schedules for reimbursement of the laboratories must be revised from time to time to reflect advances in automation.

During our investigation, the New Jersey Medicaid Division undertook the first substantial revision of the medicaid manual covering independent clinical laboratories in an attempt to close glaring insufficiencies in the controls and regulations provided by that document. We have recommended that there should be simultaneous and thorough tightening of the provisions of both the fee schedule and the manual so that they are very explicit as to the various tests and their component parts. The language of a State fee schedule and a State manual should specifically bar gross markups by middlemen-type laboratories and any practice of charging separately for component parts of a test.

The medicaid manual should, of course, contain a strong and comprehensive prohibition against any type of rebate or kickback payments from the laboratories to the doctors. We also have recommended supporting statutory reform to make it a criminal offense to engage in such practices.

Whether it is "rented space" or "office salaries" or what have you, there should be no special, favorable relationships between laboratories and physicians, even if the money paid to a doctor by a laboratory might exactly compensate the value of the work done in the doctor's office. Relationships of this type amount to an inherent conflict of interest in that the physicians have an inducement not to judge the quality and performance of the laboratories but rather to send the test business to the laboratories on the basis of personal financial gain.

The most important preventive measure, in our opinion, lies not with schedules, regulations, and laws, but rather in the detection of abusive practices both before medicaid claims have been paid to the laboratories and after such payments have been made. The medicaid division of a State must have personnel who are expert in the clinical laboratory field—individuals who can, as the experts from the State Health Department did for us in our investigation, discover and flag billing abuses in a technologically complex area. The New Jersey Medicaid Division has not had such expertise in the past, and we have recommended that this weakness be corrected.

Besides sufficient expertise, there also should be sufficient numbers of surveillance personnel to ride constant herd not only on the laboratories which have received medicaid payments but also on the State's fiscal intermediary used to process the medicaid payment claims from the laboratories. New Jersey, like many other States, uses insurance companies with extensive computer capacity to do such prepayment processing. Our investigation showed that despite one company's capacity and capability, billing abuses in numerous instances had gone unflagged.

The responsibility for alert monitoring of the performance of the fiscal intermediary rests with the State medicaid division. The division must have the expert personnel who can constantly check to see if insufficiently educated and trained personnel are being used by the intermediary to process claims or if a random sampling method of validating claims by the intermediary is insufficient or if any other failures are occurring.

Any investment by a State in a superior and effective surveillance system should be viewed as a productive and rewarding step in that it can both stop overpayments to the laboratories before those payments occur and also recover any overpayments that have been made to the laboratories.

Mr. Chairman and members of the committee, thank you for listening to me today. I will now attempt to answer any questions you may have.

ATTACHMENT A.—MEDICAID PAYMENTS TO CERTAIN INDEPENDENT CLINICAL LABORATORIES (1972–75)

	1972	1973	1974	1975 (January–April
Fair Lawn Clinical and Cytology Lab	$27,114	$127,707	$253,855	$39,650
Park Medical Laboratory	35,565	346	164,849	205,852
South Jersey Diagnostic Center		88,694	129,117	60,759
Ludlow Clinical Lab, Inc		4,700	118,747	113,080
North Bergen Clinical Lab	199	52,839	111,893	204
Laboratory Procedures	15,183	22,632	84,820	48,156
North Hudson Clinical Labs., Inc			75,591	80,495
Paterson Diagnostic Center	38,982	147,574	62,027	
Roche Clinical Lab	38,895	40,527	60,638	45,926
Elizabeth Bio-Chemical Lab	24,572	26,416	59,492	769
Center for Laboratory Medicine	12,302	30,389	53,253	33,313
Physicians Lab Service, Inc	1,509	19,300	52,466	14,377

ATTACHMENT B.—MAXIMUM MEDICAID REIMBURSEMENT FOR CERTAIN LABORATORY TESTS

Code	Name	Maximum medicaid reimbursement
8628	Complete blood count, hemoglobin white cells, red cells and/or hematocrit, differential.	$5.00
8710	Protein bound iodine (PBI)	10.00
8719	SMA–12/60	12.50
8751	T–3	10.00
8752	T–4	10.00
8961	Pregnancy test—immunologic	7.50
8962	Pregnancy test—animal (rabbit or rat)	10.00
8652	Cholesterol, total	5.00
8654	Cholesterol, total and esters	7.00
8761	Triglycerides	15.00
8936	Urine Analysis (complete routine chemical and microscopic)	2.00
8722	Glucose (sugar) quantitative or 2-hour pp/3-hour pp	5.00
8675	Flocculation tests (Kline, Mazzini, each VDRL, etc.)	2.50
8476	Ova and parasites, concentrated method	2.50
8459	Culture with sensitivity studies, bacterial disc technique, up to 10 antibodies	15.00
8911	Cytological study (Papinicolaou smear)	5.00
8745	Urea nitrogen (or N.P.N.)	5.00
8664	Creatinine or creatine	5.00

Senator Moss. I want to say that this committee will continue on this type of investigative effort; perhaps we will not be on the laboratories next time, but we will be looking at all phases of care for the elderly, and the possible medicare and medicaid abuses that may exist.

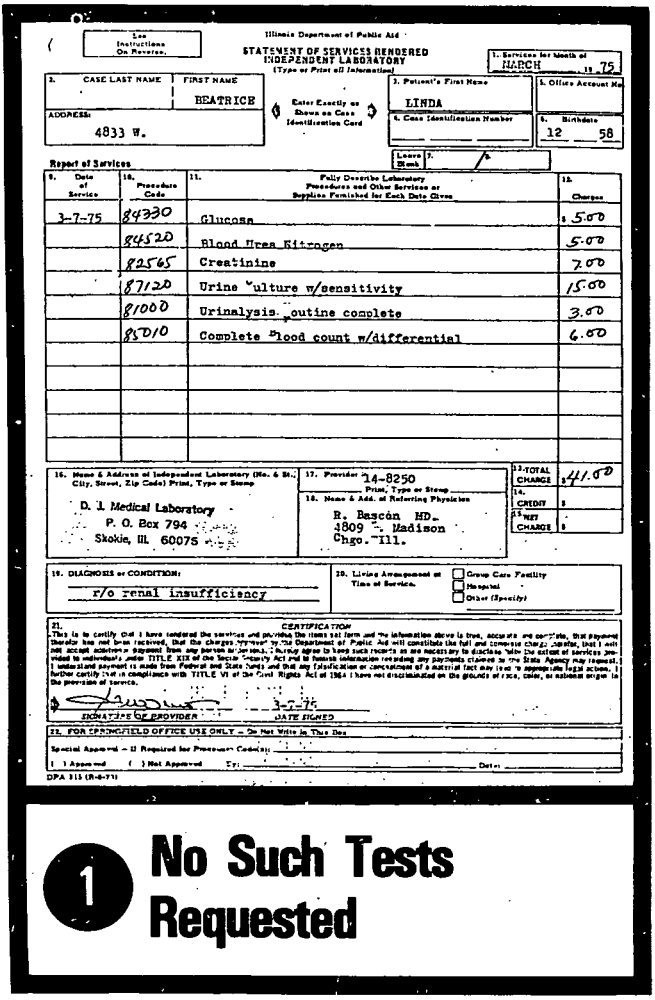
We now stand in recess.

[Whereupon, the hearing was adjourned at 12:40 p.m.]

APPENDIXES

Appendix 1

Twenty bills, chosen at random, presented for payment by D. J. Medical Laboratory in Chicago, Ill., purportedly on behalf of Dr. R. Bascon, 4809 West Madison. In 12 of the 20 cases, the physician had no record of seeing the patient. The aggregate total paid by medicaid for these 20 bills was $885. According to Dr. Bascon's records, only $119 of this amount was actually ordered by him. Following each individual bill is a caption with specific details.



See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: MARCH 75

2. CASE LAST NAME: | FIRST NAME: BEATRICE
ADDRESS: 4833 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: LINDA
4. Case Identification Number:
5. Other Account No.
6. Birthdate: 12 58
Leave Blank: 7.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
3-7-75	84330	Glucose	$ 5.00
	84520	Blood Urea Nitrogen	5.00
	82565	Creatinine	7.00
	87120	Urine culture w/sensitivity	15.00
	81000	Urinalysis routine complete	3.00
	85010	Complete Blood count w/differential	6.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp:
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill 60075

17. Provider 14-8250
Print, Type or Stamp

18. Name & Add. of Referring Physician:
R. Bascon MD.
4809 W. Madison
Chgo. Ill.

13. TOTAL CHARGE $ 41.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
r/o renal insufficiency

20. Living Arrangement at Time of Service: ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items listed herein and the information above is true, accurate and complete, that payment therefor has not been received, that the charges reported to the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individual's under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed to the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under appropriate federal and state laws. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

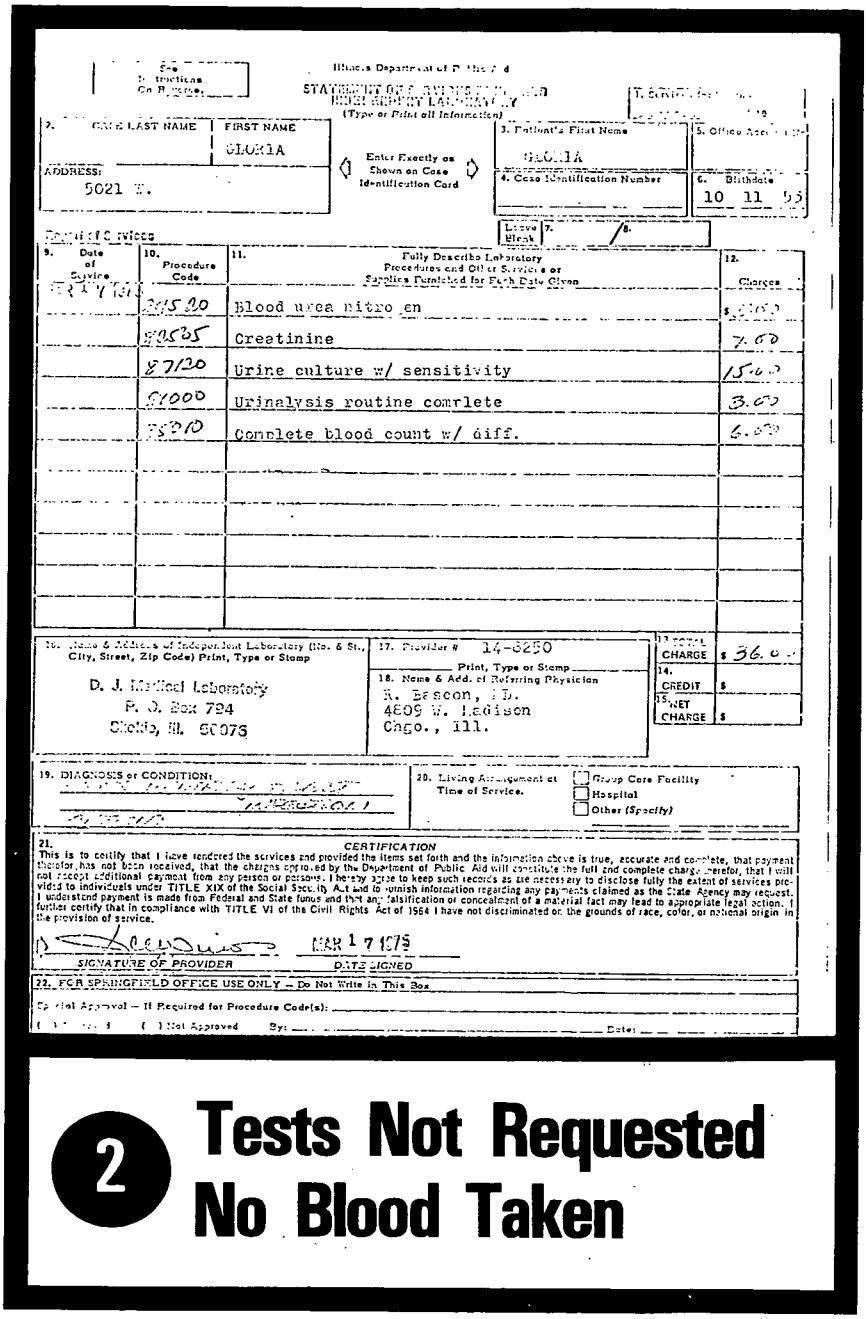
SIGNATURE OF PROVIDER — DATE SIGNED 3-7-75

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write In This Box
Special Approval — If Required for Processor Code(s):
( ) Approved ( ) Not Approved By: Date:

DPA 311 (R-8-71)

1 No Such Tests Requested

70-482 O - 76 - 5



Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED BY LABORATORY

(Type or Print all Information)

2. Case LAST NAME	FIRST NAME
	GLORIA

ADDRESS: 5021 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: GLORIA

4. Case Identification Number:

5. Office Acct. No.:

6. Birthdate: 10 11 53

Leave Blank: 7. 8.

Number of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
2-24-75	84520	Blood urea nitro en	$ [illegible]
	82525	Creatinine	7.00
	87120	Urine culture w/ sensitivity	15.00
	81000	Urinalysis routine comrlete	3.00
	85010	Complete blood count w/ diff.	6.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 724
Chicago, Ill. 60676

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician

R. Beacon, M.D.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE	$ 36.00
14. CREDIT	$
15. NET CHARGE	$

19. DIAGNOSIS or CONDITION:

20. Living Arrangement at Time of Service.
- ☐ Group Care Facility
- ☐ Hospital
- ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

[signature] MAR 17 1975

SIGNATURE OF PROVIDER — DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

2 Tests Not Requested No Blood Taken

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME: | FIRST NAME: BETTY JEAN

ADDRESS: 409 S.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: BETTY

4. Case Identification Number:

5. Office Account No.:

6. Birthdate: 10 49

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 6 1975	84330	Glucose	$ 5.00
	84520	Bloodurea nitrogen	5.00
	82565	Creatinine	7.00
	81000	Urinalysis routine complete	3.00
	85010	Complete blood count w/ diff.	6.00

16. Name & Address of Independent Laboratory (No. & St., City, State, Zip Code) Print, Type or Stamp
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250
Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE: $ 26.00
14. CREDIT: $
15. NET CHARGE: $

19. DIAGNOSIS or CONDITION: hypertension

20. Living Arrangement at Time of Service: ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges specified by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed by the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER

DATE SIGNED: FEB 6 1975

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write In This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date:

3

Visited Doctor Jan. 21, 1975. No Laboratory Work Requested

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of Aug 19 75

2. CASE LAST NAME	FIRST NAME
	Barbara

ADDRESS: 5101 W

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Barbara
5. Office Account No.: 3187.14
4. Case Identification Number:
6. Birthdate: 11 48

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
8/28/75	87095	Throat Culture W/Sensitivity	$ 15.00
	84475	Triglycerides	10.00
	83440	T-3	15.00
	83440	T-4	15.00
	85010	Complete Blood Count Diff.	6.00
	81000	Urinalysis Complete Routine	3.60
	82465	Cholesterol	5.00

16. Name & Address of Independent Laboratory (No. & St., City, St.eet, Zip Code) Print, Type or Stamp

D. J. MEDICAL LABORATORY
P. O. Box 794
Skokie, Illinois 60076

17. Provider # 14-8250

18. Name & Add. of Referring Physician Print, Type or Stamp
R. Bascon M.D.
4809 W Madison
Chg, Ill.

13. TOTAL CHARGE	$ 69.00
14. CREDIT	$
15. NET CHARGE	$

19. DIAGNOSIS or CONDITION:
Chronic Thyroiditis

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: 8/28/75

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date:

DPA 315 (R 8-73)

4 No Such Tests Requested No Blood Drawn

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME: | FIRST NAME: SHIRLEY

ADDRESS: 4901 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: SHIRLEY

5. Office Account No.:

4. Case Identification Number: 04

6. Birthdate: 4 39

Leave Blank: 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 1 0 1975	86360	Latex RA	$ 7.00
	85650	Sedimentation rate	4.00
	84550	Uric Acid	5.00
	86060	ASO Titer	7.00
	84075	Alkaline phosphatase	7.00
	86140	C-reactive protein	7.00
	87095	Sputum culture w/ sensitivity	15.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250

Print, Type or Stamp

18. Name & Add. of Referring Physician

R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE: $ 52.00

14. CREDIT: $

15. NET CHARGE: $

19. DIAGNOSIS or CONDITION: Rheumatoid arthritis, hypertension

20. Living Arrangement at Time of Service.
- ☐ Group Care Facility
- ☐ Hospital
- ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any personal person, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: FEB 1 0 1975

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (Rev-7-71)

5 No Record of a Patient With This Name

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME: | FIRST NAME: VERNON
ADDRESS: 11722 S.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: OLIVIA
5. Office Account No:
4. Case Identification Number: 04
6. Birthdate: 8 58

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 6 1975	84330	Glucose	$ 5.00
	84520	Blood urea nitrogen	5.00
	82565	Creatinine	7.00
	87130	Urine Culture w/ sensitivity	13.00
	81000	Urinalysis routine complete	3.00
	85010	Complete blood count w/ diff.	6.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE $ 41.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
Genito-urinary tract infection, anemia

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: FEB 6 1975

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box
Special Approval – If Required for Procedure Code(s):
( ) Approved ( ) Not Approved By: Date:

6 No Visit to Doctor in January or February '75

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of MARCH, 19 75

2. CASE LAST NAME	FIRST NAME	3. Patient's First Name	5. Office Account No.
	LAVERNE	ISHA	
ADDRESS: 4676 W.	Enter Exactly as Shown on Case Identification Card	4. Case Identification Number: 04	6. Birthdate: 2 74

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
3-4-75	85010	Complete blood count w/differential	$ 6.00
	85650	Sedimentation rate	4.00
	85640	Retic count	4.00
	83550	T. Iron Binding capacity	10.00
	82250	T. Bilirubin	7.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician

R. Bascon MD.
4809 W. Madison
Chgo. Ill.

13. TOTAL CHARGE $ 31.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION: nutritional anemia

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges enclosed by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: 3-4-75

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Area

Special Approval – If Required for Procedure Code(s): ____

( ) Approved ( ) Not Approved By: ____ Date: ____

DPA 315 (R-8-73)

7 No Such Tests Requested. No Visit to Doctor in March 1975

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME: | FIRST NAME: FANNIE

ADDRESS: 21 N.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: FANNIE

4. Case Identification Number: 04

5. Office Account No.:

6. Birthdate: 8 49

Leave Blank: 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 5 1975	84330	Glucose	$ 5.00
	84520	Blood urea nitrogen	5.00
	82565	Creatinine	7.00
	87130	Urine culture w/ sensitivity	15.00
	81000	Urinalysis routine complete	3.00
	85010	Complete blood count w/ diff.	6.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon, MD.
4809 W. Madisnn
Chgo., Ill.

13. TOTAL CHARGE $ 41.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION: P/o Pyelonephritis

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: FEB 5 1975

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s):

( ) Approved ( ) Not Approved By: Date:

DPA 315 (Rev-7-71)

8 1st Visit to Doctor was Feb. 17, 1975

Illinois Department of Public Aid

See Instructions On Reverse.

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: MARCH 19 75

2. CASE LAST NAME: | FIRST NAME: OTIS
ADDRESS: 5115 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: OTIS
5. Office Account No:
4. Case Identification Number: 03
6. Birthdate: 12 43

Leave Blank: 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
3-7-75	86360	LATEX RA	$ 7.00
	85650	SEDIMENTATION RATE	4.00
	84550	URIC ACID	5.00
	86060	ASO TITER	7.00
	84075	ALK. PHOSPHATASE	7.00
	86140	C-REACTIVE PRO	7.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. BASCON MD.
4809 W. MADISON
CHGO. ILL.

13. TOTAL CHARGE $ 37.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
rheumatoid arthritis

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — 3-7-75 DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-5-73)

9 No Such Tests Requested. No Visit to Doctor in March 1975

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME: | FIRST NAME: LINDA

ADDRESS: 1622 S.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: LINDA

4. Case Identification Number: 04

5. Office Account No:

6. Birthdate: 1 — 53

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 7 1975	84330	Glucose	$ 5.00
	84520	Blood urea nitrogen	5.00
	82465	Cholesterol	5.00
	84550	Uric acid	5.00
	85010	Complete blood count w/ diff.	6.00
	81000	Urinalysis routine complete	3.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon, MD.
4809 W. Madison
Chgo. Ill.

13. TOTAL CHARGE $ 29.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
Hypertension, r/o diabetes

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: FEB 1975

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Covered: _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-8-73)

10 No Such Tests Requested. No Visit to Doctor in February '75

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of July 19 75

2. CASE LAST NAME: | FIRST NAME: Clairstine
ADDRESS:

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Clairstine
5. Office Account No: 806329
4. Case Identification Number: 04 - - -
6. Birthdate: 4 1 38

Leave Blank 7. /8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
7-31-75	85010	Complete Blood count w/diff.	$ 6.00
	85650	Sedimentation rate	4.00
	85640	Retic count	4.00
	83550	T. Iron Binding Capacity	10.00
	82250	T. Bilirubin	7.00
	81000	Urinalysis routine complete	3.00
	85010	Complete Blood count w/diff.	6.00
	87095	Vaginal culture w/ sensitivity	15.00
	88100	Pap Smear	10.00
	~~87044~~ 87015	Stat Urethral Smear	~~9.00~~

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. MEDICAL LABORATORY
P. O. Box 794
Skokie, Illinois 60076

17. Provider # 14-8250
Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon MD
4809 W. Madison
Chgo. Ill.

13. TOTAL CHARGE $ 69.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION: Non specific vaginitis
Anemia

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I further agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED 7-31-75

22. FOR SPRINGFIELD OFFICE USE ONLY -- Do Not Write in This Box
Special Approval -- If Required for Procedure Code(s): ____
( ) Approved ( ) Not Approved By: ____ Date: ____

DPA 315 (R-8-73)

11 Only Three Tests Requested No Blood Drawn

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED BY INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: August 19 75

2. CASE LAST NAME: | FIRST NAME: Mamie
ADDRESS: 7007 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Herman
4. Case Identification Number: 04
5. Office Account No: 818726
6. Birthdate: 8 4 58

Leave Blank: 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
8/29/75	86360	Latex - RA	$ 7.00
	85650	Sedimentation Rate	4.00
	84550	Uric acid	5.00
	86060	Aso titer	7.00
	86140	C-Reactive Protein	7.00
	87095	throat culture w/sensitivity	15.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. MEDICAL LABORATORY
P. O. Box 794
Skokie, Illinois 60076

17. Provider # 14-825-0 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon M.D.
4809 N. Madison
Chicago, Ill

13. TOTAL CHARGE $ 45.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION: ACUTE UPPER RESPIRATORY INFECTION

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

(Rose) [illegible] 8/29/75
SIGNATURE OF PROVIDER — DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box
Special Approval – If Required for Procedure Code(s): _____
( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-8-73)

12 Only Sedimentation Rate and Sickle Cell Test Requested

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: Jun. 19 75

2. CASE LAST NAME	FIRST NAME
	Freda

ADDRESS:

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: Freda

5. Office Account No: 818676

4. Case Identification Number: 04

6. Birthdate: 10 2 52

Leave Blank: 7.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
8-22-75	84520	Blood urea nitrogen	$ 5.00
	82565	Creatinine	7.00
	87120	Urine culture with sensitivity	15.00
	81000	Urinalysis routine complete	3.00
	85010	Complete blood count withdiff.	6.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. MEDICAL LABORATORY
P. O. Box 794
Skokie, Illinois 60076

17. Provider # 14-8250
Print, Type or Stamp

18. Name & Add. of Referring Physician

R. Bascon MD.
4809 W. Madison
Chgo. Ill.

13. TOTAL CHARGE $ 36.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
non specific vaginitis
genitu urinary infection

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of service provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

R. Bascon MD 8-22-75
SIGNATURE OF PROVIDER — DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-8-73)

13 **Only Routine Urinalysis Requested No Blood Drawn**

STATE OF ILLINOIS — DEPARTMENT OF PUBLIC AID

(Type or Print all Information)

2. LAST NAME	FIRST NAME		3. Patient's First Name	5.
	JOYCE	Enter Exactly as Shown on Case Identification Card	JOYCE	
2. ADDRESS:			4. Case Identification Number	6. Birthdate
			C4	12 25 50

Place of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
[illegible]	[illegible]	Triglycerides	$ 10.[illegible]
	83440	T-3	15.00
	83440	T-4	15.50
	[illegible]	Complete blood count w/ diff.	[illegible]
	[illegible]	Urinalysis routine complete	3.[illegible]
	[illegible]	Cholesterol	[illegible]

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

[illegible] Laboratory
P. O. Box 794
[illegible]

17. Provider [illegible]
Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Brecon, MD.
4009 W. Madison
Chgo., Ill.

13. TOTAL CHARGE [illegible]
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION: Fertility control. Acute upper respiratory infection

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment has not been received, that the charges approved by the Department of Public Aid will [illegible] full and complete charge therefor, that I [illegible] accept additional payment from any person or persons. I hereby agree to keep such records [illegible] to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER ______ DATE SIGNED [illegible] 1975

22. FOR DEPARTMENT OF PUBLIC AID OFFICE USE ONLY — Do Not Write in This Box

14 **No Such Tests Requested. Throat Culture Only Requested**

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME	FIRST NAME
	EUGENE

ADDRESS: 4910 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: EUGENE

5. Office Account No.:

4. Case Identification Number: 06

6. Birthdate: 10 39

Leave Blank: 7. / 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 5 1975	86360	Latex RA	$ 7.00
	85650	Sedimentation Rate	4.00
	84550	UricAcid	5.00
	86060	ASO Titer	7.00
	84075	Alkaline phosphatase	7.00
	86140	C-Reactive protein	7.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp.

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician

R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE	$ 37.00
14. CREDIT	$
15. NET CHARGE	$

19. DIAGNOSIS or CONDITION: Rheumatoid arthritis

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons; I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed by the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: FEB 5 1975

22. FOR SPRINGFIELD OFFICE USE ONLY -- Do Not Write in This Box

Special Approval — If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-8-73)

15 All Tests Ordered

See Instructions On Reverse

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED BY INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of JULY 1975

2. CASE LAST NAME: | FIRST NAME: JUANITA

ADDRESS: 160 N.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: JUANITA

4. Case Identification Number: 04

5. Office A...: 807473

6. Birthdate: 11 3 46

Leave Blank 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
	84520	BLOOD UREA NITROGEN	$5.00
	82565	CREATININE	7.00
	87120	URINE CULTURE W/ SENSITIVITY	15.60
	81000	URINALYSIS ROUTINE COMPLETE	3.00
	85010	COMPLETE BLOOD COUNT W/DIFF.	6.00
	87095	VAGINAL CULTURE W/SENSITIVITY	15.00
	88150	PAP SMEAR	10.00
1	76815	OB STAT URETHRAL SMEAR	4.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. BASCON, MD
4809 W. MADISON
CHGO ILL.

13. TOTAL CHARGE $65.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
ACUTE PELVIC INFLAMATORY DISEASE
ACUTE URINARY INFECTION

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER

JUN 18 1975
DATE SIGNED

FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-8-73)

16 Only Three Tests Ordered No Blood Drawn

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Service for Month: FEB 1975

2. CASE LAST NAME: | FIRST NAME: GLORIA

ADDRESS: 4840 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: CYNTHIA

5. Office Account No.:

4. Case Identification Number: 04

6. Birthdate: 2 66

Leave Blank: 7. 8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 4 1975	85010	Complete blood count w/ diff.	$ 5.00
	85650	Sedimentation rate	4.00
	85640	Reticulocyte count	4.00
	83550	Total iron binding capacity	10.00
	82250	Total bilirubin	7.00
	87015	Ova & Parasite	4.00

15. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp

D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14--8250
Print, Type or Stamp

18. Name & Add. of Referring Physician

R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE: $ 35.00

14. CREDIT: $

15. NET CHARGE: $

19. DIAGNOSIS or CONDITION: Severe anemia, R/o liver disease

20. Living Arrangement at Time of Service. ☐ Group Care Facility ☐ Hospital ☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

FEB 4 1975

SIGNATURE OF PROVIDER — DATE SIGNED

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): ____

( ) Approved ( ) Not Approved By: ____ Date: ____

17 First Visit to Doctor March 6, 1975

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED
INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of: FEB 1975

2. CASE LAST NAME: | FIRST NAME: JESSIE
ADDRESS: 4927 W.

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: JESSIE
5. Office Account No.:
4. Case Identification Number: 07
6. Birthdate: 2 21

Leave Blank 7.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
FEB 7 1975	84330	Glucose	$ 5.00
	84520	Blood urea nitrogen	5.00
	82565	Creatinine	7.00
	87180	Urine culture w/ sensitivity	15.00
	81000	Urinalysis routine complete	3.00
	85010	Complete blood count w/ diff.	6.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # 14-8250 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. Bascon, MD.
4809 W. Madison
Chgo., Ill.

13. TOTAL CHARGE: $ 41.00
14. CREDIT: $
15. NET CHARGE: $

19. DIAGNOSIS or CONDITION: R/o Glumerolo-nephritis

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges quoted by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED: FEB 7 1975

22. FOR SPRINGFIELD OFFICE USE ONLY – Do Not Write in This Box
Special Approval – If Required for Procedure Code(s):
( ) Approved ( ) Not Approved By: Date:

DPA 315 (R-6-73)

18 No Such Tests Requested. Throat Culture Only Requested

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY

(Type or Print all Information)

1. Services for Month of FEB 19 75

2. CASE LAST NAME: | FIRST NAME: QUINZOLA

ADDRESS: 4949 W. - -

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: RICHIE

4. Case Identification Number: 04

5. Office Account No.:

6. Birthdate: 2 68

Leave Blank 7. /8.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
2/6/75	85010	Complete Blood Count w/ Diff.	$ 6.00
	85650	Sedimentation Rate	4.00
	85640	Reticulocyte Count	4.00
	83550	Total Iron Binding Capacity	10.00
	82250	TOTAL BILIRUBIN	7.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. Medical Laboratory
P. O. Box 794
Skokie, Ill. 60076

17. Provider # _____ Print, Type or Stamp

18. Name & Add. of Referring Physician
R. BASCON M.D.
4809 W. MADISON
CHGO. ILL.

13. TOTAL CHARGE $ 31.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
SUSP'G ANEMIA
H/O LIVER DISEASE

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION

This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons, I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED 2/6/75

22. FOR SPRINGFIELD OFFICE USE ONLY — Do Not Write in This Box

Special Approval — If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-4-73)

19 Test Not Requested No Visit to Doctor in March 1975

See Instructions On Reverse.

Illinois Department of Public Aid

STATEMENT OF SERVICES RENDERED INDEPENDENT LABORATORY
(Type or Print all Information)

1. Services for Month of 7/74 19 75

2. CASE LAST NAME	FIRST NAME
	NANCY

ADDRESS: 718 S. CHICAGO, ILLINOIS 601

Enter Exactly as Shown on Case Identification Card

3. Patient's First Name: NANCY
4. Case Identification Number: 04
5. Office Account No: 806579
6. Birthdate: 12 28 58

Leave Blank 7.

Report of Services

9. Date of Service	10. Procedure Code	11. Fully Describe Laboratory Procedures and Other Services or Supplies Furnished for Each Date Given	12. Charges
7/25/75	89370	24A-12	$ 18.00
	84475	TRIGLYCERIDES	10.00
	87120	URINE CULTURE WITH SENSITIVITY	15.00
	81000	URINALYSIS ROUTINE COMPLETE	3.00
	15010	COMPLETE BLOOD COUNT WITH DIFF.	6.00
	87075	VAGINAL CULTURE WITH SENSITIVITY	15.00
	88150	PAP SMEAR	10.00
"	87765	STAT WET MOUNT SMEAR	3.00

16. Name & Address of Independent Laboratory (No. & St., City, Street, Zip Code) Print, Type or Stamp
D. J. MEDICAL LABORATORY
P. O. Box 794
Skokie, Illinois 60076

17. Provider # 14-525 Print, Type or Stamp

18. Name & Add. of Referring Physician
R. BASCOM M.D.
4809 W. MADISON
CHICAGO ILLINOIS

13. TOTAL CHARGE $ 81.00
14. CREDIT $
15. NET CHARGE $

19. DIAGNOSIS or CONDITION:
PELVIC INFLAMATORY DISEASE
R/O HYPERTENSION

20. Living Arrangement at Time of Service.
☐ Group Care Facility
☐ Hospital
☐ Other (Specify)

21. CERTIFICATION
This is to certify that I have rendered the services and provided the items set forth and the information above is true, accurate and complete, that payment therefor has not been received, that the charges approved by the Department of Public Aid will constitute the full and complete charge therefor, that I will not accept additional payment from any person or persons. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under TITLE XIX of the Social Security Act and to furnish information regarding any payments claimed as the State Agency may request. I understand payment is made from Federal and State funds and that any falsification or concealment of a material fact may lead to appropriate legal action. I further certify that in compliance with TITLE VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

SIGNATURE OF PROVIDER — DATE SIGNED 7/25/75

22. FOR SPRINGF... OFFICE USE ONLY – Do Not Write in This Box

Special Approval – If Required for Procedure Code(s): _____

( ) Approved ( ) Not Approved By: _____ Date: _____

DPA 315 (R-8-73)

20 Only Three Tests Ordered No Blood Drawn

TOTAL Billed to Medicaid: $885.00

TOTAL Referred by Physician: $119.00

DIFFERENCE: $766.00

70-482 O - 76 - 7

Appendix 2

AFFIDAVITS SUBMITTED FOR THE RECORD BY DOUGLAS A. LONGHINI,* GERALYN DELANEY, AND WILLIAM R. HOOD, BETTER GOVERNMENT ASSOCIATION, CHICAGO, ILL.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 12, 1975, I telephoned West Lawn Medical Laboratory located at 4255 West 63d Street, Chicago, Ill. I spoke to a man who identified himself as Riaz Khan.

3. That on December 12, 1975, while speaking to Riaz Khan on the telephone, I told Riaz Khan that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill., I told Riaz Khan I was going to be purchasing medical laboratory testing services for the proposed medical clinic located at 1520 West Morse, Chicago, Ill., I made an appointment for 9 a.m., December 16, 1975, to personally meet Riaz Khan at 1520 West Morse, Chicago, Ill.

4. That on December 16, 1975, between the hours of 8:30 a.m. and 12 p.m. and 12:45 p.m. and 6 p.m., I was at 1520 West Morse, Chicago, Ill.

5. That at approximately 9 a.m. on December 16, 1975, a man entered the building at 1520 West Morse and identified himself as Riaz Khan. Riaz Khan gave me a business card identifying Riaz Khan as a technical representative of West Lawn Medical Laboratory located at 4255 West 63d Street, Chicago, Ill.

6. That on December 16, 1975, Riaz Khan stated that West Lawn Medical Laboratory would provide the medical clinic at 1520 West Morse with a laboratory technician to draw blood at the clinic. Riaz Khan stated that West Lawn would pay the laboratory's wages for drawing blood. These statements were made in the presence of Geralyn Delaney and myself.

7. That on December 16, 1975, Riaz Khan stated that if the volume of medical tests ordered from the proposed medical clinic reached between five (5) and ten (10) public aid patients a day then West Lawn Medical Laboratory would sublease space at the proposed medical clinic. Riaz Khan stated that the rent for this subleased space would be paid for by West Lawn Medical Laboratory. The amount of rent to be paid in U.S. currency would be based upon a percent of the volume of medical tests ordered from the proposed clinic and done by West Lawn Medical Laboratory. These statements were made by Riaz Khan in the presence of Geralyn Delaney and myself.

8. That on December 16, 1975, Riaz Khan stated that if the medical clinic would be ordering medical tests on between 15 and 20 public aid patients a day, then West Lawn would not take any profit on medical tests ordered by the medical clinic for private, nonmedicare, nonmedicaid patients. Khan stated: "If you draw blood from a public aid patient and blood from a private patient, we can forget the profit on the private patient; that profit is yours." These statements were made in the presence of Geralyn Delaney and myself.

*See statement, p. 425.

9. That on December 16, 1975, Riaz Khan stated that there would be no written agreement and/or contract between West Lawn and the medical clinic. Khan said there would be nothing written between the laboratory and the clinic formally arranging for medical testing services. Khan said there would be no formal, written sublease of space within the clinic for the use of West Lawn. These statements were made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 13th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 12, 1975, I telephoned Azteca Laboratory. I spoke to a man who identified himself as Dr. Velez. I told Dr. Velez that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I told Dr. Velez that I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment for 11 a.m., December 16, 1975, to personally meet with Dr. Velez to discuss the possibility of purchasing medical testing services from Azteca Labs.

3. That on December 16, 1975, between the hours of 8:30 a.m. and 12 p.m. and 12:45 p.m. and 6 p.m., I was at 1520 West Morse, Chicago, Ill.

4. That on December 16, 1975, at approximately 11 a.m., a man entered the medical clinic offices at 1520 West Morse, Chicago, Ill., and identified himself as Dr. Velez.

5. That on December 16, 1975, Dr. Velez stated what he called a "professional service discount" on all public aid billings for medical tests on public aid patients. Dr. Velez said the discount on the medical tests would be a percentage of the price and/or cost of a total month's billing for medical tests for public aid patients. This statement was made in the presence of Geralyn Delaney and myself.

6. That on December 16, 1975, Dr. Velez presented me with a copy of a billing statement of medical tests done for public aid patients by Azteca Labs for an unnamed medical clinic. Dr. Velez stated that that month's bill to the State was $3,853 for this same unnamed clinic and that by applying what Dr. Velez again referred to as the professional services discount Dr. Velez was able to give the unnamed clinic back $1,000 of the total $3,853 in medical test billings. Dr. Velez said such a discount was paid by sending the clinic a check for $1,000. These statements were made in the presence of Geralyn Delaney and myself.

7. That on December 16, 1975, Dr. Velez stated that Azteca Labs would apply a percentage of the clinic's total medical testing bills back to the clinic in the form of rent. Dr. Velez stated that there would be no written contract for medical testing services between Azteca Labs or himself and the medical clinic or its representatives. Dr. Velez said that if the medical clinic had between 10 and 15 patients a day and a corresponding number of medical tests ordered, Azteca would lease a certain amount of space in the clinic. Dr. Velez stated that the amount discounted by Azteca from the monthly billing statement would be applied to the rest of the medical clinic. Dr. Velez said, "Five hundred, a thousand, two thousand dollars, whatever, will be applied to the rent, according to the volume of business in the clinic." These statements were made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 13th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 12, 1975, I telephoned Chicago Medical Laboratory located at 1518 North Ashland, Chicago, Ill. I spoke to a man who did not identify himself. I told this man that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I said I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment for 1 p.m. on December 16, 1975, to personally meet with Mr. Robinson of Chicago Medical Laboratory.

3. That on December 16, 1975, between the hours of 8:30 a.m. and 12 p.m. and 12:45 p.m. and 6 p.m., I was at 1520 West Morse, Chicago, Ill.

4. That on December 16, 1975, at approximately 2 p.m., a man entered the building at 1520 West Morse, Chicago, Ill., and identified himself as Mr. Robinson. Mr. Robinson stated that he had believed that our appointment was for 2 p.m.

5. That on December 16, 1975, Robinson stated that Chicago Medical Laboratory would rent a certain amount of square feet in the medical clinic. Robinson stated that if the clinic had a monthly rent of $1,000, Chicago Laboratory would sublease between 10 and 20 percent of the $1,000 monthly rent for the medical clinic. Robinson stated that Chicago Medical Laboratory would set a fixed percentage on a fixed figure, Robinson here stated the rent, if the volume of medical testing business ordered by the clinic increased Chicago Medical Laboratory would raise the fixed percentage. Robinson stated that the rent was to be adjusted to whatever the volume of medical testing business was. Robinson stated that he would not be able to provide us with medical testing services without establishing a fixed percentage of the rent to be paid by Chicago Medical Laboratory. These statements were made in the presence of Geralyn Delaney and myself.

6. That on December 16, 1975, Robinson stated that Chicago Medical Laboratory would apply forty (40) percent of all the costs for medical tests done for private, non-medicare, nonmedicaid, patients to the Chicago Medical Lab's rented space in the medical clinic. Robinson stated an example of a private patient getting a series of tests for SMA–12 and urinalysis, Robinson said the cost would be $20, but the medical clinic would get forty (40) percent of that $20. These statements were made in the presence of Geralyn Delaney and myself.

7. That on December 12, 1975, Robinson stated that Chicago Medical Laboratory would send the clinic a check through the U.S. mail system each month for the rented space. This statement was made in the presence of Geralyn Delaney and myself.

8. That on December 16, 1975, Robinson stated that initially there would be no written lease, sublease, or contract between Chicago Medical Laboratory and the medical clinic. Robinson stated that "I wouldn't worry much about leases until we get started. Leases are only if you have a good thing going." These statements were made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 13th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 12, 1975, I telephoned General Medical Laboratories located at 914 West Diversey, Chicago, Ill. I spoke to a man who identified himself as Dr. Charlip. I stated that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I said I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment to meet with Dr. Charlip at 3 p.m. on December 16, 1975.

3. That on December 16, 1975, I was physically within the building located at 1520 West Morse, Chicago, Ill., between the hours of 8:30 a.m. and 12 p.m. and 12:45 p.m. and 6 p.m.

4. That on December 16, 1975, at approximately 3 p.m., a man entered the building at 1520 West Morse and identified himself as Dr. Charlip.

5. That on December 16, 1975, Dr. Charlip stated that General Medical Laboratories had two different price lists for medical tests performed by the laboratories. One price list described the prices that General Medical charged private, non-public-aid patients and the other price list described the prices which General Medical charged the State of Illinois, Department of Public Aid for the same tests. Dr. Charlip stated that the prices that General Medical charged for private patients were about three times lower than the prices for medical tests that General Medical charged the State of Illinois Department of Public Aid for patients on medicaid. These statements were made in the presence of Geralyn Delany and myself.

6. That on December 16, 1975, Dr. Charlip stated that he would speak to the two physicians that were opening the clinic at 1520 West Morse and explain to these physicians how to use the Illinois Department of Public Aid's codes for billing the department for medical tests. Dr. Charlip stated that there were a lot of tricks to a physician billing the Illinois Department of Public Aid, and that by using different codes a physician could get between $8 and $24 from the Department of Public Aid for the exact same medical test. These statements were made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 13th day of January, 1976, Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

1. Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 12, 1975, I telephoned Division Medical Laboratory located at 2625 West Division, Chicago, Ill. I spoke to a man who identified himself as a Mr. Celso (may be incorrect spelling). I told Mr. Celso that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I told Mr. Celso that I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment for 10 a.m., December 16, 1975, to personally meet a representative of Division Laboratory whom Mr. Celso said was named Felix.

3. That on December 16, 1975, between the hours of 8:30 a.m. and 12 p.m. and between 12:45 p.m. and 6 p.m., I was at 1520 West Morse, Chicago, Ill.

4. That at approximately 10 a.m. on December 16, 1975, two (2) men entered the building at 1520 West Morse and identified themselves as John Todd and Felix Salamanca. Todd gave me a business card identifying John B. Todd as director of nursing home division for Division Medical Laboratory. No title was given to Salamanca.

5. That on December 16, 1975, Todd offered to provide the medical clinic with a laboratory technician, a portable X-ray machine and, if required, an EKG machine. Todd said all of these would be provided without any charge to the medical clinic, that all costs involved with these services and/or machines would be borne by Division Laboratory. This offer was made in the presence of Geralyn Delaney and myself.

6. That on December 16, 1975, Todd offered to sublease space in the medical clinic to be used by the technician and to house the X-ray machine and EKG machine. Todd suggested that I tell him what rent the clinic would want for the subleased space and that Division Laboratory would pay something although not necessarily what I had been asked to suggest. This offer was made in the presence of Geralyn Delaney and myself.

7. That on December 16, 1975, Todd stated that the rent for the subleased space would be reviewed by Division Laboratory every 3 months. Todd said the rent would be reevaluated based upon the volume of the medical tests ordered by the medical clinic and going to Division.

8. That on December 16, 1975, Todd agreed with a statement I made that the rent collected by the clinic and paid for Division for the small subleased space could be two (2) or three (3) times greater than the rent the clinic paid for the use of the whole space at 1520 West Morse. Todd said that the rent the clinic paid for the use of the whole space would not be a ceiling on the rent collected from Division for the subleased space. This offer was made in the presence of Geralyn Delaney and myself.

9. That on December 16, 1975, Todd stated that if the medical clinic was seeing 20 to 30 patients per day, Division Laboratory would pay the full salary of the clinic's secretary and/or nurse in addition to the full salary of the laboratory technician. This offer was made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 13th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 12, 1975, I telephoned D. J. Medical Laboratory located at 1708 West Chicago Avenue, Chicago, Ill. I spoke to a man who identified himself as Joe Espino. I stated that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I said I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment to meet with Mr. Espino at 10 a.m. on December 17, 1975.

3. That on December 17, 1975, I was physically within the building located at 1520 West Morse, Chicago, Ill., between the hours of 8:45 a.m. to 12 p.m. and 1 p.m. to 4 p.m.

4. That on December 17, 1975, at approximately 10 a.m., a man entered the building at 1520 West Morse and identified himself as Joselito Espino. Espino gave me a business card that identified Joselito C. Espino as president of D. J. Medical Laboratory, Inc.

5. That on December 17, 1975, Espino stated that D. J. Medical Laboratory maintained two separate price lists for medical tests. Espino stated that there was one price list for medical tests done on public aid patients and another price list for private non-public aid, non-medicare patients. Espino said that he thought that the maintenance and application of these two lists was illegal, but that as long as he did not have the two separate lists written down there would be nothing wrong with the two separate lists. These statements were made in the presence of Geralyn Delaney and myself.

6. That on December 17, 1975 Espino gave me a small green sheet of paper with the words "Laboratory Tests" in large letters on the paper. The paper listed the medical tests performed by D. J. Medical Laboratory. Espino stated that D. J. Medical Laboratory charged $3.50 for an SMA–12 test for a private, non-public-aid patient and that D. J. Medical Laboratory collected $15 from the State of Illinois, Department of Public Aid, for the same exact test for a public aid patient. Espino stated the medical testing costs for private and public aid patients for a number of other tests. Espino stated the following:

Tests	Charge to private patient	Charge to State of Illinois for public aid patient
SMA–12	$3.50	$15.00
CBC	2.50	6.00
Urinalysis	1.50	3.00
VDRL	3.00	(1)
ABO	1.50	3.50
Rh	1.50	3.50
Glucose	2.50	5.00
Pap smear	4.00	10.00
All culture tests	5.00	10.00
GC smear	1.50	3.00
TEC	1.50	3.00
Stool O/P	1.50	3.00
TIBC	3.00	7.00
EKG	6.00	12.00
T–3	6.00	12.00
T–4	6.00	12.00
PBI[2]		
Sed rate	1.50	4.00
Pro elec	6.00	12.00
BUN	2.50	5.00
Uric acid	2.50	5.00
Cholesteral	2.50	5.00
Na. (sodium)	2.00	3.00
K. (potassium)	2.00	3.00
Creat	3.00	7.00
ASO	2.00	5.00
Pregnancy test	3.00	8.00
ANA	6.00	12.00
SGPT	2.50	5.00
Ceph. floculation	2.50	5.00
Thymol	2.50	5.00
Latex RA	2.00	5.00
CRP	2.00	5.00
Alkali phosphate	2.00	5.00

[1] No payment.
[2] D. J. send these tests to Mason and Baron Laboratories.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 13th day of January, 1976, Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 15, 1975, I was told by the answering service for telephone number 372–7100 that a man identifying himself as Mr. Simos of Hilltop Medical Laboratory had telephoned the answering service. On December 16, 1975, I telephoned Mr. Simos at Hilltop Medical Laboratory located at 1325 West 87th Street, Chicago, Ill. I stated that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open

a medical clinic at 1520 West Morse, Chicago, Ill. I said I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment to meet with Mr. Simos at 11 a.m. on December 17, 1975.

3. That on December 17, 1975, I was physically within the building located at 1520 West Morse, Chicago, Ill., between the hours of 8:45 a.m. and 12 p.m. and between 1 p.m. to 4 p.m.

4. That on December 17, 1975, at approximately 11 a.m., a man entered the building at 1520 West Morse and identified himself as Mr. Simos. Mr. Simos stated that he was manager of Hilltop Laboratory but that he was about to start his own laboratory, Claremont Medical Laboratory, and that he was representing Claremont and not Hilltop Laboratory.

5. That on December 17, 1975, Simos stated that Claremont Medical Laboratory would provide the medical clinic with a laboratory technician and that Claremont would pay that technician's salary. Simos stated that Claremont would pay that technician's salary. Simos stated that Claremont would rent a certain amount of square feet at the medical clinic for the use of the laboratory technician. Simos stated that the dollar amount of rent for this space would be based on the volume of medical tests ordered by the medical cilnic. Simos stated that the dollar amount of rent was not to be based on the actual number of square feet utilized by the laboratory technician. Simos stated that the number of square feet used by the laboratory technician would have nothing to do with the actual dollar amount of rent paid by Claremont to the medical clinic. Simos stated that the arrangement of renting a certain number of square feet in the medical clinic for the use of a laboratory technician and Claremont paying a percentage of the gross medical testing billings back to the medical clinic was to make it look like Claremont was renting space in the medical clinic. Simos stated that auditors from the State of Illinois and unspecified individuals from the Federal Bureau of Investigation will not investigate a medical laboratory's rental payments to a medical clinic if these agencies and/or individuals see that there is a written lease or sublease between the medical clinic and the medical laboratory. These statements were made in the presence of Geralyn Delaney and myself.

6. That on December 17, 1975, Simos stated that there could be an open lease for a specific price signed between Claremont Medical Laboratory and the medical clinic. Simos stated that the lease could be renewed tomorrow at a different price. Simos stated that with this arrangement "the FBI cannot catch us this way. This protects the doctors. Once FBI sees sublease, they stop investigation." Simos stated that Claremont would not actually use the rented, subleased space. Simos stated that Claremont would evaluate the rent every three (3) months always with respect to the volume of medical tests ordered by the clinic. Simos stated that if the medical clinic were seeing thirty (30) patients a day, between $500 and $700 would be applied by Claremont to the rent in the medical clinic. Simos stated that Claremont would not give back more than thirty (30) percent of gross volume in medical tests in the form of rent. Simos stated that thirty (30) percent is very hard to explain to a State auditor already, and that any percent more than thirty (30) percent was much too difficult. Simos stated that a medical laboratory giving back a percentage of gross billing for medical tests to a medical clinic was dirty business. Simos stated that "the doctors would get clobbered, so we rent space." These statements were made in the presence of Geralyn Delaney and myself.

7. That on December 17, 1975, Mr. Simos stated that Claremont would give the medical clinic a forty (40) percent discount on all medical tests ordered for private, non-public-aid patients. These statements were made in the presence of Geralyn Delaney and myself.

8. That on December 17, 1975 Simos stated that he would consult with the two physicians at the medical clinic to show them how to order medical tests for public aid. Simos stated that Claremont would like the doctors to see a minimum of 15 patients a day and order two (2) or three (3) medical tests for each patient. Simos stated that a doctor does not have to worry about the expense of ordering tests for public aid patients like he does with private patients. Simos stated that because the State of Illinois is paying for the medical tests and not the public aid patient that "what the hell, go ahead and order

ten (10) tests—just go ahead." These statements were made in the presence of Geralyn Delaney and myself.

9. That on December 17, 1975, Simos stated that he would consult with the two (2) physicians at the medical clinic to show them how to diagnose cases for public aid. Simos stated that an example of a public aid diagnosis was the instance of submitting to the State tests for anemia and hypertension at the same time. Simos stated that the State of Illinois Department of Public Aid will not pay for both tests at the same time because the tests are not related to one another. Simos stated that a laboratory can bill the State for both tests at the same time if the public aid patients' physician writes "rule out" before the word hypertension. Simos stated that writing the words "rule out" before the name of a medical test will result in the State paying the medical laboratory for performing the tests. These statements were made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 20th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 15, 1975, I telephoned Ridgeland Medical Laboratory located at 101 Madison Street, Oak Park, Ill. I spoke to a woman who identified herself as Mrs. Villanueva. I stated that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I said I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment to meet with Ernesto Villanueva at 11 a.m. on December 18, 1975, at Ridgeland Medical Laboratory.

3. That on December 18, 1975, at approximately 11:15 a.m., Geralyn Delaney and myself entered the 2d floor offices of Ridgeland Medical Laboratory in Oak Park. We met a man who identified himself as Ernesto Villanueva. Mr. Villaneuva stated that the was the owner of Ridgeland Medical Laboratory and also had another laboratory named Clinical Lab Service located at 3940 West Division, Chicago, Ill.

4. That on December 18, 1975, Villanueva stated that if the volume of medical tests ordered by the medical clinic warranted it, Ridgeland Medical Laboratory would rent a room at the clinic and place a laboratory technician there to draw blood. Villanueva stated that Ridgeland would pay 50 percent of the technician's salary and that the medical clinic would pay the other 50 percent. Villanueva stated that the technician would not be drawing blood the whole 8 hours each day she is at the medical clinic. Villanueva stated that the technician may spend 30 percent of her time drawing blood and the other 70 percent of the time the technician could spend helping out the medical clinic's secretary with filing, etc.

5. That on December 18, 1975, Villanueva stated that the medical clinic would charge the lab a base rent for a certain amount of space at the medical clinic. Villanueva stated that if the volume of medical testing business referred to Ridgeland goes up then the rent can also be increased, but that the amount of square feet used by the lab at the medical clinic would not increase.

6. That on December 18, 1975, Villanueva stated that the rent Ridgeland would pay the medical clinic would be based on the volume of medical testing business, referred to the lab. Villanueva stated that there would be no ceiling on the amount of rent the medical clinic could charge the laboratory. Villanueva stated, "I don't have to know how much rent you are paying for the medical clinic." Villanueva stated that if the volume of medical testing business warranted it, the medical clinic could receive more money in the form of rent

from the few square feet rented by the lab, than the entire amount of money that the clinic paid each month for rental of the whole medical clinic.

7. That on December 18, 1975, Villanueva stated that Ridgeland would sign a legal sublease of space at the medical clinic. Villanueva stated that Ridgeland would evaluate the lease every 6 months, or 1 year, to see what the volume of medical testing business was. Villanueva stated that the lease can be negotiated every 6 months or so, if the volume of medical testing business increases, then a new lease is drawn up and the amount of rent paid by the laboratory to the medical testing business was. Villanueva stated that the lease can be negotiated (10) times, rent could go up ten (10) times."

8. That the above statements were made in the presence of Geralyn Delaney and myself on December 18, 1975.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 20th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 22, 1975, I telephoned North Side Clinical Laboratory at 185 North Wabash, Chicago, Ill. I spoke to a man who identified himself as Mr. LaPena. I told Mr. LaPena that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I told Mr. LaPena that I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment for 12 p.m., December 23, 1975, to personally meet Mr. LaPena at the medical clinic.

3. That on December 23, 1975, Geralyn Delaney and myself were physically present at the medical clinic located a 1520 West Morse, Chicago, Ill., between 8:40 a.m. and 1:30 p.m.

4. That at approximately 12 p.m., on December 23, 1975, a man entered the medical clinic located at 1520 West Morse, Chicago, Ill., and identified himself as Mr. Nemie LaPena.

5. That on December 23, 1975, LaPena stated that North Side Clinical Laboratory would charge the medical clinic fifty (50) percent less for medical tests on private patients seen by the medical clinic than the laboratory would charge for public aid patients.

6. That on December 23, 1975 LaPena stated that the medical clinic could keep all of the billings for private patients if the medical clinic was seeing between 80–90 percent public aid patients a day. The laboratory would then charge nothing for doing medical tests for private patients.

7. That on December 23, 1975, LaPena showed Geralyn Delaney and myself a laboratory testing tally sheet. LaPena stated that he would have a copy of this sheet and that the medical clinic would have a copy of an identical sheet. LaPena stated that he would maintain a list of the tests ordered by the medical clinic each week and that the medical clinic should also keep a record of the medical tests ordered each week. LaPena stated that at the end of each week he would total the dollar amount of tests ordered by the medical clinic and then each Tuesday of the week the clinic would receive a check from North Side Clinical Laboratory equal to 45 percent of the previous week's billings for medical tests. LaPena stated that if the medical clinic were to send more than $1,000 in medical tests to North Side, then North Side would send the medical clinic a check for 50 percent of the previous week's billing, again so long as that billing exceeded $1,000. LaPena stated that the weekly checks would be for payment of rental of space at the medical clinic. LaPena stated that North Side would not actually use the space North Side would rent at the medical clinic.

8. That on December 23, 1975, LaPena stated that North Side would sign a written sublease for space at the medical clinic. LaPena stated, "I don't know how legal, but rental agreement could say that we are giving you back 45 percent of the volume of medical tests ordered." LaPena stated that he presently maintained this type of sublease with a number of medical clinics.

9. That on December 23, 1975, LaPena stated that if the volume of medical testing business referred to North Side was high enough that North Side would pay the medical clinic a flat fee of $600 a week for rental of space at the clinic. LaPena stated that the medical clinic would have to order tests on at least eight (8) patients a day if North Side was to collect $1,200 in lab fees a week.

10. That on December 23, 1975, LaPena stated that if the volume of medical tests ordered by the medical clinic exceeded $1,200 per week that North Side would then pay part of the salary of the clinic's secretary and/or nurse. La Pena stated that North Side could pay some of the clinic's utility bills.

11. That the above statements were made in the presence of Geralyn Delaney and myself on December 23, 1975.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 20th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 22, 1975, I telephoned United Medical Laboratories located at 8 South Michigan, Chicago, Ill. I spoke to someone who did not identify themselves. I stated that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I said I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment to meet with Ms. Judy Pedgrift, a representative of United Medical Laboratories, at the medical clinic at 1520 West Morse, Chicago, Ill., for 9 a.m. on December 23, 1975.

3. That on December 23, 1975, Geralyn Delaney and myself were physically present at the medical clinic located at 1520 West Morse, Chicago, Ill., between 8:40 a.m. and 1:30 p.m.

4. That at approximately 9:40 a.m. on December 23, 1975, a woman entered the medical clinic located at 1520 West Morse, Chicago, Ill., and identified herself as Judy Pedgrift of United Medical Laboratories.

5. That on December 23, 1975, Pedgrift stated that United Medical Laboratories would make available to the medical clinic two separate price lists for medical tests. Pedgrift stated that one price list would be for private patients, and the second, and higher price list, would be for public aid patients. Pedgrift stated that in order to use the lower private patient prices, the medical clinic would have to directly bill the private patient. Pedgrift stated that "on private patients, if you [the medical clinic] bill the patient, then the medical clinic will pay the prices indicated on the [lower] price list and then the clinic can charge the patient whatever it wants to charge." Pedgrift stated that "some doctors still pay higher prices for tests on private [patients]. They don't realize the lower prices. If volume is good than $5 is fine, instead of $8, for the same test."

6. That on December 23, 1975, Pedgrift stated that United Medical Laboratories would "pay back rent to the medical clinic [based] on all public aid tests" ordered by the medical clinic. Pedgrift stated that "on public aid, we have to cover rent and equipment, rent for room and technician. We work out equitable rent situation with you."

7. That on December 23, 1975, Pedgrift stated that United would not pay any rent to the medical clinic during the first month of business at the clinic.

Pedgrift stated that after the medical clinic's first month of business, United would "get [an] idea of volume and then figure monthly rent." Pedgrift stated that some medical clinics serviced by United have rents of $800 and Pedgrift says United absorbs the entire $800 rent. Pedgrift stated that if United is paying a flat rent the laboratory is constantly evaluating the rent. If a medical clinic's volume of medical tests goes down United will call the clinic and tell them that they had better get their volume up.

8. That on December 23, 1975, Pedgrift stated that if the volume of medical tests ordered by the laboratory is constantly low, then United will lower the amount of rent it is paying to the lab. Pedgrift stated that if the volume increases United will re-evaluate the rent and raise the rent.

9. That on December 23, 1975, I asked Pedgrift if United actually looked at the volume of medical tests ordered by the medical clinic and take a percentage of that and apply it to the rent for the clinic. Pedgrift stated, "Right."

10. That the above statements were made in the presence of Geralyn Delaney and myself on December 23, 1975.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 20th day of January, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of December 1975.

2. That on December 22, 1975, I telephoned Norsom Medical Reference Laboratories, Inc., located at 710 Higgins Road, Park Ridge, Ill. I spoke with a man who identified himself as Mr. Paradise. I told Mr. Paradise that my name was Luke Kolman and that I represented two (2) licensed Illinois physicians who were going to open a medical clinic at 1520 West Morse, Chicago, Ill. I told Mr. Paradise that I was going to be purchasing medical laboratory testing services for the proposed medical clinic. I made an appointment for 1 p.m., December 23, 1975 to have Mr. Paradise come to the medical cinic at 1520 West Morse.

3. That on December 23, 1975, between the hours of 8:40 a.m. and 1:30 p.m., I, along with Geralyn Delaney, was physically present at the medical clinic located at 1520 West Morse, Chicago, Ill.

4. That at approximately 1 p.m., December 23, 1975, a man entered the medical clinic and identified himself as Mr. Paradise of Norsom Medical Reference Laboratories, Inc.

5. That on December 23, 1975, Mr. Paradise stated that if the clinic did the billing on private patients and drew the specimens the lab would have a flexible profile on private patients. Mr. Paradise stated that the lab would charge less for private than they would for medicaid.

6. That the above statement was made in the presence of Geralyn Delaney and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 5th day of February, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Douglas A. Longhini, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am an employee of the Better Government Association located at 360 North Michigan Avenue, Suite 1118, Chicago, Ill. I am employed presently as an investigator by the Better Government Association and was so employed throughout the month of January 1976.

2. That on January 8, 1976, Geralyn Delaney telephoned Tenn Clinical Laboratory, located at 1057 West Argyle, Chicago, Ill. Ms. Delaney told a man, who identified himself as Mr. Diancin, that two (2) licensed Illinois physicians were going to open a medical clinic at 1520 West Morse. Ms. Delaney said that the doctors would be purchasing medical laboratory testing services for the proposed medical clinic. Ms. Delaney made an appointment for 10 a.m., January 9, 1976, to have Mr. Diancin come to the medical clinic at 1520 West Morse.

3. That on January 9, 1976, between the hours of 9 a.m. and 11:30 a.m., I was present at 1520 West Morse, Chicago, Ill. Also present at this address during this period was George Bliss and Jean Butzen.

4. That at approximately 10 a.m. on January 9, 1976, a man entered the building at 1520 West Morse and identified himself as Ted Diancin. Diancin gave me a business card identifying Ted Diancin as president of Tenn Clinical Laboratory, Inc.

5. That on January 9, 1976, Diancin stated that Tenn would charge the medical clinic 50 percent less for medical tests performed for private patients than the laboratory would charge the State for tests performed for medicaid patients. Diancin stated that if a test cost $5, Tenn Laboratory would charge the medical clinic $2.50 for private patient tests.

6. That on January 9, 1976, Diancin stated that Tenn Clinical Laboratory would rent space at the medical clinic for a blood drawing station. Diancin stated that the rent the laboratory would pay the clinic would be based on a percentage of the volume of medical testing business that the clinic referred to Tenn Laboratory. Diancin sated that if the clinic referred $1,000 in medical tests to the laboratory a month, the monthly rent paid by Tenn would be 15 percent of that $1,000. Diancin stated that if the clinic referred more than $4,000 in medical tests to the laboratory, the monthly rent paid by Tenn would be 25 percent of that month's billings.

7. That on January 9, 1976, Diancin stated that Tenn could sign a legal sublease or lease of space at the clinic. Diancin stated that the rent would be evaluated monthly by Tenn. If the volume of medical testing business referred by the medical clinic would decline than the rent paid by Tenn to the medical clinic would also decline proportionately. Diancin stated that Tenn would rent as little as one square foot of space at the medical clinic. Diancin stated that Tenn would not actually use the rented space. Diancin stated that the only reason Tenn would legally sublease the space at the clinic was "just for the IRS, just to make it look legal."

8. That on January 9, 1976, the above statements were made in the presence of Jean Butzen, George Bliss, and myself.

DOUGLAS A. LONGHINI.

Subscribed and sworn to before me this 5th day of February, 1976. Geralyn L. Delaney, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 16, 1975, at 11 a.m., I was present at 1520 West Morse, Chicago, Ill., when a man entered the premises. He identified himself as Dr. Velez from Azteca Laboratory.

3. That on December 16, 1975, Dr. Velez stated for private patients our clinic would get a "professional service discount" on lab test prices and if our clinic received 10–15 private, medicare, or medicaid patients a day, Azteca would lease a certain amount of space in our clinic. Our clinic would get a statement every month which would show us our volume, gross, etc., and Dr. Velez said, "The lab will give you some percentage applied to your facilities. This is legal." Dr. Velez gives "$1,200 a month to one clinic, but he has the volume."

4. That on December 16, 1975, Dr. Velez showed Doug Longhini and myself a statement to the Illinois Department of Public Aid showing the amount Azteca charged for a certain test, for example $49, and the cash value the State pays

for the same test, for example $39. Other tests were listed on the statement for public aid patients and the total amount charged came to $4,994 and the total amount received from the State was $3,853. Dr. Velez stated Azteca would give the clinic the $1,000 difference, about a 25 percent discount applied to our rent.

5. That the above statements were made in the presence of Doug Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 13th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 16, 1975, I was present at 1520 West Morse, Chicago, Ill., at 10 a.m. when two (2) men entered the premises. Both men identified themselves as being from Division Laboratories; one identified himself as John Todd and the other as Felix Salamanca.

3. That on December 16, 1975, John Todd stated Division would sublease space in our clinic for the technician to draw the blood. Mr. Todd stated Division would review the payment for the subleased space every three (3) months. Mr. Todd also stated Division could provide electrical and plumbing contracting services for our medical clinic.

4. That on December 16, 1975, Mr. Todd stated Division would pay the salary of the clinic's secretary and/or the nurse that draws the blood.

5. That Division would provide the necessary equipment—ekg and X-ray, and a technician who would be on Division's payroll or the doctor's payroll.

6. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 13th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 16, 1975, I was present at 1520 West Morse, Chicago, Ill., at 9 a.m. when a man entered the above-stated premises. His business card identified him as Riaz Khan from West Lawn Medical Laboratory.

3. That on December 16, 1975, Mr. Khan stated that West Lawn Medical Laboratory would not charge our medical clinic for the tests done on private patients if we got five (5) to ten (10) public aid patients a day. He also stated that if our clinic received a volume of between 15–20 patients a day, West Lawn would charge us the minimum on lab tests.

4. That on December 16, 1975, Mr. Khan stated the prices on West Lawn's medical testing price list were negotiable, but he would have to talk with the doctors. If the doctors could guarantee the private and medicaid business, prices of lab testing could be negotiated.

5. That on December 16, 1975, Mr. Khan stated that business between our medical clinic and West Lawn would not be arranged by contract; rates would all be verbal.

6. That on December 16, 1975, Mr. Khan stated West Lawn would sublease space in our clinic for a technician to draw the blood and West Lawn would pay

us for this space. The amount of rent West Lawn would pay us would be based on volume.

7. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 13th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 16, 1975, at 2 p.m. at 1520 West Morse, Chicago, Ill., I was present when a man entered the premises. His business card identified him as Mr. James Robinson from Chicago Medical Laboratories.

3. That on December 16, 1975, Mr. Robinson said, "We make arrangements in terms of rent." Mr. Robinson stated the lab could lease space in our clinic. Douglas Longhini asked Mr. Robinson if our clinic would sign a sublease with Chicago Medical, and Mr. Robinson said, "I wouldn't worry much about leases until we get started." "Leases are only if you have a good thing going." Mr. Robinson stated the clinic could expect a check back, and put it toward rent. Mr. Robinson said, "Rent is adjusted to whatever volume is."

4. That on December 16, 1975, Mr. Robinson stated Chicago Medical Labs could give back to the clinic a percentage based on a fixed figure and if the volume of medical tests rose the percentage would be adjusted substantially. Mr. Robinson said, "I can give you service in terms of percentage." Mr. Robinson said, "I can't deal without a fixed percentage," and stated the percentage is higher on private patients, two times as much. He also stated that if Chicago Medical got an SMA–12 and a urinalysis from the clinic, which would amount to $20, then the clinic would get back 40 percent of that figure (this being on private patients).

5. That on December 16, 1975, Mr. Robinson stated it would be to our advantage to let Chicago Medical license the clinic, that way we can get a tax writeoff. Chicago Medical does this for large facilities.

6. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 13th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 16, 1975, at 3:05 p.m., I was present at 1520 West Morse, Chicago, Ill., when a man entered the premises. He identified himself as Dr. Charlip from General Medical Laboratories, Ltd.

3. That Dr. Charlip stated General Medical had two separate price lists; one for private patients, the other for medicare and medicaid patients, the latter two paying a higher amount of money. Dr. Charlip said he would send us the two price lists.

4. That on December 16, 1975, Dr. Charlip said when the physician is billing his patients, "There are a lot of tricks so you can get the full benefit, so when you need it, let me know." Dr. Charlip stated there are codes that will get the clinic $8–$25.

5. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 17, 1975, at 10:50 a.m., I was present at 1520 West Morse, Chicago, Ill., when a man entered the premises. He identified himself as Mr. Simos, manager of Hilltop Labs, but was representing himself for Claremont Laboratories, a lab that he was going to open soon.

3. That on December 17, 1975, Mr. Simos said, "If you have good volume you will get very good rent from us. We have to make it look like rent. Which is a way to say thank you. We are renting the availability of business within the premises and that is legal." Mr. Simos stated the rent his lab would pay the clinic is based upon volume.

4. That on December 17, 1975, Mr. Simos stated that his lab will give the clinic a discount of up to 40 percent but it is up to the clinic to draw the blood. No technician is provided to draw the blood if the clinic gets a 40 percent discount. Mr. Simos said, "The lab will give you a discount on lab prices if you want to collect the money yourself. You can get a discount on private patients."

5. That on December 17, 1975, Mr. Simos stated after 1 to 2 months the lab would evaluate our volume and if it increases the amount of discount will increase, but the discount is not to exceed 30 percent of the volume. Mr. Simos said, "I can give you up to 50 percent but auditors can check up on it."

6. That on December 17, 1975, Mr. Simos stated if the clinic received 30 patients the clinic could get $500 toward rent plus salary of the blood drawer. The lab must have a sublease, but the lab will not need that space. Mr. Simos said, "As soon as they [auditors] see the rental agreement they will stop talking to the doctor." There is an "open lease that we could negotiate and renew tomorrow."

7. That on December 17, 1975, Mr. Simos stated he could provide the clinic with a pharmacy, but it would be more profitable for the clinic to have their own pharmacy set up.

8. That Mr. Simos stated that if the clinic received 30 patients the lab would provide a technician to draw the blood; and if the clinic receives under 30 patients the clinic must draw the blood themselves.

9. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 13th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 17, 1975, at 10 a.m., I was present at 1520 West Morse, Chicago, Ill., when a man entered the premises. His business card identified him as Joselito C. Espino, president of D. J. Medical Laboratory, Inc.

3. That on December 17, 1975, Mr. Espino stated D. J. Labs has two (2) separate price lists for their medical testing; one for private, the other for public aid. Following is the list of prices Mr. Espino stated to Douglas Longhini and myself:

Test	Prices charged for private	Prices charged for State
SMA-12	$3.50	$15.00
CBC	2.50	6.00
Urinalysis	1.50	3.00
VDRL	3.00	(1)
ABO	1.50	3.50
Rh	1.50	3.50
Glucose	2.50	5.00
Pap smear	4.00	10.00
All cultures	5.00	10.00
G.P. smear	1.50	3.00
TEC	1.50	3.00
Stool O/P	1.50	3.00
TIBC	3.00	7.00
T-3	6.00	12.00
T-4	6.00	12.00
PBI[2]		
Na	2.00	3.00
K	2.00	3.00
Creatinine	3.00	7.00
ASO	2.00	5.00
Pregnancy	3.00	8.00
ANA	6.00	12.00
SGPT	2.50	5.00
Floculation	2.50	5.00
Thymol	2.50	5.00
Latex	2.00	5.00
CRP	2.00	5.00
Ekg	6.00	12.00

[1] No payment.
[2] D.J. does not take these tests, they send to Mason and Baron.

4. That on December 17, 1975, when asked by Doug Longhini if our clinic could get into trouble because of the low prices charged for private patients as compared to public aid, Mr. Espino stated the clinic would not get into trouble because none of these prices are written down, they are all verbal.

5. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 13th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 18, 1975, at approximately 11:15 a.m., Douglas Longhini and myself entered the Ridgeland Medical Laboratories, which are located on the 2d floor at 101 Madison Street, Oak Park, Ill. The man who met us introduced himself as Mr. Villanueva, the owner of Ridgeland.

3. That on December 18, 1975, Villanueva said, "If it warrants we rent a room from you and place a girl there to draw the blood." Villanueva stated that Ridgeland will evaluate the lease every 6 months to a year, to see what the volume is. If the volume increases then a new lease is drawn up and the amount of rent increases. Villanueva stated that if the volume warrants we could be getting more than what we pay for the whole rent. If the volume goes up 10 times, the rent could go up 10 times. Villanueva stated there is no ceiling on the amount of rent the clinic can charge the lab. Villanueva said, "I don't

have to know how much rent you are paying." Our clinic would charge the lab a base rent for a certain amount of square feet of space. If the volume goes up the clinic can increase rent, but the amount of square feet of space does not increase. Villanueva stated his lab would only need to rent from the clinic just a couple square feet of space, just enough for the girl to be able to draw the blood.

4. That on December 18, 1975, Villanueva stated the technician will not be drawing blood the whole 8 hours she is at our clinic. She may spend 30 percent of her time drawing blood and the other 70 percent helping out secretarially with filing, etc. Ridgeland would pay 50 percent of her salary and the clinic would pay the other 50 percent of her salary, even though she might work 30 percent drawing blood and 70 percent doing secretarial work.

5. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 23, 1975, at 12:10 p.m., I was present at 1520 West Morse, Chicago, Ill., when a man entered these premises. He identified himself at Mr. LaPena from Northside Clinical Lab.

3. That on December 23, 1975, Mr. LaPena stated he had a special price list of medical tests for private patients. For example, for an SMA–12 the State would pay $15, but for private an SMA–12 would be $4.50. Mr. LaPena stated if the clinic's public aid patients comprised 80–90 percent of entire volume, Northside would not charge for private patients. LaPena said Northside charges "50 percent less for private patients on all tests."

4. That on December 23, 1975, Mr. LaPena stated the percentage paid back to the clinic by Northside is up to the clinic. Anything the clinic has in mind Northside will compromise. Northside will give the clinic a percentage of the volume or a flat fee.

5. That on December 23, 1975, Doug Longhini asked how the lab will work the arrangement stated in (4) above. LaPena stated that some medical clinics have a flat fee of $600 and some get back a percentage on total volume of both public aid and private. The clinic totals up its gross for the day, then multiplies that by 45 percent, and this is applied to the rent. For one week if the clinic grosses more than $1,000, the clinic gets back 50 percent. Doug asked, "How is it paid back?" LaPena replied, "Every Tuesday I will be ready with a check." Doug asked, "For rental of space?" LaPena said, "Yes." Doug asked LaPena, "Will you be using that footage?" LaPena answered, "No. All we need is a blood machine and a chair. If you have EKG machine, then we wlil need a room."

6. That on December 23, 1975, LaPena stated if the lab provides a blood technician then his salary will be taken out of the 45 percent given back to the clinic.

7. That on December 23, 1975, Doug asked LaPena if there would be a sublease written up. LaPena stated it would be up to the clinic, whatever the clinic would want. LaPena said, "I don't know how legal it is, but rental agreement could say that we are giving you back 45 percent." LaPena stated any surplus over the $1,200 gross, the lab would apply to paying clinic's secretary and telephone bill, etc.

8. That on December 23, 1975, Doug asked LaPena if the clinic's volume was high enough will the clinic get a $600 flat fee back. LaPena stated that if the clinic had at least eight patients a day for tests to equal $1,200 in lab fees for a week, then yes we would get a $600 flat fee back.

9. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 23, 1975, at 9:45 a.m., I was present at 1520 West Morse when a woman entered the premises. She identified herself as Judy Pedgrift from United Medical Laboratory.

3. That on December 23, 1975, Ms. Pedgrift stated United charges $15 for an SMA–12 test downtown for public aid. In the suburbs United bills the patients $10, because the patients in the suburbs cannot afford the $15.

4. That when Douglas Longhini asked Ms. Pedgrift if the prices for lab tests would remain the same despite the volume, she replied, "Yes."

5. That on December 23, 1975, Ms. Pedgrift said, "On public aid we pay back rent to cover your expenses." Ms. Pedgrift stated that with private patients, if the clinic bills the patients, the clinic pays the price indicated on the list and the clinic charges the patients whatever it wants. Ms. Pedgrift stated that United Labs would help the clinic cover its rent and equipment expenditures, the rent for room and technician. She said, "We'll work out an equitable rent situation with you."

6. That on December 23, 1975, Doug asked Ms. Pedgrift if the clinic would have an actual sublease. Ms. Pedgrift stated that United Labs would have to get an idea of the clinic's volume and then figure the monthly rent. Usually United does not give a first month's rent because they want to get an idea of the clinic's volume first. Ms. Pedgrift stated that all the clinic's expenses must be paid. Some clinics ask for 60 percent of their volume to be paid back by the lab, some ask 40–50 percent. Ms Pedgrift said, "How can we make any money? We would rather work out something fair to both parties.

7. That on December 23, 1975, Doug asked Ms. Pedgrift if the percentage was based on volume. Ms. Pedgrift stated that some clinics pay a straight rent of $800 and the lab absorbs that $800.

8. That on December 23, 1975, Doug asked Ms. Pedgrift how often the rent was reevaluated Ms. Pedgrift stated that for flat rent United constantly evaluates the rent. When some clinic's volume goes down, United calls them up and tells them they had better get their volume up again to where it was. Doug asked Ms. Pedgrift if United would lower the rent paid back if the clinic's volume were to go down. Ms. Pedgrift stated that if the volume of the clinic is constantly low, then the clinic takes a cut in rent. Doug asked Ms. Pedgrift that if the volume of the clinic were to go up would United reevaluate the rent, and Ms. Pedgrift replied, "Yes."

9. That on December 23, 1975, Doug asked Ms. Pedgrift if United would provide the clinic with a lab technician. Ms. Pedgrift stated that the clinic would have to find their own technician for that area. United has to pay $600 a month for the technician's salary.

10. That Doug asked Ms. Pedgrift if United actually looked at volume and took a percentage of that, and Ms. Pedgrift said, "Right."

11. That Doug asked Ms. Pedgrift if the clinic would have a legal lease and she answered, "That can be done."

12. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on December 23, 1975, at approximately 1 p.m., I was present at 1520 West Morse, Chicago, Ill., when a man entered the above-stated premises and identified himself as Mr. Paradise from Norsom Medical Reference Laboratories, Inc.

3. That on December 23, 1975, Mr. Paradise stated that Norsom had reference fees that they would charge the clinic, and the doctors could set their own fee of what they would want to charge. Paradise stated that for a chemistry profile test Norsom would charge us $4.80 (reference fee) and public aid allows $15. The only time Norsom would not charge us $4.80 is when they take care of the billing on public aid patients. On a glucose test Norsom would charge the clinic $2.40, public aid pays $6–$8.

4. That on December 23, 1975, Mr. Paradise stated Norsom could provide Ph. D. consultation services for the doctors.

5. That the above statements were made in the presence of Douglas Longhini and myself.

GERALYN DELANEY.

Subscribed and sworn to before me this 5th day of February, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on January 6, 1976, at approximately 4:25 p.m., I was present at 1520 West Morse, Chicago, Ill., along with Douglas Longhini and Patrick Riordan, investigators for the Better Government, when Bill Footlick and Felix Salamanca, both from Division Medical Laboratory, entered the above-stated premises.

3. That on January 6, 1976, the following conversation took place:

Footlick stated Division was the largest Public Aid lab in the State. "If we charge private patients less than the State, then we lose the privilege of dealing with the State. We charge private the same as the State. You can charge more if you want," said Footlick.

Doug asked what the arrangements were.

Footlick: ". . . percentage of the volume of business in dealing with public aid. Our lab is in good standing with the State. We do a legitimate business. We pay a flat rental and determine that rental on the first month's volume." Rental "must stay as fixed amount but rent is reviewed every 3–4 months."

Riordan asked what percentage Footlick was talking about.

Footlick: "Depends on volume. It ranges between 25–30 percent. Any lab that talks more than that is only kidding you. The lab cannot afford more than that for rental."

Doug asked if Division makes an estimate during first month based on volume, somewhere between 25–30 percent. Is rent evaluated every 3–4 months and does it depend on the volume.

Footlick: "Not drastically and not on a constant basis; on a long period of time because again we don't want a part of percentages."

Doug asked if this arrangement is just between Division and the clinic.

Footlick: "I am able to be looked at. What we discuss here . . . by FBI. This is not frowned upon. It is a percentage as starting base."

Footlick stated that the lab gets business by (1) physician requesting lab work, (2) public aid or private patients call Medi-Car and are transported to the lab which is very expensive for the State, and (3) by having a station within the clinic where the blood can be drawn which substantiates the rental payment which is based more on the amount of people than business. Sending 20 people by Medi-Car costs the State more than rental they could work out with clinic, Footlick rationalized.

Doug asked Footlick how many square feet the lab would need to draw the blood.

Footlick: "A blood drawer, chair and cabinet."

Doug stated the clinic's rental is $450 a month. If the clinic's business is brisk in the beginning the clinic could get that $450 back in rent.

Footlick: "Oh sure, $5,000–$6,000 a month."

Doug asked if the clinic would get $5,000–$6,000 a month for rent.

Footlick: "Sure. . . . volume of people."

Doug asked if the clinic would sign a lease.

Footlick: "Sure. . . . wouldn't be able to refer to rent until we look at volume. We would have to renegotiate the lease."

Riordan asked if the clinic's rent would change four times a year.

Footlick: "I don't think it would be fair to do once or twice and get good idea of volume."

Riordan asked if Division provides a technician to draw the blood.

Footlick: "Depends on volume."

Doug asked Footlick if the clinic gets a rebate off of the volume.

Footlick: "A rose, is a rose, is a rose. I look at it as a rental."

Doug asked if the clinic was safe from the FBI.

Footlick: "FBI frowns upon an incentive for the doctor to draw in a lot of . . . on kickback system. . . . I justify it would cost more to bring these patients to the lab than if I were to do the work here."

Riordan asked Footlick how much he is saving the State by giving us rent, instead of having the patients brought to the lab.

Footlick: "On Medi-Car . . . would be somewhere around $4,000–$5,000. . . . charge $25–$50" for one trip to lab in the Medi-Car.

4. That at this point, Mike Wallace entered and stated that the remainder of this conversation was being recorded for broadcast.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary and have been employed there since April 1, 1974.

2. That on January 6, 1976. at approximately 3:25 p.m., I was present at 1520 West Morse, Chicago, Ill., along with Douglas Longhini and Patrick Riordan, investigators for the Better Government Association, when Harry Keshian from United Medical Laboratory entered the above-stated premises.

3. That on January 6, 1976, the following conversation took place:

Doug asked Keshian how much he would charge here for an SMA.

Keshian: "We charge 50 percent."

Riordan asked if this was across the board.

Keshian: "Yes."

Doug asked if the clinic could charge 50 percent of what the public aid schedule is.

Keshian: "Yes. I have to charge same prices downtown. You are charging patients directly here."

Riordan asked if United would do the billing.

Keshian: "Yes. We keep record and receipt book."

Doug asked if United would give the clinic back 50 percent.

Keshian: "Yes."

Doug asked if the clinic gets a rebate for all public aid.
Keshian: "Yes."
Doug asked if this would be in the form of rent.
Keshian: "Yes. We give to factoring agency . . . they charge 8–9 percent interest."
Doug asked if 50 percent was left from the factoring company.
Keshian: "Yes."
Doug asked how payment is arranged.
Keshian: "Pay you in advance and readjust at the end of the month."
Doug asked if the payment was in the form of a check.
Keshian: "Yes, of course."
Riordan asked Keshian if at the end of the month the clinic gets back 50 percent of the gross volume.
Keshian: "Yes."
Riordan asked if there would be any problem if the rent check fluctuates up and down.
Keshian: "I would rather keep it the same, steady; it looks better in the books."
Keshian was asked if the clinic is getting 50 percent back.
Keshian: "We bill you the prices given to you."
Keshian: "We charge you one price and the doctor bills what he wants."
Doug asked Keshian if the volume goes up would United re-evaluate the rent.
Keshian: "We do not reevaluate the rent."
Doug asked if some doctors ask for up to 60 percent back.
Keshian: "That is right."
4. That at this point, Mike Wallace entered and stated the rest of the conversation was being recorded for broadcast.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:
1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.
2. That on January 6, 1976, at approximately 2:05 p.m., I was present at 1520 West Morse, Chicago, Ill., along with Douglas Longhini and Patrick Riordan, investigators for the Better Government Association, when Joe Espino from D. J. Medical Laboratory entered the above-stated premises.
3. That on January 6, 1976, the following conversation took place:
Doug asked if D.J.'s prices for private patients are competitive.
Espino restated the prices for private as being $3.50 for an SMA–12 with the State paying $15; $2.50 for CBC with State paying $6; $4 for pap smear with State paying $10; $6 for EKG with State paying $12.
Riordan asked if a discount would be applied, and if there would be a limit on private patients.
Espino: "I am basing this when medical center is working full time. As far as prices are concerned the number of patients doesn't matter. If you have 1 or 100 a day prices will be the same. Mason and Baron will charge $5.50 for an SMA–12. When you increase volume, prices will not vary."
Riordan asked Espino if his lab was offering a 50 percent discount for private patients.
Espino: "Right."
Dough asked Espino if these prices are legal, since they are not written down. Are there any problems with this.
Espino: "There is nothing we can do about it. It is illegal for us to publish different private prices."
Riordan asked if he would lose his license; if this is illegal for the doctor.
Espino: "I don't know."

Riordan asked Espino if what he was doing is illegal.
Espino: "Right."
Doug asked Espino if he had any problems in the past with prices; has there been any auditing.
Espino: "I was asked by them how much I charged for patients. For quite some time I know whatever we charge for private we are supposed to charge for public aid."
Doug asked if the charge for private should be the same as charged for the State.
Espino: "Yes."
Riordan asked if the auditors would get after him for the different prices.
Espino: "I don't think so. In the first place—I do not know, I cannot answer your question."
Riordan asked if the clinic would get a 50 percent discount on private patients.
Espino: "Right."
Doug asked if we get a 25 percent rebate.
Espino: "Yes."
Doug asked how this rebate is paid.
Espino: "A check."
Doug asked if the check is sent in the mail.
Espino: "Right."
4. That at this point Mike Wallace entered and stated that the remainder of this conversation was being recorded for broadcast.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:
1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.
2. That on January 6, 1976, at 10:55 a.m., I was present at 1520 West Morse, Chicago, Ill., along with Douglas Longhini and Patrick Riordan, investigators for the Better Government Association, when Mr. Simos, representing Claremont Laboratories, entered the above-stated premises.
3. That on January 6, 1976, the following conversation took place:
Doug asked Simos to explain about the technician.
Simos: "As I explained there are changes . . . I got in touch with my lawyer and . . . they printed in the paper where someplaces small space is rented for $500 in different areas. According to the paper, one lab, not mine, is being sued. Might be changes here. Alternative is to give flat rate and not go up and down. What we would like to avoid is making it look like a kickback to you."
Riordan asked if the payment will look like kickback.
Simos: "We have to set up fixed payment . . . $200 a month on one room here to be used. Drawing room and EKG room."
Riordan asked Simos if he is proposing $200 a month.
Simos: "We gage amount of rent in this . . . center . . . we should agree on how much rent in one space and provide you with technician."
Doug asked if the rent is reevaluated.
Simos: "Yes. Based on volume."
Doug asked if the rent is changed once or twice a year.
Simos: "Raise rent? Fine."
Doug stated then that if the clinic has 30 patients a day, we can have a sublease and get between $500 and $700 a month. Can we still be getting that amount of money for a small amount of square footage being used in this clinic.
Simos: "Yes."

Riordan asked if the clinic can get $200.

Simos: "That was an example figure. We can vary from $200, $500, $600. . . ."

Riordan asked if Simos was proposing this to look like rent.

Doug asked Simos if the rent is a rebate on the volume.

Simos: "Yes. Have to base it if getting good volume . . . fine with me."

Doug asked if the clinic can charge $1,000 for footage.

Simos: "Yes. If you have business and I am making money out of it."

Doug asked Simos if he was changing his business style with his other clinics, too.

Simos: "I have started calling them up and telling them the problem . . . we fix rent looking at volume . . . it has to be fixed to look like rent."

Riordan asked if the authorities could go through the bills and find something.

Simos: "They don't do that very often, and once public aid gets on you and makes audit of operation. . . ."

Riordan asked if public aid, FBI, etc., have audited Simos' lab.

Simos: "Not my lab . . . your expenses are first thing they look at."

Doug asked if Simos was being audited now.

Simos: "I would like to get ahead of them."

Doug asked if Simos' lab had been audited yet.

Simos: "No, not yet."

Riordan asked if the clinic has 70–80 percent public aid would we be charged for private patients.

Simos: "They will be charged same as public aid. If you order five tests we want to take it easy on private patients. We just charge them for two tests. Most of . . . patient charges not collected on insurance and doctor wants lab tests and test becomes useless and doctor does test all over in hospital."

Riordan asked Simos if the clinic gets a break on private patients.

Simos: "Yes."

Doug asked Simos if he would be using much footage in the clinic.

Simos: "Not necessarily."

4. That at this point Mike Wallace entered and stated that the rest of this conversation was being recorded for broadcast.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

STATE OF ILLINOIS,
County of Cook, ss:

AFFIDAVIT

I, Geralyn Delaney, being first duly sworn, do state under oath that the following is true to the best of my knowledge:

1. That I am employed by the Better Government Association, 360 North Michigan, Suite 1118, Chicago, Ill., as a secretary, and have been employed there since April 1, 1974.

2. That on January 6, 1976, at approximately 9:40 a.m., I was present at 1520 West Morse, Chicago, Ill., along with Douglas Longhini, investigator for the Better Government Association, and Patrick Riordan, investigator for the Better Government Association office in Springfield, Ill., when Nemie LaPena and Bill Minor, business manager, both owners of Northside Clinical Laboratory, entered the above-stated premises.

3. That on January 6, 1976, the following conversation took place:

Longhini asked LaPena or Minor to explain how the daily lab sheet functions?

Minor: "Each patient has a test . . . will put patient's name on what kind of panel ordered and check it. The log sheet comes in with blood specimen daily. You make a copy of the daily log sheet and figure how much you have coming by check on the daily log sheet . . . and we can calculate the percentage by the sheet and that is your percentage."

LaPena: ". . . 45 percent we provide you everything, lab test tubes, EKG and from that we give you 45 percent of gross billing. If you have 10–20 percent private we do not charge for private."

Riordan asked then that as he understood it, we put a check mark by the patient's name and add up and take 45 percent of gross and that is what the clinic gets back.

LaPena: "If gross volume is $1,000, then we give you 45 percent of gross billing."

Riordan asked how the payment is made.

Minor: "By check only."

Riordan asked if the payment was weekly.

Minor: "Every Tuesday."

Longhini asked how the check is delivered.

Minor: "Check is delivered on every Tuesday . . . put attention on envelope to person. . . ."

Doug asked if the clinic signs a lease for a certain amount of footage.

Minor: "Much . . . to do that in that manner . . . we justify so no one can question anything."

Riordan asked if a signed lease protects us all?

Minor: "Right."

Doug asked how rent is established?

Minor: "What you do is set price for rent then we are allowed to give gratuitous for drawing of specimen. If you have girl and draw blood for yourself we will pay her salary."

Doug asked if the lab would take up much space in the clinic.

Minor: "Just one small room would be more than sufficient."

LaPena: "Without EKG even hallway would be sufficient."

Riordan asked if the clinic could possibly receive $500 a week for space in the hallway.

Minor: "Right."

Doug stated that the clinic's rent is now $450 a month, and if the clinic grosses $500 a week. . . .

Minor: "You're privileged to charge anything you see fit in this facility. No one can tell you how much to charge."

Riordan stated that we are qualified medical people in this business; have you researched carefully and is there any difficulty in this arrangement.

Minor: "We have been in business 3½ years and haven't had any difficulty. The facilities we deal with are . . . pleased after service. We haven't had any difficulty."

Riordan asked from a tax standpoint can the clinic charge this kickback to business income.

Minor: "Business income? Sure."

Doug asked if this is a rebate.

Minor: "Right."

Doug asked based on volume of business we refer patients to your medical testing lab . . .

Riordan asked that if volume increases will the amount of space increase.

Minor: "No."

LaPena: "Not unless . . . CBC, then we require space. Only possibility requiring more space."

4. That at this point Mike Wallace entered and stated that the rest of the conversation was being recorded for broadcast.

GERALYN DELANEY.

Subscribed and sworn to before me this 20th day of January, 1976. Robert C. Howard, notary public.

AFFIDAVIT OF WILLIAM R. HOOD, INVESTIGATOR, BETTER GOVERNMENT ASSOCIATION

West Lawn Medical Laboratories, 4255 W. 63d St., Chicago

Upon the invitation of Dr. Herbert Meyer, I was present in his professional office at 3430 S. Martin Luther King, Jr., Drive during the afternoon of October 20, 1975. Acting as Dr. Meyer's attorney, I was party to a conversation between him and the president and a salesman for West Lawn Medical Laboratory. The conversation among the four of us lasted from approximately 2:30 p.m. to a little after 3 p.m. I had never seen either of the two men from the medical lab before that day.

Dr. Meyer had been visited by the salesman, Riaz Khan, on several occasions prior. This was the first meeting between Dr. Meyer and Dharat Trivedi, the head of West Lawn. Khan had brought Trivedi around because he wanted to

close a deal with Dr. Meyer whereby the doctor would use West Lawn exclusively for his medical testing.

I was introduced as a replacement for Dr. Meyer's regular attorney, Mel Lewis, who was out of town. Dr. Meyer explained that he had had some trouble in the past and wanted to clear the "arrangement" that was being proposed to avoid any legal or tax problems later.

The arrangement would allow the doctor to get back from the lab 25 to 30 percent of the gross monthly medicaid billings he sent to the lab.

The lab would pay the money back by one of several modes. Trivedi said that some doctors he dealt with leased him a portion of their office space. Others let Trivedi pay all or part of the salary of one of the doctor's regular office personnel. A third suggestion would have the lab lease an office machine or refrigerator from the doctor. The amount paid to the doctor would reflect the amount billed by the doctor for the first 90 days after a verbal agreement was reached.

Trivedi was firm that he would not deal in cash and that he had had people, presumably lawyers, advise him on the setup. He said that most doctors simply leased him space using a standard real estate lease with 30-day cancellation rights on both sides. He also referred to it as a "sublease."

Dharat did say, "I don't want to do anything legally detrimental to either of us." But, he also did not "want too much in written form" except the lease.

Trivedi was interested to know that Meyers presently got nothing back from the lab where he sent work and that Meyers did not use a factoring firm. He got off the point to offer to set Meyers up with his factor. He went through the standard routine how factors got money for you within days. He uses a subsidiary of Main Bank called Health Management Corp. and touted their efficiency. He also referred to a new computerized billing system that had been put in which would speed up payments for the doctor. He added that his factor charged 10 percent but that it was worth it because the State was about 4 months behind on paying labs. He then threw out the suggestion that perhaps they could pay Meyer's factoring charges as their compensation to him.

I asked a question about quality and reputation of West Lawn. Trivedi responded that he was licensed, used to be a pathologist at Mt. Sinai Hospital, and had bought West Lawn recently. The quality and patient benefit seemed secondary to his main pitch—that the doctor would get substantial money back.

Throughout the conversation, the two lab reps reassured Dr. Meyer and me that the proposed arrangement was quite normal and that no one ever questioned it. They proposed issuing checks to the Doctor's professional corporation for the monthly lease amount or to pay the selected employee. It was made clear that no other doctor had ever brought an attorney along to approve the practice.

They claimed that Internal Revenue would be satisfied by the arrangement because they could legitimately claim that the leased space was used to store patient samples waiting for pickup by the law couriers. Alternatively, they said the space could be the area where blood samples were taken; or that samples were stored in a leased refrigerator; or that the employee followed a set of printed instructions provided by the lab for dealing with samples and specimens—said instructions also mandating that the employee assist the doctor in his regular duties unrelated to testing.

Trivedi concluded that: "My personal feeling is that the best way is for us to pay you some rent or pay an employee. It works simplest that way."

I followed Khan and Trivedi outside Meyer's building and talked briefly with them there. They both expressed amazement that Meyers had any doubts about the system they proposed. They said he was the first doctor who had ever raised any legal questions to them. "After all, we are just being fair and sharing our profit with him," said Trivedi.

Appendix 3

LETTERS FROM INDIVIDUALS

ITEM 1. LETTER FROM DR. DENNIS B. DORSEY, PRESIDENT, COLLEGE OF AMERICAN PATHOLOGISTS; TO SENATOR FRANK E. MOSS, DATED FEBRUARY 27, 1976

DEAR MR. CHAIRMAN: The College of American Pathologists is a private nonprofit professional organization, headquartered in Skokie, Ill., and represents some 6,400 physicians, who practice in the specialty of pathology. Our members practice in the hospital setting, in medical schools, in independent medical laboratories, in the various military branches and in the Federal Government.

The College of American Pathologists would like to take this opportunity to express its abhorrence to the illegal practices, including kickbacks, involving the medicare and medicaid programs which were disclosed by your subcommittee during public hearings held February 16, 1976. The College views such practices with great alarm and we wish to state emphatically that the College does not condone in any manner such illegal and unethical practices.

During the February 16 public hearings there was testimony presented which indicated certain medical laboratories were involved in kickback schemes with certain physicians. The names of the individuals involved were not disclosed during the hearings. We would like to request a list of the physicians involved in such practices so the College may have such information to determine if any of those physicians are members of the College and to consider possible action in accordance with our bylaws. Your assistance and cooperation would be appreciated very much.

The College again wishes to commend you for your efforts to root out fraud and abuse where it may exist in the medicare and medicaid programs.

Sincerely,

DENNIS B. DORSEY, M.D.

ITEM 2. LETTER AND ENCLOSURE FROM GERALD J. REILLY, DIRECTOR, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, NEW JERSEY DEPARTMENT OF INSTITUTIONS AND AGENCIES; TO VAL HALAMANDARIS, ASSOCIATE COUNSEL, SENATE SPECIAL COMMITTEE ON AGING, DATED MARCH 17, 1976

DEAR MR. HALAMANDARIS: Pursuant to your conversation with Andrew L. Rothman, press secretary to Senator Harrison A. Williams, Jr., and Mr. Rothman's letter of February 25, 1976, please find enclosed herein my statement for inclusion in the record of hearings before the Senate Committee on Aging chaired by Senator Moss.

Thank you for the opportunity of allowing New Jersey to supplement the record which, we feel, does not accurately reflect the state of affairs in the New Jersey medicaid program.

Sincerely yours,

GERALD J. REILLY.

[Enclosure]

STATEMENT

New Jersey has been an innovative leader in the area of investigating, uncovering, and correcting fraud and abuse patterns of clinical laboratories participating in the New Jersey medicaid program. Commencing more than 1 year ago, the Division of Medical Assistance and Health Services, in cooperation with the State Commission of Investigations (SCI) and the State Department of Health, began a probe of New Jersey clinical laboratories participating in its medicaid program. The probe culminated in public hearings on June 24, 25, and 26, 1975.

As a direct result of New Jersey's efforts, five clinical laboratories were suspended from the medicaid program and appropriate cases were referred to the Attorney General's Office for possible criminal prosecution.

Significant modifications were made to medicaid regulations governing clinical laboratories, which include: (1) The express prohibition of rebates or kickbacks of whatever nature; (2) the prohibition against multiple billing for automated testing procedures, e.g., the SMA–12; (3) the limitation that medicaid reimbursement shall be limited to the lowest charge made by a referred laboratory to the referring laboratory or physician; (4) the requirement that all claims be itemized; (5) that all claims indicate whether a specimen was referred to another laboratory, the name of the other laboratory, and the charge for the service by said laboratory.

Over $350,000 was withheld from payment to laboratories which, in the opinion of the division, were engaged in abusive practices.

Laboratory fees were reduced by 40 percent.

A laboratory committee consisting of knowledgeable persons throughout the State was convened to revise laboratory procedure codes and reimbursement.

Laboratory claims processing staff attended special seminars conducted by a medical doctor for the purpose of reviewing both the technical as well as medical aspects of the laboratory claims processing procedure.

A computerized system is currently being developed for the purpose of analyzing and screening group tests, and should be operational in the near future.

An analysis of laboratory billing was recently conducted and claims were compared for an 8-month period prior to June 1975 (SCI public hearings) with claims submitted for an 8-month period subsequent to June 1975. For the period October 1974 through May 1975, a monthly average of 17,966 claims were submitted at an average payment per claim of $15.52. For the period June 1975 through January 1976, a monthly average of 16,915 claims were submitted at an average payment per claim of $8.27. The total volume of claims for the pre-June 1975 period, as compared to the post-June 1975 period, showed a 5.8-percent decrease in total volume. Payment per claim decreased 46.7 percent. When these figures are annualized for calendar year 1976, a $1,400,000 savings is projected. The modest 5.8-percent decrease in claims volume suggests that essential services are being provided despite a substantial fee reduction. Part of the 5.8 percent could also be attributed to the elimination of some overutilization that may have existed. Considering the fact that fees were reduced by 40 percent, a 46.7-percent decrease in the payments would suggest that the above-stated program modifications together with the deterrent effect of the SCI hearings resulted in a significant 6.7-percent decrease in payments.

For the reasons above stated, it is obvious that we in New Jersey find it disturbing to be lumped together with States where serious and widespread abuses allegedly still exist. Consequently, we ask that the record be made clear that the subcommittee investigators did not uncover a "continuing" and abusive situation in New Jersey. The fact is, our work in this area had been substantially completed at a time when many other States had just begun their efforts.

ITEM 3. LETTER AND ENCLOSURES FROM ANTHONY G. DICKSON, COUNSEL, COMMISSION OF INVESTIGATION, STATE OF NEW JERSEY; TO VAL HALAMANDARIS, ASSOCIATE COUNSEL, SENATE SPECIAL COMMITTEE ON AGING, DATED FEBRUARY 17, 1976

DEAR MR. HALAMANDARIS: I have had an opportunity to review pages 33 and 34 of the committee print of the staff report on fraud and abuses among clinical laboratories which was prepared for the Special Committee on Aging of the U.S. Senate. I am submitting some information and documents which you may want to consider in connection with statements appearing on these pages.

Document 1 consists of a letter to the *Newark Star Ledger* newspaper from Leon S. Wolk, attorney at law, concerning certain statements made by his client, Saul Fuchs, of Physicians Lab Service, Inc., during the public hearings held by the State Commission of Investigation on June 24, 1975. In it, Mr. Wolk contends that his client only remitted a 30 percent payment "for services" to the Chestnut Hill Convalescent Center. Document 2 consists of a letter dated July 3, 1975, which was directed to Mr. Joseph Rodriguez, chairman of the State Commission of Investigation, by Mr. Harvey Adelsberg, executive director of the Daughters of Miriam Center for the Aged, Clifton, N.J. Mr. Adelsberg contends that there was no type of rebate arrangement made with Mr. Fuchs. He claims

that the Daughters of Miriam Center for the Aged did not "get anything in return for the services Mr. Fuchs renders to our institution." Document 3 is a letter, dated July 22, 1975, addressed to the New Jersey State Commission of Investigation, by Kevin G. Conway, attorney for Hoffmann, La Roche, Inc., concerning the employment by Roche Clinical Laboratory of a phlebotomist on the premises of the Newark Family Health Center.

I would also indicate to you our understanding, which I believe is borne out by the public session testimony of Mr. Fuchs at page 148 through 152 that the gentleman involved in the ownership and management of the International Pharmacy was also involved in the ownership and management of the Park Medico Clinic which was located across the street from the pharmacy in Paterson, N.J. At least part of the moneys flowing from Physicians Laboratory Service, Inc. (Mr. Saul Fuchs) to International Drugs represented payment in connection with the referral of specimens from Park Medico to Physicians Laboratory Service, Inc.

I would like to compliment you and your staff on the fine investigative efforts in the clinical laboratory field. The State Commission of Investigation was happy to be of assistance to you. As you know, we have not yet issued a final report on the New Jersey medicaid program. If we can be of further assistance to you, please do not hesitate to contact us.

Thank you again for giving us the opportunity to appear before your special committee.

Very truly yours,

ANTHONY G. DICKSON, *Counsel.*

[Enclosures]

LAW OFFICES OF LEON S. WOLK,
Fort Lee, N.J., June 27, 1975.

S. I. NEWHOUSE, Publisher,
The Star-Ledger,
Star-Ledger Plaza,
Newark, N.J.

DEAR SIR: I represent Saul Fuchs and Physicians Lab Service, Inc. Mr. Fuchs testified at a public hearing of the State Crime Investigation Commission on June 24, 1975, which testimony was erroneously reported in the *Star-Ledger* by your reporter, Daniel Hayes, in the June 25, 1975, edition.

I am formally demanding the publication of a retraction and clarification of so much of that article as refers to Saul Fuchs' testimony. Mr. Fuchs' testimony, in general, was not accurately stated in the article and specifically he never testified to giving 30 percent of billings for services rendered to the following Nursing Homes: Daughters of Miriam and Hartwyck Nursing Home. Mr. Fuchs' testimony with reference to the 30 percent payment for services was limited to the Chestnut Hill Convalescent Center.

This demand for clarification and retraction is made on behalf of Saul Fuchs and Physicians Lab Service, Inc., as well as the aforesaid Nursing Homes.

Yours very truly,

LEON S. WOLK.

DOCUMENT 2

DAUGHTERS OF MIRIAM CENTER FOR THE AGED,
Clifton, N.J., July 3, 1975.

Mr. JOSEPH RODRIGUEZ,
Chairman, State Commission on Investigation,
28 West State St.,
Trenton, N.J.

DEAR MR. RODRIGUEZ: The testimony of Mr. Saul Fuchs, laboratory director of Physicians Laboratory Services, Passaic, has come to my attention through an article that appeared in the *Star-Ledger* on Wednesday, June 25, 1975.

In Mr. Fuchs' testimony to the commission on Tuesday, June 24, it is alleged that he stated that he did testing for nursing homes as well as doctors and that he billed them directly for medicaid work and "they got 30 percent."

Daughters of Miriam is one of the facilities to whom Mr. Fuchs provides services. As the executive director of the Daughters of Miriam, I would like to state that our records are open to inspection. We have never made any kind of arrangement with him. We will not be a party to any kind of rebate arrangement and we never have been. We do not get anything in return for the services Mr. Fuchs renders to our Institution.

The Daughters of Miriam is a nonprofit institution that has been in existence for over 54 years and we have always respected the requirements of regulatory agencies, including the regulations of medicare and medicaid.

Attached to this letter you will find a statement from Mr. Fuchs' attorney confirming the above.

I would greatly appreciate it if my letter and the attachment would be read into the official record of your commission.

May I hear from you? Thank you.

Yours sincerely,

HARVEY ADELSBERG, *Executive Director.*

DOCUMENT 3

HOFFMANN-LA ROCHE INC.
Nutley, N.J., July 22, 1975.

Re Investigation of New Jersey's Program of Medical Assistance and Health Services: Public Hearings 6/23/75–6/26/75.

NEW JERSEY STATE COMMISSION OF INVESTIGATION,
28 West State Street, Tenth Floor,
Trenton, N.J.

GENTLEMEN: On June 26, 1975, Mr. James Dimitrion, supervisor of the Fair Lawn Clinical Laboratory, appeared before you and testified that a female working at the Newark Family Health Center was affiliated with Roche Clinical Laboratories (3T31–3T32)*.

The management of Roche Clinical Laboratories has advised me that a Ms. Maria Ortiz was hired by Roche Clinical Laboratories on October 21, 1974. Ms. Ortiz was employed as a phlebotomist for the purpose of drawing blood and preparing patient specimens at the Newark Family Health Center for transmission to Roche Clinical Laboratories for testing and analysis. Ms. Ortiz's employment with Roche Clinical Laboratories and her assignment at the Newark Family Health Center were arranged by Mr. Robert Kupchak, a former Roche employee who was employed as the Sales Coordinator at Roche Clinical Laboratories during October of 1974.

Mr. Murray Blaivas, General Manager of the Roche Clinical Laboratories Division, first became aware of Ms. Ortiz's employment and assignment after Mr. Dimitrion testified on June 26, 1975. Mr. Blaivas reviewed this situation, determined that the amount of blood drawing and specimen collection being performed at this account did not warrant the assignment of a full-time phlebotomist and eliminated this position effective July 4, 1975.

The management of Roche Clinical Laboratories has advised me that no sum of money was ever rebated to the Newark Family Health Center and that no discounts were ever given to this medical group.

Mr. Blaivas and I would be pleased to meet with you at your convenience in the event you wish to discuss this matter further. As in the past, you may be assured of our continuing cooperation during the course of your investigation.

Kindest regards,

KEVIN G. CONWAY, *Attorney.*

*3T31–3T32—Transcript of public hearing of the State Commission of Investigation June 26, 1975, volume III, pages 31–32.

○

FUTURE DIRECTIONS IN SOCIAL SECURITY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 25—MEMPHIS, TENN.

Impact of High Cost of Living

FEBRUARY 13, 1976

Printed for the use of the Special Committee on Aging

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Future Directions in Social Security:

Part 1. Washington, D.C., January 15, 1973.
Part 2. Washington, D.C., January 22, 1973.
Part 3. Washington, D.C., January 23, 1973.
Part 4. Washington, D.C., July 25, 1973.
Part 5. Washington, D.C., July 26, 1973.
Part 6. Twin Falls, Idaho, May 16, 1974.
Part 7. Washington, D.C., July 15, 1974.
Part 8. Washington, D.C., July 16, 1974.
Part 9. Washington, D.C., March 18, 1975.
Part 10. Washington, D.C., March 19, 1975.
Part 11. Washington, D.C., March 20, 1975.
Part 12. Washington, D.C., May 1, 1975.
Part 13. San Francisco, Calif., May 15, 1975.
Part 14. Los Angeles, Calif., May 16, 1975.
Part 15. Des Moines, Iowa, May 19, 1975.
Part 16. Newark, N.J., June 30, 1975.
Part 17. Toms River, N.J., September 8, 1975.
Part 18. Washington, D.C., October 22, 1975.
Part 19. Washington, D.C., October 23, 1975.
Part 20. Portland, Oreg., November 24, 1975.
Part 21. Portland, Oreg., November 25, 1975.
Part 22. Nashville, Tenn., December 6, 1975.
Part 23. Boston, Mass., December 9, 1975.
Part 24. Providence, R.I., January 26, 1976.
Part 25. Memphis, Tenn., February 13, 1976.

(Additional hearings anticipated but not scheduled at time of this printing)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

FUTURE DIRECTIONS IN SOCIAL SECURITY

FRIDAY, FEBRUARY 13, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Memphis, Tenn.

The committee met, pursuant to notice, at 9 a.m., at 1188 North Parkway, Memphis, Tenn., Hon. Bill Brock, presiding.

Present: Senator Brock and Congressman Harold E. Ford.

Also present: William E. Oriol, staff director; John Guy Miller, minority staff director; Kathryn Dann, assistant chief clerk; and Alison Case, assistant clerk.

OPENING STATEMENT BY SENATOR BILL BROCK, PRESIDING

Senator BROCK. I wish you a good morning. Thank you all for coming.

I appreciate very much your being here this morning, and I particularly am pleased that our mayors, the Honorable Roy Nixon, mayor of Shelby County, the Honorable Wyeth Chandler, mayor of Memphis, and Richard Block, chairman of the board of the Josephine K. Lewis Center for Senior Citizens are all here. I appreciate very much their expression of interest.

The topic of our hearing is "Future Directions in Social Security." In particular, today we will focus on the issue of social security and inflation. We have selected this topic for two basic reasons.

First, inflation is without a doubt the cruelest and most difficult economic problem facing older Americans today. As the rate of inflation continues to climb, those people who live on fixed incomes find themselves paying a hidden tax to support the deficit spending that fuels this inflationary spiral. Hard-earned dollars that were saved in previous years rapidly lose their value as inflation cuts the worth of savings. The 12-percent inflation rate this country felt 2 years ago was exactly like increasing the taxes we each pay by 12 percent of our total income. This makes it obvious that inflation is a burden that no one can bear, particularly our elderly.

Second, because of the nature of inflation, it relates directly to many other subjects. Transportation services for the elderly, nutrition programs, retirement income, senior citizens centers, social services, and many other aspects of the total environment of our elderly are directly affected by increases in inflation.

Like all work done by the Special Committee on Aging, our aim is to find out here—at the grassroots level—how well the programs

authorized by the Congress are actually serving individual older citizens. Are they doing the job we hoped for? What can Congress do to make them better? What additional older American legislation should be considered?

Bill Passage Provides Encouragement

The passage of two recent bills should provide some encouragement for all of us here today. I am thinking of the 1975 amendments to the Older Americans Act, which I supported, and which President Ford recently signed into law. To cite another example, last week the Senate gave final approval to a bill which I introduced in 1975 to prohibit discrimination in credit against the aged. This bill now goes to conference and from there to the White House. I look forward to its speedy passage and implementation.

Unfortunately, all the legislation proposed by the White House currently before the Senate is not encouraging. For example, I am deeply troubled by the 6-percent increase in social security taxes recently suggested. As I said earlier, inflation is taking an increasing toll on everyone—the aged, the middle-aged, and the youth. Within the past 2 years, medical costs have increased 21 percent; utility prices 31 percent. I think in Tennessee it is a little higher than that—food 27 percent and fuel prices 78 percent. Against this background of rapidly increasing prices for the average Tennessean, another increase in social security taxes at this time is unacceptable.

This does not mean that I feel that the social security system is without serious financial problems. It is because of overspending, and undertaxing, that the social security system is destined for severe financial difficulties in the years ahead. However, we can deal with these problems without a drastic increase in social security taxes.

In my judgment, there are different and better ways to solve this problem. Last November, with the crisis facing the social security system well in mind, I introduced a bill with the clear purpose to affirm the responsibility of the Federal Government to maintain a strong social security system. The Finance Committee, of which I am a member, will take up consideration of this bill soon, and I am looking forward to establishing, with my colleagues, new methods of making our social security system truly sound. Those who pay social security taxes—as well as those who receive social security payments—should be relieved from doubts and worries about the continued strength and viability of the social security system.

Hopefully, these are topics that we can explore more fully here today. This is an official public hearing by the U.S. Senate Special Committee on Aging. Everything that is said will be taken down by the committee's reporter to become part of the printed record of the hearing. Copies of this record will be made available to members of the committee and to other Members of the Senate for their review. Any of you who desire a copy may secure one by writing to me or the committee in Washington.

It is committee custom to invite Members of the House of Representatives to hearings in their district. Therefore, it is a special

pleasure to me to welcome Congressman Harold E. Ford from the Eighth Congressional District of Tennessee, who is sitting with me at the committee table and will participate in this hearing.

Because time is limited, and in order to assure that some of you in the audience have an opportunity to participate, each scheduled witness has been asked to limit their oral presentation to 5 minutes. Their complete prepared statement, if longer, will be made part of the official record.

There may be some of you here today who wish to be heard, but do not want to speak from the floor. For your convenience, we have made available a special form. Statements written on these forms may be submitted today or mailed to Washington at any time within the next 30 days. Such statements will also become part of the official printed record of this hearing.

I think we must get to the root problem, and try to deal with it without a dramatic increase in payroll taxes.

Difficult and Complexing Problems

I would like to thank each of you again for being here. The problems of older Americans are some of the most difficult and complex facing our entire society. I appreciate your interest, your concern, and I very much value your advice as to how we can resolve some of these difficulties. I look forward to working with you to find new solutions.

At this point, I would like to insert in the record a statement by Congressman Robin L. Beard from the Sixth Congressional District of Tennessee, who is unable to be here. It will be inserted into the record at this point.

[The statement of Congressman Beard follows:]

STATEMENT BY CONGRESSMAN ROBIN L. BEARD

Mr. Chairman, I am very pleased that you have provided me with this opportunity to express my views before this Senate hearing.

In recent years, there has been increased interest in the older American, beginning some 40 years ago when the Social Security Act was signed. Unfortunately, since that time the level of rhetoric has far exceeded performance. A great number of new governmental programs have been implemented to help the elderly, but their performance has been marginal at best. It seems to me that the Congress has done a great disservice to older Americans by initiating costly and ineffective programs while failing to recognize and deal with the most severe problem facing senior citizens—*inflation.*

It is because of continued deficit spending practices that all Americans are suffering the effects of high inflation, and the aged suffer more than any other single group from the ravages of inflation. This is the issue that the Congress must address if it intends to alleviate the major problem facing our older citizens.

There is no question that we have seen a decline in our rate of inflation. However, the Congress should take little credit for that encouraging sign. In the 94th Congress, there have been little or no effective measures to bring inflation under control by balancing the Federal budget. There has even been less interest shown in attempting to cut waste out of existing programs, waste that costs the taxpayers of this country billions of dollars a year.

The majority in Conress apparently feels that it can solve all the Nation's difficulties by simply creating new and costly Federal programs. Almost without exception, these programs are expanded and the huge bureaucracies that are created lead to even more inefficiency.

The American people have a right to require that the money they pay in taxes is spent as efficiently as possible, and more than that, they have the right to demand that the Federal Government lives within its means. Congress can do something about this problem if it wants to. It can bring a halt to deficit spending and it can bring inflation under control. This will provide the kind of relief that the elderly of this country really need.

There is other action that should be taken to ease the burden on this Nation's elderly. For example, unfair provisions of our tax system as it applies to elderly citizens should be changed. The Congress should act immediately to remove the limitation on the amount of money social security recipients can earn without losing their benefits. This inequity in our tax law robs this country of a tremendous talent and an experienced resource that we cannot afford to underutilize.

System Discriminates Against the Elderly

Many of our older citizens want to continue to lead productive working lives, and yet our tax system discriminates against those who do. As I'm sure most of you are well aware, a 65-year-old person eligible for social security benefits may earn up to $2,520 and pay regular taxes, but take home pay is reduced to approximately 25 cents for each dollar earned above that level. This system leads to widespread nonreporting of income by persons who have never knowingly violated the law.

Taken together, inflation and these oppressive tax laws create a nearly hopeless situation for older people. Senior citizens in this country deserve far better. They deserve to have a Congress that is willing to come to grips with the real cause of inflation that is destroying the buying power and the dreams of older Americans.

The issues I have discussed so far apply to the burdens placed on today's older citizens. However, another issue I would like to address deals with our ability to provide for the elderly of the future—the status of the social security system.

As you know, this system was designed in 1935 to cover a limited number of workers in commerce and industry when they reached 65. Since this attempt, we have seen the social security system grow to become a giant entity which is currently paying $68.7 billion a year to one out of every seven Americans. It is now the second largest source of Federal funds with a majority of American taxpayers paying more in social security tax than they do in Federal income tax. There is little doubt among economists that the social security system will be in serious financial trouble this year unless revenues are raised or benefits drastically cut.

Contrary to popular belief, the social security system is not insurance nor is it based on sound banking and insurance standards. Social security benefits are paid almost entirely by the payroll taxes of current workers and employers. In other words, the social security system is a transfer system whose solvency rests upon the willingness of the next generation to pay taxes 30 years from now to support the current working generation, most of whom will then be retired.

Because the social security system has been overly optimistic with regard to future trends, an immediate reform of the system should be implemented or the system is likely to face abrupt bankruptcy. This impending scarcity of funds has been caused by a drop in the birth rate, meaning that less workers will be available in the future to pay for a larger number of beneficiaries. Also, a decline in real wages will mean lower incomes and therefore lower contributions to the system. Unless the system is altered, the extra funds needed to provide expected income to those retiring at the turn of the century will not be there. The present "pay as you go" system will simply not result in an accumulation of capital sufficient to meet expected future needs.

It is my feeling that a complete reassessment and investigation of the social security system must be conducted at the earliest possible time. I think that it should be reorganized to better reflect private trust funds and pension plans. Patterning the system after the private sector will provide more efficient and equitable management than now exists. It seems imperative that more actuarially sound principles be applied to the system. If we fail to follow this route we may not be able to provide adequate benefits to future beneficiaries.

Once again, I would like to express my appreciation to the Chairman for focusing attention on the problem of the aged in Tennessee.

Senator BROCK. I would appreciate it if my colleague, Harold Ford, would make whatever comments he wishes to make at this point. I appreciate your joining us today.

STATEMENT BY CONGRESSMAN HAROLD E. FORD, EIGHTH CONGRESSIONAL DISTRICT OF TENNESSEE

Congressman FORD. Thank you very much, Mr. Chairman.

Let me first say to my distinguished colleague and distinguished Senator from the State of Tennessee, Senator Brock, I sincerely appreciate your taking the time in bringing the Special Committee on Aging to appear here in Memphis, and let me thank all of the people who are participating today; and I, like Senator Brock indicated earlier, must say it is good to see so many people concerned about elderly problems, and those problems with regard to the elderly, and I am happy to participate with Senator Brock, and as a member of the House Select Committee on Aging, it is good to be here, and good to be among the people in Memphis.

Let me say I am happy to have a chance to be with you today. It is good to be back home and hear what you have to say about inflation impacting the ability of the elderly to make ends meet.

There is no question about the problems that elderly are facing right here in Memphis, problems of inflation eating away hard-earned dollars, problems of paying next month's doctor bills, next month's rent, next month's food, and let us not forget, next month's utility bills.

You people might be interested to know that I have cosponsored a bill in Congress to reduce the cost of utility bills for small residential users, especially for older Americans who are struggling to survive on a fixed income and just can't afford to keep paying higher costs for water and electricity.

As a member of the Select Committee on Aging in the House of Representatives, I am especially interested in the concerns of the elderly. This committee has just put out a report on health problems of the aged. We want to try to help people to stay in their own homes, where they have lived 10, 20, 50 years, without having to go into a nursing home.

I am going to continue to look out for your interests, and I am here to find out what needs to be done and how to do it right.

MANY PROGRAMS NOW IN OPERATION

My friends, we all know that more needs to be done. We've got programs operating now in Memphis to try to alleviate some of the problems of the elderly. Last month 127,000 people in Shelby County received food stamps.

Almost 28,000 people received aid from medicaid in Shelby County. Eight Memphis community agencies receive Federal assistance to purchase special buses and vans for elderly and handicapped people. I have seen the worthwhile programs sponsored by the Sen-

ior Citizens Services Agency and right here in the Lewis Center, these dedicated people are doing a first-rate job for Memphis.

We in Congress know that these programs do not solve all the problems of the elderly. That's why I've come back to the people, back to the Memphians who know what needs to be done. This committee is here to learn from you and to take this information back to Washington.

I appreciate this opportunity to participate in the hearings with Senator Brock. I know that what will be heard here today is the key to making good laws in Washington, laws that will benefit the elderly people of Memphis and across this great Nation. Thank you.

[Applause.]

Senator BROCK. Thank you very much.

We asked our scheduled witnesses to limit their oral statements to 5 minutes, so that the Congressman and I may have an opportunity to ask questions. If at all possible, and I do not know how long it will take, we would like very much to have some comments or questions from the floor at the end of the formal witness list. We will proceed as rapidly as we can, and try to accomplish as much as possible.

First, our most distinguished witness, Mr. Richard Block, chairman of the board of the Josephine K. Lewis Center for Senior Citizens.

He is one of the founders of the Senior Citizens Services, Inc., which is so important.

Mr. Block, we very much appreciate your being here, and we would be delighted in hearing your statement.

STATEMENT OF RICHARD BLOCK, CHAIRMAN OF THE BOARD, JOSEPHINE K. LEWIS CENTER FOR SENIOR CITIZENS, MEMPHIS, TENN.

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

As chairman of the board of the Josephine K. Lewis Center for Senior Citizens, I am very pleased that we are able to sit down here and make these remarks.

I find I can stand up a little, and I speak a little, but I cannot do them at the same time.

As a member of this club, it is my privilege to welcome you here. I do wish to take this opportunity to thank Senator Brock and Representative Ford for being with us, and also the entire Special Committee on Aging.

They have evidenced their interest in old people. This is the second such conference held in Tennessee. There was one in Nashville about 3 or 4 weeks ago. That was a tremendous conference, and quite frankly, we accepted as a challenge, and I think we admit that challenge, as I look at the turnout we have here today, we have done very well, so we thank you very much for being here.

We have a statement from our former colleague and chairman of the Tennessee Commission on Aging, Dr. Bill Cole. He had expected to be with us, but unfortunately he is unable to do so, but he

sends his greetings, and his statement we offer as a part of the record.*

Our two mayors, and this is the first time I have been on the program with two mayors, they found it necessary to depart because of the duties of their office.

They also send their regards. They were with us earlier. I was going to take one dig at Sheriff Nixon, and since he is not here, I cannot do it, but I will tell you, I was going to say to him, when I introduced him here, and Mayor Chandler, that we will give the mayor priority, because we have deficit funding, and we do not receive county funding, but I was going to state to him that we would give him an opportunity to correct this. [Laughter.]

This about concludes the informal remarks I will make, other than to again emphasize how very grateful we are to you gentlemen and to your colleagues, who have our interests at heart, and very much appreciate your efforts on our behalf.

Senator BROCK. Thank you very much.

Mr. BLOCK. If I may, I will now continue with the prepared statement which I have, and which I will make as brief as possible.

Senator BROCK. Please continue.

Mr. BLOCK. Those of you who know me, including Senator Brock, with whom I have had conversations on the subject, will not be surprised at my urging of funding of title V of the Older American Act. This being the title under which multipurpose centers, such as this, will be subsidized if and when funds are obtained. Depending upon the size of such a center and the depth of program offered, the cost per member for the operation of a multipurpose center varies between 20 cents and 40 cents per person per day. Contrast this with $17 a day for institutional care. Many of my friends, members of this center, would be institutionalized or in need of institutionalization were it not for Lewis Center. Consider, also, the many persons whose lives have been enriched and vitalized by the existence of such facilities.

SIZABLE NUMBER OF ELDERLY OVERLOOKED

A very sizable portion of our older citizens are in fact overlooked and inadvertently neglected in Federal programs enacted for the benefit of all senior citizens. I refer to those persons in an income bracket slightly above what is termed the "poverty level." In many instances, these persons being denied programs and benefits available to persons with a slightly lower income find themselves possessing lesser net income than the more indigent person. I realize it is far easier to indicate inequalities than to provide workable solutions. However, I would suggest that programs and/or benefits made available to indigent persons also be made available to the group to whom I refer, on a sliding or graduated scale.

We all regret the sad state of our social security system and are sympathetic toward the fiscal problems of this administration. Very little is known, other than what has appeared in the papers, of the administration's restructuring of the social security program. Al-

* See p. 2153.

though, it is stated that the increased social security tax will be only three-eighths of 1 percent, this amount when doubled becomes three-quarters of 1 percent with the inclusion of the employer's contribution. All employers must consider fringe benefits as part of his payroll expense. Also, if I properly understand these proposals, they are regressive in that the hospital and medical expense allowance is actually reduced to those persons who most need the protection of medicare and medicaid. [Applause.]

Senator BROCK. Thank you very much, Mr. Block.

I have two or three questions. One is a comment rather than a question, I very much agree with your statement on the social security tax. I think the thing we fail to realize when we increase social security taxes is that this is directly inflationary. It raises the price of everything we buy, by just about the same amount of money. So we are robbing Peter to pay Paul, and losing in both ways. That is what bothers me about it.

CASH REVENUES FROM THE GOVERNMENT?

If we are going to deal with this problem of social security funding, what we should do is look at the items we loaded onto social security. Maybe they should be paid for out of the cash revenues of the Government, such as is done with medicaid, and some of the other areas that are not directly social security.

If we did that, I think the social security fund would be very strong, and that is exactly the obligation we have to all of the people in this country.

It is a fundamental obligation to be sure the social security fund is intact. I would like to see social security funded by those taxes which relate to retirement, and not burden social security with anything else that destroys its strength.

I also wonder if it is not time we took a look at medicaid and medicare, to see if they are doing an adequate job. Medicare last year only covered, I think, 38 percent of the actual health costs of the people over 65. That leaves a pretty high burden on those people who are in the very groups you are talking about—not quite low enough to qualify for medicaid, but not wealthy enough to carry their own medical burdens.

As you may know, I have introduced a bill which would, in effect, be an additional guarantee, that says if your medical expenses excludes 15 percent of your net taxable income, which includes social security, we would cover the remaining 85 percent of the expense. This would guarantee that you cannot be destroyed in this country by medical expense. I think we have the obligation to do something like that.

One thing I wanted to comment on is this local center. I am a fan of it, so I would hope that you do understand I am prejudiced, but I think this stands for more than economic security.

I think this demonstrates the fact that a sense of community and friendship are tremendously important to someone who is retired. I think that is equally true of the determination, if at all possible, to remain in your own home, or with your family.

I wonder, Mr. Block, if you would comment upon the development of the homemaker-home health program in this community, your own interest in it, and the prospect for enhancing it.

Mr. BLOCK. Senator Brock, I am not very familiar with this program at the present time. You referred to the years that I was with the Senior Citizens Services, and at that time I was, but I do know that this agency is doing a great job, and I admire the work that they are doing.

I think it is very constructive. Unfortunately, I believe I am correct in this, they are inhibited in that they could only work with persons below a certain income level.

Senator BROCK. Right; well, I hope we can get into that some time today. I would like to know just how we can make it more effective. I deeply believe that if there is some way in which we can help people stay with their families, or in their own home, rather than being put in an institution, that it is to our advantage, and I know it is to the advantage of the senior citizens.

Congressman Ford, do you have any questions?

Congressman FORD. No, I do not have any. I thank you very much, Mr. Block, for your very fine testimony.

Senator BROCK. Thank you very much, Mr. Block.

The statement of Dr. William E. Cole, chairman, Tennessee Commission on Aging, will be inserted into the record at this time.

[The statement of Dr. Cole follows:]

STATEMENT OF DR. WILLIAM E. COLE

The Tennessee Commission on Aging is pleased to cooperate with the Senate Special Committee on Aging in this second public hearing in Tennessee on the "Future Directions in Social Security." Since June of last year, members and staff of the commission have been involved in several public hearings conducted by members of both the State legislature and of Congress.

These hearings have brought to the public many of the problems faced by older persons attempting on the meager fixed incomes many of them have to lead an independent and useful life. Those individuals who presented testimony at the hearings—most of whom were describing their own situation—described vividly what may be one of the contributing causes of many elderly persons' inability to remain independent members of our society today.

The provision of basic services such as financial assistance, transportation, information on programs, and nutrition supplements can mean the difference between independence and institutionalization for many older persons. Because of public hearings such as this, the needs of the elderly are effectively communicated to those who are in a position to seek public financial support for additional services.

We are happy that Senator Brock and Representative Ford could meet here today to focus the attention of the Aging Committees of both the U.S. Senate and the House of Memphians as they describe the impact of the cost of living on older Tennesseans. As a result of the series of hearings conducted by the Committee on Aging of the Tennessee General Assembly, favorable legislation has been introduced on the State level to assist Tennessee's elderly citizens. The Commission on Aging hopes that this hearing will produce similar results with the Congress.

Senator BROCK. We will now hear from a panel of witnesses. Mr. L. O. Gillespie of Ripley; Mr. Leon Stevenson, of Memphis; and Mr. Null Adams, of Memphis.

If I may ask, gentlemen, will you make your statements short, and then we will try to ask questions as soon as all three of you finish with your testimony.

Mr. Gillespie, you may proceed first.

STATEMENT OF L. O. GILLESPIE, RIPLEY, TENN.

Mr. GILLESPIE. Senator Brock, Representative Ford, other Federal representatives, county and State officials, ladies and gentlemen, the first thing that I did after I consented to appear on this important program was to contact and talk with as many older people and organizations dealing with older people that time would allow me to interview or talk with. I felt that whatever I had to contribute to this program would be more effective if I could represent the reaction or feeling of other older people along with my thinking on "Future Directions in Social Security: Impact on High Cost of Living."

STANDARDS OF LIVING LOWERED

The older people that retired several years ago are affected more by the impact on the cost of living than those recently retired; however, if the cost of living continues to increase the present retirees will be in the same situation as those who retired earlier, within a few years, unless the formula for retirement is changed because the cost of living has been increasing faster than the incomes of many people, which means the standards of living have been lowered by many people.

There were people drawing other checks. Example: Widows drawing veteran's checks. When they received an increase for social security because of the cost of living, they were cut more on their veteran's checks than they received on their social security, which means as a total they received less than they did before they got the increase in social security.

There are other groups that do not qualify for social security and they receive SSI checks. One person, the head of household, receives a check for $157, all the income that person has. He will have to pay $33 for $50 worth of food stamps. It seems to be going in the right direction but not far enough. It seems that a senior citizen in a low income bracket could get a better break.

There is a group of older people who contribute to a retirement fund matched by the State. After the retiree receives the amount paid into the fund, the other part received is taxable, which causes the retiree to be hit harder by the impact on the cost of living. Some have felt that this other part received should be untaxable.

Many of us feel that any person with good health, able to produce and has a will to produce, should have an opportunity to produce without being penalized. If penalized, many of us feel it should be beyond 65 years old at least. At 72 there is no limit to what a person can make without a penalty, which many of us feel is just opposite to what it could be to help the most people.

I have only tried to say that the high cost of living has caused many senior citizens to lower their standards of living by neglecting things that should be cared for or substituting inferior products or service.

Thank you.

Senator BROCK. Thank you very much.

[Applause.]

Mr. GILLESPIE. Thank you.

Senator BROCK. Mr. Leon Stevenson is the assistant to the State director of the National Retired Teachers Association, and a member of the American Association of Retired Persons, and a member of the Mayor's Advisory Committee on Senior Citizens. Mr. Stevenson, I do appreciate your coming before us today.

STATEMENT OF LEON STEVENSON, MEMPHIS, TENN.

Mr. STEVENSON. Thank You, Senator Brock and Congressman Ford, and other distinguished people, and ladies and gentlemen.

I feel complimented to be asked to participate in this hearing, and would like to touch on some aspect of the housing situation in our area.

I am not an expert on the subject, but after serving 15 months on the board of commissioners of the Memphis Housing Authority, I have become aware of some problems which may be pertinent for this meeting.

The Memphis Housing Auhtority provides quality housing for approximately 2,500 elderly residents, of whom nearly 900 live in 3 highrises, designed specifically for the aged—95 percent of those living in the highrises live alone, and have limited contact with other individuals. The remainder of the elderly population resides in a number of other authority projects which house low-income families. The major concerns to be addressed place emphasis on those elderly residents living in the highrises for four reasons: (1) There is a high concentration of homogeneous individuals, who share similar concerns and problems; (2) there is a sense of isolation from established residential areas, which can offer different experiences; (3) the majority of these people are new tenants of public housing, and have had to establish new relationships with unfamiliar people; and (4) priority issues have been identified by elderly residents, and the social service staff that provides services to these residents.

ISSUES THAT NEED ATTENTION

It is felt that the following issues need immediate attention:

First, there is no adequate police protection. There has been a steady increase in the number of elderly persons who have been victims of crime against persons and property.

Issue No. 2, check-cashing policy. Many elderly residents have experienced difficulty in cashing their checks, especially those that do not hold an account with one of the local banks.

These residents, who live on a minimum fixed income, more often than not, choose only to cash their checks to pay their rent, buy their food stamps, and use the remainder of their money to pay personal items.

They neither possess a driver's license or credit card, for identification purposes, therefore, it would appear that more lenient check-cashing policies on the part of local banking institutions would be beneficial for the aged.

Issue No. 3, the food stamp program. The present food stamp program does not appear to benefit a single person who receives a minimum social security benefit, or supplemental security income.

At the present time, the single person family receiving minimal benefits must pay $38 for $50 worth of food stamps. This does not seem to be sufficient.

Issue No. 4, medicaid eligibility. Many elderly persons are declared ineligible for medicaid benefits because their income is slightly above the minimum; however, these persons spend much of their meager income on needed medical treatment and drugs. Perhaps the eligibility requirements need to be reconsidered for those individuals who need medical attention and maintenance drugs, and do not have any adequate finances to purchase them.

We have over 200 elderly people on the waiting list for units in our development. The average income from social security of our elderly is about $157.50. Now it is not likely that any more public housing can be built in the foreseeable future; however, we have been allocated by the Housing and Community Development Act of 1974, under section VIII, an authorization to certify applicants for 294 units in existing housing, and they have been allotted $553,000 for this rent subsidy program.

In public housing, residents are allowed a certain amount of energy consumption as a part of their rent, and gas and electricity used in excess of this amount is to be paid for.

Utility Expenses Most Repressive

The increased cost of electricity in recent months has had an impact on these residents, as well as those in private housing. In fact, the amount of utility bills is becoming one of the most repressive expenses for everyone, especially the elderly with fixed incomes. [Applause.]

In many cases, it has thrown their budgets completely out of kilter.

In the matter of private housing for the elderly, there are some excellent accommodations in the form of highrise apartment buildings, sponsored by churches and charitable organizations.

There are some medium priced apartments available and owned by real estate firms, but the demand exceeds the supply. The type of housing which is in abundance supply is in the $200 to $300 a month price range, which is out of the financial reach of all but a very few of the elderly.

In Shelby County, the housing authority has a new development for the elderly, and possibly has another being built in the future, and Shelby County Hospital is one of the older facilities in the area, but it should probably be classified as a nursing home.

There are a number of nursing homes in the area which range from adequate to mediocre, depending on the facilities, and the price paid by the resident, or paid by someone for him.

I feel these are some of the more important and significant issues that face the elderly in the field of housing, Senator Brock. [Applause.]

Senator Brock. Thank you very much.

Now we will hear from Null Adams, a longtime friend, who recently wrote a letter to the editor of a local newspaper in which

he addressed an issue that I have been concerned about ever since I have been in Congress.

I think the first bill I put into Congress, certainly one of the first, was a bill to prohibit the Federal Government from putting in an earnings ceiling on people over 65.

I just resent it deeply, I do not think the Federal Government has any right to tell somebody he cannot earn money.

I do not think there is any justification for it at all. You wrote a letter which I have seen which addressed this point, and I hope you will address that and any other matters of concern to you because I find it is something we need to do something about.

STATEMENT OF NULL ADAMS, MEMPHIS, TENN.

Mr. ADAMS. Thank you, Senator. Senator Brock, Congressman Ford, and friends who voted for me. [Applause.]

I had planned to read this letter, but since Senator Brock has already told you of the contents, I will skip over it, because I have so much to say, that 1½ hours would not be adequate time for me, instead of 5 minutes, but I will hold myself to 5 minutes.

This letter simply suggested that the age be lowered from 72 to 70 on the restrictions that limit earnings of persons drawing social security retirement benefits of $230 a month, without losing all of the benefits.

My suggestion No. 2 in this letter, was the $230 limitation on persons on social security retirement be removed altogether for persons past 65. [Applause.]

I talked to Congressman Mills, who was once chairman of the powerful Ways and Means Committee in the House, and which our friend, Harold Ford, is now a member, some years ago about this problem, and he said he did not want to work any hardships on the labor force by letting old folk hold down jobs that young people would be handling.

I don't find that to be true. [Applause.]

This letter was published on July 9, 1975, and since that time I have been in touch with hundreds and hundreds of senior citizens.

Maybe I ought to explain why, for the benefit of our visitors from both sides of the aisle of Congress, but you know, I ran for the city council last summer, and I was warmly supported by the senior citizens.

That gave me an opportunity to keep data on what they said, so if I was elected, I might try to remedy some of the problems they face, and in a nutshell, here is what I found: Many would like to see the limitations removed on the earnings as outlined in this letter just referred to. Most of them have a pension of some sort besides social security, and believe me, they need it.

I know from personal experience. They have to pay income tax on their pensions, they also have to pay income tax on additional earnings, and well, you say that would be very small, when in my particular case, I do not mind telling you, last year, my first year of retirement, I had to pay $1,500 in income tax.

Well, they also have to pay 8½ percent on social security on all earnings outside of their retirement pay, except their pensions.

All of the senior citizens I know anything about have problems with inflation, as Senator Brock and Congressman Ford mentioned earlier; that has been covered pretty well, and much has been said about the cost of food, drugs, and clothing increases. I have heard very little about the skyrocketing costs of utilities until I came to this meeting today.

I did not believe the things I heard from my senior citizens about utility bills. I got real curious and went home and dug up my canceled checks to see what had really happened to me.

Five years ago, my annual utility bill was running $25 to $27 a month, and that was a year-round average. That bill in the last few months has been $66 to $58. I live in the same house. I do not have any new appliances.

Utilities Increase Steadily

My bill runs completely steady the year around, because I heat with gas, and cool with electricity in the summer, and there is not a whole lot of variation, but we have jumped from $25 to $58 a month just on utilities.

I do not include the telephone bill, and it has gone up too.

I found everybody really upset about medicare, because it does not pay anything on medicine.

Now, I do not know whether Senator Brock and Congressman Ford know that older persons usually have to take a little of what they call maintenance medicine to keep their blood pressure down. [Applause.]

For instance, Congressman Ford and Senator Brock are too young to know anything about that, but if they live long enough, some day they will know what we are talking about. [Applause.]

Another thing I found very hard to believe; when I was campaigning for office, and, bless you, I do not think there is a person in this room who did not vote for me, was that the cost of this medicine people have to buy to stay alive and stay in good health, averaged out, from all of the people I talked to, at $508 per year per family.

I thought this was outrageous, and those of you who told me those things were exaggerating a little bit, I thought, but I went home and checked my own medicine bills. For Mrs. Adams and myself, the average is just about right.

The prices of drugs are still rising. Now, personally, I have had two interesting experiences with medicare, and I am running a little longer than I want to, but I want to take one moment to tell you about them.

One is that I had three doctors who attended me during the year 1975, and they had to fill out medicare forms and mail them to me.

I filled out my part of it, and I mailed it to Nashville. I received a check back for 16 cents. [Laughter.]

Well, it costs the doctors 30 cents to mail those forms, and it cost me another dime to mail it on to Nashville, and I suppose the Federal Government franked it, and did not pay any postage to send the check back to me for 16 cents, so when I received the check, and I started to frame it, but then felt that this would

probably cause a national crisis, because it would throw the whole Federal bookkeeping system out of kilter, so I went on down to the bank and cashed it, all 16 cents, and I burned another 20 cents of gas to do it.

Congressman Ford and Senator Brock, I am not telling jokes here, I am telling you facts. [Applause.]

Experiences Encountered With Medicare

The other experience I had with medicare is not funny by any means, but it is an interesting thing. Mrs. Adams had two checkups during the year, and we go every 6 months now, we used to go every 5 years, and then every year, you know what I am talking about.

She had two bills, and each one of those was for $69, and were from the same doctor.

One was in April, and one was in October; so I waited until the end of the year. To save a lot of bookkeeping and postage on behalf of the Federal Government, I sent them all in at one time.

They processed one and dropped the other. Well, they processed this one, sent it back, and I saw immediately what had happened, and I sent off a letter to them, and sent along the canceled checks, one dated in April, one in October, and they straightened it out all right. They processed the other one. Because it was the same doctor, and some of the same examinations were on each application, they thought I just sent them a duplicate for their amusement, I reckon. They did not look at the dates.

I just want to say one word to Senator Brock and Congressman Ford, a word that will benefit them.

In my experience with the senior citizens this summer—believe me, I have had experiences with them, and they practically ran my campaign for me—but these older persons are better organized than any political machine it has been my pleasure to fight through the years, and that includes the Crump machine.

If you do not think they are organized, look at this crowd here today, and remember, there was just a little bitty newspaper article that showed this meeting was to be held. [Applause.]

These senior citizens do vote and work in elections like no other group I have ever known about, and I have known a lot about political groups in my time.

One day at a meeting—I do not know how many people are here today—but upstairs at a luncheon, there were 340 persons present. I personally went around and solicited their votes, and 335 of the 340 were registered to vote. Before the day was over, four of the other five were registered, because we had those forms where they fill them in and mail. These people have a way of knowing Members of Congress who try to do something for them, and you know by the people who are here today, that they are interested. They want to hear from you and get your suggestions. If they do not know how to evaluate these things, when election time comes, they will find out.

Believe me, they will find out. These are smart people, Senator, and I thank you.

Senator BROCK. Thank you very much. I know the frustration that you feel, and the frustration that I feel. You know, sometimes you wonder where to start.

I had two hospital administrators from Chattanooga—my hometown—come to see me last week.

One was from Park Ridge, a private hospital. The other was from Memorial, a nonprofit Catholic hospital. They are fine places, fine facilities. Bill Furor, the administrator of Memorial Hospital, brought me his accountant's statement, showing that he had to increase his charge 17 percent per patient per day over last year.

He brought me a list of the increased expenditures, and this is the frustration. Virtually every increase on his list was an increase that was not coming from improved services. It was coming from things that were done by our Federal Government that forced up the cost of his operation.

He said:

You know, if somebody comes to us, just plain old and sick, and they are covered by an ordinary private insurance plan, we still have to fill out six forms for them, that is too many forms. But if you come in under medicare, we have to fill out 26 different forms for every person that comes into our hospital.

MONEY WASTED ON FORMS

Well, now, if we are going to spend all our money on forms, how will we put money into medical care, and that is the insane thing. I am so weary of trying to argue with these agencies that the money is supposed to go to the people. That is why I think, if you can be organized, and can get active, and if we can get people involved in this country, that is the only way we will straighten it out. It really is.

Mr. ADAMS. I know what you are talking about. I would like to tell you what almost happened to the Memphis Hospital.

For a long time, when I was on the paper, I served on the better relations committee between the medical profession and the journalists in trying to work out our mutual problems.

Also on the legal side of it with the lawyers, and at one point, not more than a year ago, one of the major hospitals in this town threw up its hands, and they said: "to hell with medicare, there are just too many forms and too many problems, and we are not going to take any more medicare patients."

I jumped to my feet, and I started shouting, and said they could not do anything like that, that they would wreck the town.

They could not, I do not suppose under the regulations or the law, but that was the frustration they felt about these 26 forms that Senator Brock mentioned, and those sort of things are serious, and I am glad we have people in Washington concerned about it, and coming down here and hearing our problems about it.

I do not want anybody to feel sorry for me. I want to take care of myself. As long as the Lord gives me health, I will eat regularly, and do all of the things I want to do, but I am concerned about all of the people I was associated with—the senior citizens group—this summer, and a lot of them have a lot more serious problems than I have.

Thank you.

Senator BROCK. Thank you, Null. We will have to move on fairly quickly, if we want everybody to speak.

I want to say one thing to Mr. Gillespie. He mentioned the problems that our teachers have in Tennessee, where they have a State match of their own private funds, and they get different tax treatment than you get under social security.

I would like to ask your help. I am cosponsoring a bill that would stop that. It is with Senator Fong, the Senator from Hawaii, S. 2402. If we could get some people in the other States aware of what is happening, aware of the discrimination against people who find themselves in that situation, maybe we could deal with it, because I think it is an important problem. I think a lot of people just do not understand the problems created by our current tax system. It is not right.

ELDERLY'S VOTES COULD CHANGE THINGS

If Null is right, if everybody 65 starts getting involved, we will change that educational system real quick, and we could do something about the problems.

Congressman Ford, do you have any questions?

Congressman FORD. I would just like to say to these three gentlemen that I certainly enjoyed hearing their testimony. I want you to know that every word was well taken, and I can say, Mr. Adams, you know even before entering into politics, I talked with you, and some of the things that you talked about, we had even discussed a few years back, when I first chaired a special committee in Nashville to investigate rates and practices of utility charges across the State. I think it is one that all of you ought to emphasize, and I think it is very clear, and it should be very clear to the Congress and other legislative bodies, I think at this point, if utility rates continue to rise, not only elderly people will not be able to afford them, the average person working will not be able to afford the cost of utilities. [Applause.]

You know, in talking with people on weekends, while I am home, I have met many people, and not just one or two, but their utility bill is more than their house notes per month. [Applause.]

I just do not see how elderly people on fixed incomes being able to afford it. Certainly you have a friend with Senator Brock and Harold Ford in the Congress of the United States. [Applause.]

Senator BROCK. I do have other questions of you. But if you do not mind, we will just have to drop you a note, and if you please, you can answer them later, so that we can get on to some of the other witnesses.

Thank you very much for your testimony.

Mr. ADAMS. Thank you.

Senator BROCK. Our next panel is made up of Erika K. Voss, M.D., director, Poor People's Health Center, Rossville, Tenn.; Mrs. Larn E. Bloodworth, Covington, Tenn.; Mrs. Mary Bell Reeves and Mrs. Evelyn Taylor, Memphis, Tenn.

I think we will start with Dr. Erika K. Voss, so if you will proceed, please.

STATEMENT OF ERIKA K. VOSS, M.D., DIRECTOR, POOR PEOPLE'S HEALTH CENTER, ROSSVILLE, TENN.

Dr. Voss. Thank you, Mr. Chairman.

The remarks which I am going to make reflect our experiences in the delivery of primary health care in a rural area of west Tennessee, about 30 miles east of Memphis. Of the total number of patients we have served thus far, about 30 percent are elderly. Their major problems being hypertension, diabetes mellitus, and arthritis. In the process of treating this age group, some of the problems they face in attempting to obtain adequate or even minimal health care have been repeatedly brought to our attention:

One: Lack of transportation.—Few elderly patients have private automobiles. Most of the elderly must hire rides to and from the health facility. This can add $3 to $5 to the doctor visit charge. Trips to Memphis can cost as much as $10. Many of the elderly are completely isolated with not so much as a telephone to call for assistance. Roads during rains are often impassable due to mud and this adds to transportation problems in rural areas.

Two: Lack of health insurance.—Many of the elderly, and those who will soon be elderly, seem to have been misguided and are paying for insurance which is of little benefit. With many policies, weekly or monthly premiums are expensive relative to the benefits received. Those patients qualifying for and receiving Tennessee medicaid benefits appear to be in an excellent position with many health services and prescription drugs provided. Medicare recipients receive little assistance from part B because drugs for ambulatory patients must be purchased and there is a large deductible applying to physician visits. Indigent patients may have their physicians' fees reduced but then medicines must still be purchased. Patients not receiving medications or receiving medications in part remain in an ill state of health thus resulting in a wastage of overall medical services.

Three: Food is often as difficult to obtain as health services. Most of the elderly who live alone do not have an adequate, balanced diet. They often pay high prices because, of necessity, they must shop at convenience stores. They complain that they are unable to purchase food stamps which may be due to a lack of understanding as to how to use them. Some of the elderly must travel 25 to 30 miles or even more to the food stamp office. This can be an all-day project and cost an additional $10 to hire a ride.

Four: Lack of adequate housing.—Lack of adequate housing with no indoor plumbing, running water and, in some cases, electricity, often exposes the elderly to colds and other respiratory infections for which treatment may not be affordable by some individuals.

Suggestions

One: Transportation.—Expansion of transportation services with a nominal fee would aid more than just the elderly in reaching needed health services. Improvement of the rural roads would help everyone with their transportation problems and may eliminate a perpetual obstacle to receiving health care.

Two: Lack of health insurance.—Expansion of medicare part B to include drugs for ambulatory patients may make it possible for more medicare recipients to comply with their treatment. Medicare and medicaid should subsidize preventive service such as provision of annual physical examinations and ordinary screening procedures, thus making it possible for all recipients to have at least one annual examination. It would be helpful if a physician or other health care provider could recommend individuals for additional assistance in specific cases where cost of an illness seems beyond the reach of an individual.

Three: Food.—Improvement of the transportation problem would improve food purchase problems. A mobile food wagon which accepts food stamps would help the elderly get better food and fresh produce. This could be a local project and at the same time employ local persons. Homemakers who could assist the elderly in preparing food could also participate in a local project utilizing welfare recipients who are able to work. Food stamps should be brought closer to the access of the recipients and provision of assistance in budgeting should be offered where possible.

Four: Housing—Those individuals living in rented dwellings often live in unhealthy environments due to deterioriation of the structures. There are frequent large spaces between floorboards and walls, making the occupants vulnerable to rat infestation and making it possible for cold air and insects to easily enter the dwellings. Assistance in making these homes a better shelter would contribute to better health for the elderly.

Five: Development of any program to assist the elderly should provide for the preservation of the feeling of integrity and independence which many rural elderly individuals currently possess.

Six: Home health nursing services provided through medicare should provide for drugs and monitoring by some individual, for example, clinical pharmacist, to ascertain adverse effects, optimum compliance, and so forth.

Cost to the patient having hypertension or diabetes mellitus for drugs, laboratory tests, and physicians is calculated on an annual basis as follows. Mild hypertension: drugs, $40; laboratory tests, $55; physician visits, $50; total cost, $145. Moderately severe hypertension: drugs, $175; laboratory tests, $110; physician visits, $80; total cost, $365. Mild diabetes: drugs, $75; laboratory tests, $95; physician visits, $50; total cost, $220. Moderately severe diabetes: drugs, $285; laboratory tests, $195; physician visits, $80; total cost, $560.

Cost does not include transportation expense, treatment of acute or concurrent chronic diseases (for example, hypertension and diabetes), or hospitalization if required.

Senator BROCK. I will go on with the other witnesses. Before we do, Dr. Voss, I would like to say I appreciate your coming, particularly with regard to the area that you testified to. I think that is one of the most neglected single areas in our whole program, and Senator Domenici and I have introduced legislation which would amend medicare part B so that it will provide for prevention, and for an annual physical examination for everyone covered by medicare. I think it will be cost effective.

I appreciate your coming very much.

We are going to proceed to Mrs. Larn E. Bloodworth of Covington.

STATEMENT OF MRS. LARN E. BLOODWORTH, COVINGTON, TENN.

Mrs. BLOODWORTH. Senator Brock, Representative Ford, and friends. I am particularly interested in the prescription drugs that so many of our senior citizens need and still they are not too sick to be hospitalized.

It is true that the hospitals do pay a portion of that, but when they come home, they still have to continue this medicine, and I am speaking for myself and my husband. He was sick for the past 15 years before he was deceased, and in the last few years, I would say approximately 9 years that he was seriously ill, his drug bill each month was not any less than $100.

Well, I was thankful, and we were fortunate, that we could pay it.

We have other retirement besides our social security, and had we not had it, why, we would have been in a very bad situation. So I think that something really should be done about these prescriptions for these elderly people who are sick and in need.

It has not been too many days ago, that I happened to be in the drugstore. Two ladies were there, and one had to be helped, and she had come for her prescription, and as she turned, not knowing, we all know, we see how food and rent and things like that have gone up, while drugs have also gone up, and she turned, and said, "well, I will tell you, I do not know what I am going to do. I have spent most of my social security on this medicine." Then I hear them say, "well, I just want a half a prescription filled, because, with other things that I need, my food, I cannot get the full prescription." So the need is great.

I have done quite a bit of visiting among the sick senior citizens, and I have seen the places where they live, and it is enormous, it really is, and I think that speaking to you, Senator Brock and Representative Ford, you know, I am glad you could come to the people to find out the things that we really do need, and now I must say something about our senior citizen project in Covington, Tenn.

I think it is one of the greatest things for people of that age to go to, and I have seen the fellowship, and the different things that they do there. I want to speak for the food program, which is so nutritious, and I know they have to pay a certain amount, but it is not demanded. If they do not have it, they get one good meal there each day for 5 days. They also have the buses to pick them up on different days to bring them to the senior citizens center, and so I think that is one of the important things that they are doing in these urban cities. I also think, seeing this through myself, the cost of medicine, I think really that something should be done about the prescriptions. [Applause.]

Senator BROCK. Thank you very much.

I do not think that any of us can argue with anything you said. My own mother has a very extended heart problem. She has had

it for a very long time, and I just cannot believe what it costs for medication.

Mrs. BLOODWORTH. May I add about my husband's condition. He is deceased, but for years and years, he had emphysema, and you only got shots for that, 10 cubic centimeters in one bottle.

You get three bottles, that was $9, and you were to use that at 2 cubic centimeters three times a day, and you know, one bottle did not last very long, and you add that all up, it really runs into money, and you would be surprised at the people that are having that disease today.

Senator BROCK. I know very well.

Ruby Proctor of Memphis could not come, but instead we have in her place Mary Bell Reeves. I gather you do not have a formal statement, Mrs. Reeves.

STATEMENT OF MARY BELL REEVES, MEMPHIS, TENN.

Mrs. REEVES. Thank you. Senator Brock and Congressman Ford, and the other members here, I am employed by the Senior Citizens Services.

I am a homemaker. The problems that I have found in the homes is one of the problems of loneliness. The most important problem I would say is lack of money for necessities, the rent, the people do not get enough money to pay their rent.

The utility bills are so high that the seniors are not able to pay. If they pay the utilities, they do not have money to buy food. The doctor bills are so high, they are not able to pay their doctor bills. Sometimes they have to go without medicine because they are not able to buy it.

Food, of course, that is high also, and income is not sufficient. They have such a limited income, it is not enough to buy food.

This is what I have found going into homes. [Applause.]

Senator BROCK. Thank you very much.

Mrs. REEVES. Thank you.

Senator BROCK. One of the very strong feelings I have is that if we can help people to stay in their own homes that they and we are better off, and I cannot help but believe that this homemakers service is just essential—that we are going to give people that opportunity. I do not know how else we can do it.

Mrs. Evelyn Taylor, a Memphis practical nurse. Give us your practical experience.

STATEMENT OF EVELYN TAYLOR, MEMPHIS, TENN.

Mrs. TAYLOR. Senator Brock and Congressman Ford, and all my friends, humbly, I am very grateful to have this opportunity.

Maybe I will use this turn to get something off of my chest. I speak from experience. I work as a volunteer with the senior citizens, I witness firsthand many problems of the low income, the sick, the withdrawn, the castouts.

My major concern is for the aged and the needy. I am proud of the progress that has been made to alleviate many of the problems, but there are still more problems to be solved.

My chief concern is for the old, the ill, the helpless, and many times those rejected by relatives, and forgotten by friends. [Applause.]

Many times I have had to take these folks in my home because they are broke, they are homeless, too ill to live alone, too poor to go to a nursing home, and not sick enough to be admitted to a hospital. [Applause.]

These people need supervision and someone who can make sure that they have a decent meal, supervise their medication, and that is important, and see that they live in a pleasant surrounding. [Applause.]

I feel that this need can only be met by the building of not more housing for the elderly, but more homes for the aged.

I am very proud of the progress that has been made in the field of housing for the elderly and hopefully, this program will always continue, but let us remember that housing for the elderly will not solve all of the problems of the low income and the elderly.

Shortage of Funds

We realize that there is a shortage of funds in some areas, but we feel that the problem of the lower income and the aged could be best solved if the available funds were divided among the services needed, such as maybe, and I say maybe, fewer nursing homes and more homes for the aged, and maybe, fewer housing for the elderly, and more homes for the aged that meet State standards.

So with the hardship of inflation, the rising health costs, may the powers that be take a long hard look at the problems of the low income and elderly.

Thank you very much. [Applause.]

Senator Brock. Thank you. I wonder, Mrs. Taylor, if you would describe for me what you would consider to be the ideal home for the aged.

Mrs. Taylor. Well, Senator Brock, as you know, the home for the aged, some people get the home for the aged and housing for the elderly mixed up.

Senator Brock. I know that. That is why I am trying to determine what you mean.

Mrs. Taylor. The home for the aged is the same structure as the nursing home. The only difference is the staff. I was told this in Nashville, when I applied for a license for a nursing home.

Senator Brock. The staff?

Mrs. Taylor. The staff. For a nursing home, as many of you know, you must have doctors and licensed R.N.'s, but in that same building, the home for the aged, you do not have to have an R.N.

Of course, a doctor must be available. Does that answer your question?

Senator Brock. Yes. You are saying something that I very much agree with, and I just wanted to be sure everybody understood.

The best description I heard was made by a friend of mine from Nashville, who has written a series of articles, and won a Pulitzer prize on those articles. The man is Nat Caldwell. He has written

for the *Nashville Tennessean* on nursing homes, and he and I had a long talk about the difference between a nursing home and a home for the aged. He said: "You know, Bill, I think in Government, you tend to think too much about mechanical statistics and criteria, like the ratio of registered nurses or doctors to numbers of patients."

He said there is something you cannot put in a bill. It is called love. If you do not have that, you do not have anything. [Applause.]

BEST PRESCRIPTION IS LOVE

Mrs. TAYLOR. Senator Brock, I feel that is one prescription that is needed. I spent many years in the nursing profession, and there was one prescription I found was necessary was the TLC, tender loving care. [Applause.]

Senator BROCK. It is a prescription that is most important.

We have had a pretty widespread panel discussion. We had Dr. Voss talk about the problems that really apply more in rural areas, and, of course, Covington fits that description, too. But it seems to me that one of the things we have paid the least attention to, that Dr. Voss made some reference to, and that I very much agree with, in this medical area, is the problem of prevention, and how do we get more adequate treatment before things become critical, before we get to the acute stage.

I just think it makes so much sense in terms of saving money, as well as helping people, but would it be feasible, would it not be helpful, if we had an annual physical covered by medicare, for example?

Are there other ways that we could improve our outreach program? I would like a comment, both from the rural as well as urban perspective, in this particular area of health care and health prevention.

Anyone want to take it to start?

Dr. Voss. Well, I am very much interested in health education, and I find that probably the elderly are the most interested in health education. Although we talk a lot about it, most people, when you get down to it, are not too interested in health education.

I think the elderly are more concerned about their physical condition because they have to be, and I think that outreach programs, which include screening, and maybe some knowledge about the problems that can be faced, and the problems that can be prevented, when we get older, would be something that would be very worthwhile. Unfortunately, medicare and medicaid do not provide any reimbursement for educational programs or for health education. Therefore, this aspect of health care is often ignored, and that is unfortunate.

Senator BROCK. That is also true, is it not, of nutrition? I think you would almost have to include that among your educational needs.

NUTRITION EDUCATION IS BIG PROBLEM

Dr. Voss. I think nutrition is one of the big problems. I think a lot of people suffer from obesity, and I think that is a nutritional problem, which becomes very complex. It is tied up with eating

habits, how you shop, what you have money for. It gets you into budgeting, and it has all sorts of ramifications, of how to use the money, how you shop, but I think food is certainly a big problem for older people, especially rural areas.

Mrs. BLOODWORTH. I think this is one of the things that senior citizens in Covington do need to address themselves to, because we have some of these people that bring the food in by truck, and it is brought in a container, and it will stay hot for 4 hours, and it is very nutritious. Because so many people come there, I do not say so many, several, that they get there, and there were two ladies that came out, and they explained that, and how they made up the menus, and they gave the senior citizens an idea of it, and we have some that are elderly, and they explained all of that.

In fact, they showed a film, so I think that is one of your health educational items that they are trying to tell you as to what you should eat.

Senator BROCK. In Covington, it is all brought to the center?

Mrs. BLOODWORTH. Yes, it is brought to the center.

Senator BROCK. Do you have any meals-on-wheels program, or anything like that, for delivering to the home?

Mrs. BLOODWORTH. No, we do not have that.

I beg your pardon, we do, because so many that come there, then if there is some left over, they can carry a tray home with them for the evening meal.

Senator BROCK. But that would not be a regular program to take meals to those that are bedridden.

Mrs. BLOODWORTH. No; a lot of younger citizens that come, maybe the parents, or whoever it might be in the home, come and get the meals for them, and take them home to them, but as far as delivering to the homes, they have not gotten to that yet.

They have done an awful lot in Covington, and possibly some day, we have not been at it very long, but really, there is some progress being made.

Senator BROCK. I think you have come a long way. It is particularly hard in the rural areas. Because you have such distances, you begin to get into an expense problem there that is awesome.

LONELINESS AND HEALTH RELATED

Just one last point, Mary Bell Reeves mentioned the fact that the biggest problem she saw in their home visits was loneliness, and then health. I don't know whether you want to comment on this or not, but I think these two are related to each other.

I think if you are lonely, you tend to get sick.

Mrs. BLOODWORTH. That is what the senior citizens project is doing, and I only speak for myself, and I lost my husband last September, and I had a dear friend that called me up, and said, "Why don't you come over there, we have fellowship, we have singing." I am a musician, and since I have gone to the center, why, everyone there, they love to sing, and we gather around the piano, and you would be surprised how happy everybody is, it is just togetherness there and fellowship.

I invite you to come some time, Senator, to see.

Senator BROCK. I would be glad to. That is what is great about the center.

Thank you all very much. I guess we will have to move along to the next panel.

Our next panel is made up of Elizabeth Leach, W. E. Crawford, and Lucille Waller, all from Memphis.

Mr. TURNER. I am Rex C. Turner of Savannah, Tenn., and may I be heard for 1 minute, with reference to the panel that has just concluded, before you start a new subject?

Senator BROCK. All right, Mr. Turner, proceed.

STATEMENT OF REX C. TURNER, SAVANNAH, TENN.

Mr. TURNER. I understand you are a little late now, and I would not even take the trouble to get a microphone to talk to you, because having been a schoolteacher for 50 years, and a principal 40 of that, I think I can talk loud enough to be heard.

I listened carefully to the talk about medicare.

Well, a few years ago, it was $54 that we had to put in it, and then it went up to $82, or $84; and then to $90, and now it is $104 that we have to put into it. You know what, I have health insurance men sell me three supplementary medicare policies, so I think I will be able to take care of myself, if and when that time comes.

Now, finally, we find ourselves, the aging, a minority group. We are in a minority group in the way some kind of people think about us. We are not a minority group in numbers. We are not a minority group in spirit and attitude, and when I think of spirit and attitude, I think of a little verse of seven lines, of a sportswriter for the Nashville Tennessean, I cut it out in 1923.

I dated myself, didn't I?

Anyhow, you all know of the last of the ninth inning of a baseball game, we as senior citizens are in the last of the ninth.

This man was in World War I. He came back with lung trouble—he had been gassed—he was in the hospital in Boston. His name was Kirk, he was dying, and he asked the nurse to bring him a pencil and paper. I want to write before I die, and this is what he wrote, and this is what I think describes us. The last of the ninth, as you know, usually ends the baseball game.

> The doctor knows what he is trying to see,
> Says it is the last of the ninth for me.
> One more swing while the clouds went dark,
> And I must leave this noisy park.
> It was a glorious game from the opening bell.
> The speed of it burned my life away,
> Yet I thank great God that he let me play.

[Applause.]

Senator BROCK. Thank you very much.

I expect to get a message to Null Adams saying, "Don't let him come to Memphis to run for office." [Laughter.]

You know, that reminds me of something I should have said to you earlier, but I hope you in the audience get this form and use it in giving your comments to the committee. You can fill it out either before you leave, or you can fill it out after. It says "If

there had been time for everyone to speak at the hearing in Memphis, I would have said." Then there is a whole blank sheet there.

If you want to fill it out, and give it to me today, I would appreciate it. If you cannot do it today, send it to me. The address is there on the form. We will keep the hearing record open for 30 days. If anybody here, or any of your friends want to make any comment on the problems that you have, or that you think we should do something about, or any suggestions, send it to me, and we will put it in the committee record. We would very much appreciate it.

The panel we now have will deal with employment, and that is a matter that is of great interest to me. I appreciate your all being here. We will run right down the panel.

Mrs. Leach, if you will start off.

STATEMENT OF ELIZABETH LEACH, MEMPHIS, TENN.

Mrs. LEACH. Good morning, Senator Brock, ladies, and gentlemen.

My name is Elizabeth Leach and I am from Memphis. I am currently employed as a senior aide by Senior Citizens Services. The senior aides program is administered through the National Council of Senior Citizens and is a part of the senior community service employment programs funded by the U.S. Department of Labor.

Since August 1, I have been assigned to work in the legal services for senior citizens office. This program is a part of the Memphis and Shelby County Legal Services Association.

In the last 6 months I have worked in the legal services office. I have seen many senior citizens with problems which could only be solved by help from persons with legal training. Senior citizens are constantly being exploited and taken advantage of. I would like to give you two examples of how I helped senior citizens regain money that they deserved.

Mrs. X was 68 years old and living on a low, fixed income. Early in her life she had been adopted. Mrs. X's mother was left an inheritance by an uncle in Canada. Unfortunately, Mrs. X's mother had died. Mrs. X was the rightful heir to this money, but could not prove it because she had no legal proof of her adoption. She came to our office for help. A letter on her behalf was written to the executor of the estate. Several months passed and nothing had happened. I talked to her on the phone one day and asked her to return to our office to see what could be done for her. She said this was "God's will" and she was giving up on ever getting her money. I finally convinced her to come in.

She came in and one of our attorneys worked with her and was successful in obtaining her money for her. Eventually she got $11,755 from the estate. Without "legal services for senior citizens" Mrs. X would never have gotten her money.

Mrs. Y came into our office needing help on her unemployment compensation claim. She was 69 years old.

She was denied unemployment because of her age and because she was receiving social security. The employment security office felt

because Mrs. Y was 69 there was no hope for her finding a job. Obviously, that office is not aware of the contributions older workers are making to society.

One of the attorneys in our office filed an appeal on behalf of Mrs. Y. Mrs. Y not only collected $2,400 in back benefits, but also received approval for an additional 18 months of unemployment benefits.

Again this was another case where a senior citizen had suffered actual dollar loss. Mrs. Y was deserving of a Government benefit but was told she could not receive the benefit because of her age.

The low-income elderly person has a great need for legal services to be made available to him or her. The two cases I have related to you are two cases in many that the legal services office has helped to recover dollar losses. Both of these ladies lived on a low, fixed income and needed the money.

I would like to leave you with one statistic: I conducted a telephone survey for the legal services office. I talked to all of the former clients. 79 percent of all the people that had been helped by the legal services office told me they would have given into circumstances or not have sought help elsewhere if our office had not helped them—in other words the "legal services for senior citizens" office was their only source of hope and help.

Just think of the amount of money senior citizens are losing because of not knowing what to do or where to go.

Thank you for your time.

Senator BROCK. Thank you very much. One of the things I hope this hearing will accomplish today is to let people know what is available. There are an awful lot of people in this community, and all across Tennessee that do not have an idea of the existence of these various services and programs.

I have six offices in the State of Tennessee. I have 14 people who work here, and their primary function is to handle personal problems like that. Because we are not legal people, we have to refer you to that sort of thing. But so many people do not even know that they can call my office, and find somebody who understands the problem, knows where to go to get the answer, whether it is social security or veterans benefits. I hope this kind of thing will help people understand that there are places where we can be of help, and we would like to very much.

I appreciate your statement.

We will now hear from Mr. W. E. Crawford of Memphis.

STATEMENT OF W. E. CRAWFORD, MEMPHIS, TENN.

Mr. CRAWFORD. I am W. E. Crawford, president of the Gertrude Williams Senior Citizen's Club, a CETA employee, working with the area agency on aging.

My job is to help reach more people and increase the number of senior citizens clubs.

At this point, I would like to agree with Mrs. Leach; because of age, and no information, many seniors are denied services needed. An example—pardon the personal reference, since I was part of it—these are the facts:

Wednesday morning, February 12, 1976, approximately 8:05 a.m., I had a call from a staff person at the nursing home where my father-in-law was convalescing. I was told that he had a slight stroke. The staff person was told to send him to Baptist Hospital. I would be there soon.

I arrived at approximately 8:40 a.m. and found out that he did not have a stroke.

After waiting for a report from the doctors, about noon, I was told that he had a blood clot in the leg and lung. They immediately began to give him oxygen, and said he would be admitted, about 12:25 p.m. I was told that the staff had decided to send him back to the home.

Without their knowledge, I could hear them speak about his age, such as—someone 87 years old was just too old to bother about.

At this point I became disturbed, and told the doctors and nurses present that I was to appear before this committee, and this would be a part of my testimony.

I was told to wait before taking him to the home, and about 5 minutes later it was stated that he would be admitted. At 4 p.m., he was assigned a room. I am thankful to God that everybody doesn't feel this way.

I feel that senior citizen's clubs are doing a good job, when it comes to Outreach. They bring many people together, with their programs, such as craft, recreation, and information. One should see the job expressed in seniors on their club meeting dates, or other activities. The sick and shut-in have been visited along with many other valuable services.

I am a barber by trade, and in my visits to the nursing homes, I found men there needing haircuts, shaves, et cetera. Some offered to pay what they could, many didn't have anything to offer. To keep them from being unequal, by not being able to pay, I cut their hair free of charge.

All of us may never be able to do a great or outstanding work, by the standards of our time, but if we do what we can for each other, this will be a better world to live in for all Americans.

Senator BROCK. Thank you very much.

We will now hear from Mrs. Lucille Waller of Memphis.

STATEMENT OF LUCILLE WALLER, MEMPHIS, TENN.

Mrs. WALLER. Ladies and gentlemen, and those of you interested in the problems of the aging, I want to tell you about a case in point of aging. This man received a notice from the insurance company to have a physical before his car insurance could be renewed, I suppose, because he is past 70. He got the physical, the doctor mailed it to the insurance company, and 2 weeks later he received this notice that his car insurance was being canceled after March 3. The medical reports showed that he has a cataract on his left eye. The insurance premium was $169 last year. If he has insurance this year it will cost $220. That makes for a $61 aging problem.

I am an employment counselor here at Lewis Center and all of the people that we deal with are either retired on social security, or

they are below the poverty level in income, which means they need a job to supplement their income.

One of my applicants that registered for a job needed to have her house painted. Two days later I had found a live-in job for her at $20 a day. She called the center asking for us to send out two or three painters to make bids for the job. Some retired man from the employment register will paint her house. I would like to say that the worst difficulty is the burden of "limited income" that the senior citizen can earn if he is drawing social security benefits. We have more than 700 people who have registered with us, seeking employment to supplement their social security checks. By the way, may I add, that we found jobs for between 400 and 500 people in the past 10 months that I have been here.

They accept a job and have to quit before the year is up, or return half of their earnings. This causes dissatisfaction with the employer and works a hardship on the elderly.

I recommend removing the limits of what a senior citizen can earn and it will create a more stable and secure position for the elderly, and I do not think that the kind of jobs the elderly will accept can detract anything from the labor market, because they are not trying to build a career. [Applause.]

Face it, retirement is fine for those who wish to retire, but for a person that needs to work and is able to still do a good job, to lose that job solely because he or she is too old is nothing less than an outrage.

Thank you.

Senator BROCK. I could not agree more.

I think, for some reason, too many people have the attitude that social security and SSI are all that are necessary for a person when he gets to be 65, and that is ridiculous. It is not so.

If someone wants to work, I would think it is the height of something or other for this Government of ours to say you cannot work. I do not think we have a right to do that. [Applause.]

I was interested in the example that was listed by Mrs. Leach, I think it was an example of the 69-year-old person who was denied employment because of her age and because she was receiving social security. The employment office felt because she was 69 there was no hope of her finding a job.

All they are saying, in effect, is that we do not think anybody 69 years old should work. That is what they really were saying.

"SHE REALLY NEEDS TO WORK"

Mrs. LEACH. And she really needs to work.

Senator BROCK. Even whether she needs to or not, he or she has a right to work whenever he or she wants to. [Applause.]

Well, we started off on this topic, and we are finishing off with the same topic.

One of the points that is hardest to explain, both to me, and from me to you, is why we have not changed that. Just so you understand the argument that I get, I have had a bill in to try to do this for 10 years, every year I put it in, and we have made some progress, we have raised the earnings ceiling some.

When I first started, it was either $1,400 or $1,600, and now it is around $2,500, but the argument is made that this will cost the social security system money and we cannot afford it. You know, I do not accept that argument. I think we gain money because people are productive again, and to me, we need people working in this country. We have too few people working now, that is one of our problems. That is one of the reasons we have inflation, but maybe we are going to have to do it in stages.

Mr. Adams suggested that this year we reduce it from 72 to 71, and next year to 70, and each year until we get to 65.

I would hope it does not take that long, but I think maybe enough people are becoming aware of the problem, and enough people in the senior citizens groups across this country are getting active, to where the Congress will act.

I know we will bring it up this year again, and I am going to try on my committee to get it adopted. Hopefully if other groups like this across the country are expressing their concern to their Congressmen and Senators, we will have enough support to do something.

I might point out one other thing too. I have five different bills that relate to employment of people who retire, older Americans. I think the most fundamental is that limitation. There is another one, though, that I think would be helpful, that relates again to Mrs. Leach's example. That is a bill that prevents, or would prohibit, employment discrimination on the basis of age.

As far as I am concerned, if you are capable of holding a job, it does not matter how old you are, you ought to be able to hold it. I do not see how, under the Constitution, somebody can automatically say you cannot have a job because you happen to be 67 years old. Maybe I should ask Mrs. Waller, in your experience, if you have run into that problem with your placing of people?

At least from what I have heard, it is a problem, and maybe you can expand on it.

Mrs. WALLER. Yes, we do run into those problems. They seem to think you are dead after you are 40. [Applause.]

Senator BROCK. Now you are really getting close to home. [Laughter.]

The closer I get, the more concerned I am. [Applause.]

Thank you all very much. I appreciate your comments and your statements.

I did have one other question I want to ask you if I could hold you just for a second longer.

Mrs. Leach, you were talking about the legal services program that is available, and I gather you are in sort of a paralegal situation?

Mrs. LEACH. Yes, we screen and interview people.

Senator BROCK. Tell me, if you will, what kinds of cases you have.

Mrs. LEACH. Social security problems, they need more money, people do not have enough money, and they just need more money to exist on really.

Senator BROCK. And the social security payment has been unfairly calculated, or it did not take income into account?

Mrs. LEACH. Sometimes they get lost, and sometimes the client does not have enough time, enough hours to cover them, and they are turned down, and they have to wait a long time without any kind of a fund.

Senator BROCK. I think when I was first elected to the Congress from Chattanooga, a lady came to me, and she had gone to Estes Kefauver in 1952, and he tried to help her. She had been to her Congressman, James Fraser, in the early 1950's. I tried to help. She had been working for 10 years to get her claim for social security in, and for 10 years she had not been given an answer, and I could not believe it.

When we finally were able to get some attention for her, we had to kick a few shins. The problem was not in the Chattanooga Social Security Office, it was in the central office in Baltimore, and we finally identified it, and got it solved. She got a check, and I have forgotten what it was, it was an enormous amount of money, thousands and thousands of dollars. But the thing I could not understand was how you can possibly delay a decision for 10 years.

You know, people deserve better than that. You have to have some answer. Even if it is a "no" answer, at least you know where you stand. Thank goodness we have your office, and hopefully mine, and we do provide some kind of services.

What else have you got besides social security? Do you have problems in the medicare area?

PROBLEMS WITH DISABILITY

Mrs. LEACH. The people with disability, they have trouble getting it, sometimes they do not accept their qualifications on behalf of disability, and they have to have further proof.

Senator BROCK. Anyway, at least in the experience we have had in our offices, proof is the hardest thing to come up with, because different Social Security offices establish different criteria for what constitutes proof.

All right; Mr. Crawford, I just want to ask you one other question. Was the age factor the only reason for denying the hospital admission to which you referred, or was there any other?

Mr. CRAWFORD. As far as I was concerned, the age factor was the only factor involved.

Senator BROCK. That is all you heard?

Mr. CRAWFORD. Yes.

Senator BROCK. I think that is incredible.

Thank you very much; I appreciate it.

Let us change our approach a little bit. We have more witnesses. But before we go to that, I would like to ask you, if you want to take about 10 or 15 minutes, if anybody in the audience wants to make a statement, or ask a question.

Yes, mam?

STATEMENT OF MRS. WILLIAM C. KIRKESS, MEMPHIS, TENN.

Mrs. KIRKESS. I wanted to say something that has not been brought us. My husband had to retire at the end of last year and we

have spent the entire year on social security which was not very much, and he worked for a company that was supposed to have a good retirement. Everyone thinks we are rich, which was not so. It was stocks and at the end of the year, when he retired, it went down and it was nothing—was worth nothing. We have tried to get a VA pension which he is eligible for. They have turned him down. They told him he was eligible for it. He was totally eligible and continually his examination and everything showed that; but they turned him down because he had too much income. We have social security of $339.60 a month, and that is tops for us. I cannot get one penny for myself because I'm only 56 years old and I am disabled to work, to stand on my feet all day, I cannot do it. I have arthritis, and that's what I am saying, there's a lot of people that are not 65 that are in our same situation, that you all have not come up with today.

I think that the social security is entirely too low. You may not agree with it, but when you get our age you will find out.

A couple should be getting $750 a month to live on, because a lot of people do not have income other than that little bit of social security. My husband worked for Sears, Roebuck and they have taken everything out that they gave him. They gave him a raise and they would take it back. One year he worked for them and I figured out the income tax, and he got a raise that year, more than he did the year before, and when the year was over he made less money than he did the year before, and I couldn't figure it out.

Senator BROCK. I would like to say something else. Sears, Roebuck is known to have the best insurance in Memphis.

Mrs. KIRKESS. That is true, but when you retire they say your medicine bill and your doctor bill has got to come up to over $200 apiece, and then we pay 80 percent of it; so my medicine bill has to be $200 a year. My husband's has to be $200, that's $400 for both of us, and then they will start to paying, so they're not helping us a bit and they are charging us over $400 a year for that insurance.

We can't go to another insurance company because we've got disabilities that no other company will take us, so we are stuck with Sears until we die, and still, we are not going to get anything from them unless we go into the hospital. You see, that's the things I'd like for you all to start working on.

STATEMENT OF JOSIE E. LANE, MEMPHIS, TENN.

Mrs. LANE. I work with the Klondike Seniors and various other clubs. I am a churchworker and I work with older people and people that are ill, and I do a lot of volunteer work. I love volunteer work. Of course, I am ill myself, but whenever I feel like it I am always someplace doing something for somebody. I was mightly glad to hear of this utility bill being discussed because I have been very upset over mine.

My utility bill was $37. I live alone and I don't have too many different things that will pull electricity. Poor people usually don't; but they make us pay as much money and sometimes more than they do those people and I am very much displeased over that. My light bill and gas and water was $37.

Well, I knew that it was impossible for me being alone to use that much, because I don't have the facilities for that, and I went up to see them, because I am a person like that. I went up and talked to somebody about it and I was very impressive about it because it really disturbed me, so they cut $6 off my bill, but they did not tell me what caused it to go up like that. They just cut it and I thanked them and I went on and paid what they told me. Everybody all over Memphis was very distressed about the utilities.

I have a friend that lives out in the, well lower income, way out; and her bill, I heard somebody say that really—I know Mr. Somebody, that I know is not poverty stricken—said his bill was $60. Well, her bill is $85 and $90. She doesn't have the facilities to use that type of electricity and we are very much disturbed about electricity and I hope somebody will do something about it.

I want to say just this one thing about the food stamps. We get stamps and they say work, go to work. I know a mother that took a little motherless granddaughter in and they told her to, you know, if she could find some work, to do it, so she found some work in a private home. She finally was paying $10 for her stamps. They found out that she had worked 4 days in this private home and they cut and made her pay $70 instead of $10, and that's what she's paying.

STATEMENT OF ABBIE J. ROULE, MEMPHIS, TENN.

Mrs. ROULE. My most concern, I pay medicare and I paid over $100 last year for my medicine and my doctor bill, not the medicine, but for the doctor bill and they haven't paid one penny of that money. And my doctor—every time I go to him—it's $24, $9, and sometimes I go twice a week for the complaint that I have. I have medicine that I have to take the balance of my life, three or four medicines and they went up from $30 to $43.44. That's what I had to pay this past month for medicine, and I can't even, Mr. Brock—and to the other people who are intelligent—I am a widow woman and I'm living off of a fixed salary. I don't know what they take out for medicare from the social security.

My social security check is as low as it can be and I worked on social security from the time it began until I retired in 1962. I worked on social security, but I'm not getting that kind of money back.

Now my utility bill have went from $21 to $47.83 the last month and now, I'm down here today, there's no heat on at my house.

There's nobody at my house hardly, I go away from home everyday. I go over to the center and eat lunch every day and the lights—and there's no one at my house.

You understand, sometimes it's 5 when I quit, I want to know—and they said that if you don't burn it, they charged you with it; they didn't talk to me like they did to the other lady. I had it to pay and I would like Mr. Ford and two more men to have to straighten them out some years ago about running this up.

Now they read my meter on the 11th of the month and on the 28th they look for their money, and I can't pay it; I have to pay late

charges. I get my money after the 1st, understand, and I would like for you all, if there is anything that can be done, to do something about it.

STATEMENT OF ODELL DOTSON, MEMPHIS, TENN.

Mr. DOTSON. First, I would like to make my comment to Lewis Center for opening the doors for senior citizens day. We have a great opportunity today. I am the chairman of the citywide community council and I have to work with all the people in the city of Memphis on crimes and also social security and also a better place to live in the city of Memphis, and so, I have a whole lot to do. We are working also, I am the president of the Odell Dotson Senior Citizen Club, and they named the club after me and I certainly appreciate that. I have done many things in the city of Memphis besides help in humanity and a better place for all people, and I certainly wish you all would do something about the light and gas. Also, the lady spoke about employment and spoke about the people walking around on the streets and can't get around and not able to get, not even getting, enough money to live on.

I want to bring you one the brother talked about awhile ago. The doctor sent my wife a bill for $85 while she was put to sleep in the hospital and I was working for a firm that was supposed to have paid this bill and didn't pay it. Now, they want to take my wife and probably, maybe, put her in jail to work this time out. I don't think that is fair.

I spent over 32 years under the civil security and therefore I certainly will want you to do something about the situation in the city of Memphis. I have walked in thy steps. Another thing I want to say is this—let me say this: I have lost my blood right here in the city of Memphis for human beings and human rights. I've walked; I marched on Washington in 1963 where I was jammed in Lincoln Memorial and liked to almost took my breath, but the Lord was with me and there I happened to look down and there was a man in a rolling wheelchair standing there for his human rights in 1963.

And I marched with Dr. Martin Luther King through Jackson, Miss., for human rights. I lost my blood right here in the city of Memphis, but I didn't lose my life. I thank God he left me here for some reason. God bless you and thank you very much.

STATEMENT OF BYRON HUNTER, MEMPHIS, TENN.

Mr. HUNTER. I am a World War I veteran, charter member of the American Legion of the State of Washington, charter member of the World War I in California, past commander of the Veteran's Post here, past president the Peabody Center had, past president of the Jefferson Square Center.

What I want to do is to thank Congress for taking up pensions for us. We know that they have to have the money up there for them to send overseas, so if anything can be done that they need more money—of course, they say they haven't got, but they send millions overseas. I still want to thank them for cutting up my insurance. They cut me from $80 in a year down to $22.

If they need the money worse than I do, God bless them.

STATEMENT OF LILLIE M. PHILLIPS, MEMPHIS, TENN.

Mrs. PHILLIPS. I am a volunteer working for Hardin Garden Senior Citizens Club, and I would like to ask you why some senior citizens don't get but $62.90 social security.

Senator BROCK. OK, then if they don't get but $62.90 for social security aren't they entitled to SSI.

Mrs. PHILLIPS. They are?

Senator Brock, in the county we need aid for the senior citizens. Out in the rural, I am the only volunteer worker out there and would you try to help us get some more people concerned about the aged in the rural. Thank you

STATEMENT OF BEULAH ROSS, MEMPHIS, TENN.

Ms. Ross. Senator Brock, and to the staff, I was at Lovell at the time I retired 4 years ago, and I wasn't able to get my compensation. They said I had to accept a job to get my compensation. I am 69 years old and when I retired I didn't think I quit. I quit because I was up to age 65 and they wrote me a separation blank.

They said I had to work, accept a job when I hadn't left a job. I did not get it, and I haven't gotten it, and I wish you would look into it. I was working for the house cleaning. The housecleaners took over. The Union Planters Bank, I worked there 15 years, and I worked for them 3 years—the housecleaners—and I was unable to get not 1 penny for my compensation.

I was 65 when I retired and I am now 69. My utility bill is $38; of course, I won't bring all that up. I do appreciate it. Thank you for the information you all have given us. I would like for you all to help me to try to get my money.

STATEMENT OF MRS. FRANKIE B. JOHNSON, MEMPHIS, TENN.

Mrs. JOHNSON. I worked a long time for the Volunteer Construction Co. and they went out of business, and after they had gone out of business, I got a job in a private home of Mrs. Glennis Smith.

During that time Martin Luther King was marching so I asked her to let me go downtown and let me off that day. She said, you can be off today. So, I went on downtown and got in the march and the next day when I came back she told me: "You were down there in that march and if you were in that march, I'll never let you work in my house no more." She said: "Now go down to the employment office and you'll never get another job down there." So, she fired me, and she didn't pay me, and I never have been able to get another job at the employment office at 1295 Poplar, in Memphis.

Since then, I bought me a lawnmower and I went around and cut hedges and cut yards.

I was buying a house, therefore, I didn't . . . that ran out. I got me two wheels and made me a pull wagon and sold bottles and finished paying for my house. I bought the house from D. Glen Arnes on Airways Boulevard. The gasman cut my gas off 4 years ago.

Me and my children didn't have water or lights; we took baths in the Wolf River during the summer.

So we met a lady, then called Mrs. Crankshaw. We told her about our troubles. She took us to the gas company and finally got our gas back on, so now, with the three adopted children I have, they get $132 welfare check. I pay $28 for the food stamps out of that. This time I had to pay $72 tax on the house which made a total of $100. There's only $32 left for detergent and things like that.

They had me going back and forward to the social security board to get a SSI check which January, a year ago, they gave me one check for $235 and told me I would get a check each month.

Then, they had me coming back every 2 weeks and calling back every 2 weeks until yesterday. Yesterday they told me that I was denied. Now then, what I want to say, if I can't get a job at the social security board, if I can't get a SSI check—they tell me down there when you get 40 years old, you lean on your children. I don't have any children to lean on, what could I do. Thank you. What could I do.

Senator BROCK. We are down to our last witness, and you have been more than patient. I have learned a lot, I hope you have.

Our last witness is the former Memphis city commissioner who retired to Covington, Stanley Dillard.

STATEMENT OF STANLEY DILLARD, COVINGTON, TENN.

Mr. DILLARD. I always like to think the people who voted for me as the number of years go by. It has been many years too, and I do thank you for letting me make my statement here today.

My name is Stanley Dillard, and I am a resident of Tipton County, near Covington, Tenn. I serve on the Tipton County Committee on Aging, and the advisory council to the area agency on aging.

Tipton County is composed of rich farming land, some 300,000 acres of which are under cultivation. The county agriculture extension agent states that the number of persons making gardens has risen noticeably over the last 5 years, because of rising food prices. The 5 percent this year who are growing and preserving their food has become a meaningful alternative for persons who live on irregular incomes or fixed incomes such as social security. However, many families, especially elderly persons, are unable to preserve food products because of the expense involved in acquiring canning equipment such as pressure cookers, adequate sinks, food choppers, and other necessary equipment. Furthermore, the elderly people who live alone and who do have canning equipment often find that their ability to move pressurized pots which are very heavy and extremely hot at appropriate times, prevents them from using canning as an alternative.

REVENUE-SHARING FUNDS HELPFUL

Through the help of the area agency on aging and the Lau-Fay-Ton Community Action Agency, we are constructing a facility—a cannery, at Burlison, Tenn., in Tipton County. The city of Burlison is constructing the building out of revenue-sharing funds.

The primary objective of this program is to provide Tipton County's elderly residents, rich and poor, black and white, the op-

portunity to maintain a well-balanced diet through their own resources. By providing a facility where food products may be canned and preserved at no expense, area residents save money on their grocery bill, have the convenience of not having to shop as regularly, and enjoy the pleasure of homegrown vegetables, fruits, and meats. In addition, Lau-Fay-Ton currently sponsors an annual garden seed program whereby seeds and fertilizers are given to low income and elderly families to make a garden.

We feel that the program will have a direct cash benefit to older people.

We can only estimate the savings that these people have realized from using existing canneries in other west Tennessee communities. During 1975, these canneries processed 222,824 jars of homegrown fruits and vegetables, 16,863 pounds of sausage, 8,184 gallons of lard, and 385 pounds of souse. Based on current prices in west Tennessee markets, the retail value of this food is $289,671 for fruits and vegetables, $25,294 for sausage, $22,833 for the lard, and $327 for the souse. I might add that I am using conservative food values so that the actual retail value should be much higher. The cost to area residents for putting up sausage, lard, and souse is less than 50 percent of the retail or grocery store value and the cost for preserving fruits and vegetables has only been the purchase of jar lids. Roughly speaking, the direct cost to these families has been less than $25,000, representing a savings of approximately $330,000 to the 8,993 families that participated in 1975.

Younger Persons Take an Interest

Aside from these economic gains, a number of other benefits have accrued. Where canneries have been established, they have had a tendency to become a focal point or gathering place for elderly residents. From this has developed a community spirit that is extending across religious, racial, and age barriers. For example, one of the interesting things that we have discovered is that interest in the elderly from younger persons has been generated. Younger persons are also preserving food and are consulting older persons for garden techniques and tips on almost forgotten canning recipes. Additionally, a number of homebound older persons are able to get out of their homes since free transportation is provided when it is needed. The important thing, however, is that a number of elderly citizens are persons who never acquired the skills of preserving food.

Additionally, the community of Burlison, Tenn., a small town of less than 400, approximately 11 miles west of Covington, has recognized the importance of this project to their area residents. This community has pledged $8,000 toward the construction of a suitable building in which to house the cannery, and this represents the first investment that this small community has ever made on behalf of economic benefits for its residents.

I do want to thank Senator Brock and Congressman Ford and the staff of the Senate committee for allowing me to relate how important this project is for persons who live on fixed and marginal incomes.

Thank you.

Senator BROCK. Thank you very much. I wish we had more time, because I can really get excited about that sort of thing, Mr. Dillard.

I would like to spread this sort of thing on the record, and use it to give people all over the country something they could be excited about, not just canneries, but in every area where people could cooperatively get together, and gain a sense of participation and do something of value.

We are at the end of this session, and I want to just make two or three concluding comments. First, Harold Ford had an emergency and had to leave. I know he regretted that.

Second, as I mentioned to you, these forms are available for comments from the audience. If you want to send them in, we would be very grateful to hear from you.

Third, my office is here in Memphis. If you have any problems we can help you with personally, please call. I am in the phone book.

Finally, and I guess this is as important as anything else, I want to thank you for coming, and particularly Richard Block and the people at the center for being such incredibly fine hosts.

It has been a super morning for me, and I appreciate it very much. Thank you.

Mr. BLOCK. May I have your attention, it looks like we are kind of batting the ball back and forth between us.

I think this has been a beautiful conference. I thank you all for being here. I want to particularly thank Senator Brock, his staff, and the staff of the Special Committee on Aging for making this the success it has been.

Those of us who have been here and you have participated in the conversation with Senator Brock, there can be no doubt about his very great interest and dedication to our services, and we do thank you, Senator Brock.

Senator BROCK. Thank you very much.

The hearing stands adjourned.

[Whereupon, the hearing was adjourned at 11:30 a.m.]

APPENDIXES

Appendix 1

STATEMENTS TAKEN BY SENATOR BILL BROCK AT A MEETING IN JOHNSON CITY, TENN., FEBRUARY 14, 1976

ITEM 1. STATEMENT OF CATHY ASTIN, COORDINATOR, PROJECT SEND, ELIZABETHTON SENIOR CITIZENS CENTER, ELIZABETHTON, TENN.

I am Cathy Astin, coordinator for Project SEND (Services Elderly Need Directly).

Our program currently serves 220 homebound elderly in the counties of Carter, Johnson, Unicol, and Washington. Project SEND employs three registered nurses and five nurses' aides to provide home health care to the elderly in these four counties. Our program is presently funded until June 30, 1976 by the Tennessee Mid-South Regional Medical Program. At this time we will have to seek other sources of funding in order to maintain the services of Project SEND.

The main objective of Project SEND is to provide health care to elderly who can and want to remain in their own homes, thus reducing admissions to hospitals and nursing homes. Studies have shown that the cost of nursing home operations greatly exceed the cost of in-home nursing care.

Speaking for the elderly population we serve, there is a tremendous need for better availability for durable equipment to be used in the homes. These would include beds, walkers, wheelchairs, commode chairs, and hydrolic lifts.

Another main concern of the elderly population served by Project SEND is the continuation of the medicaid program. The loss of this program would affect many elderly now receiving home health care benefits under the medicaid program.

There are only two health care programs serving the eight counties of upper east Tennessee, with three counties, Greene, Hawkins, and Hancock, having no health care programs at all. This in itself indicates a need for expanded home health care. On behalf of the 220 elderly homebound patients served in our program, and for those who could benefit from it in the future, I ask that any consideration for funds to operate our program be given.

ITEM 2. STATEMENT OF CATHY DAVIS, RESOURCE DIRECTOR, SENIOR INFORMATION AND REFERRAL SERVICE, INC., KINGSPORT, TENN.

I am Cathy Davis, resource director of Senior Information and Referral Service, Inc. As an information and referral center, our organization is very aware of the needs of the elderly. Utmost among these, and usually the most difficult to solve, are financial needs.

In discussing the financial needs of the elderly, it is natural to begin with the individuals in the most desperate situation; namely, those who have Supplemental Security Income as their sole source of income. If an individual is in this category, he is probably drawing around $158 per month. From this monthly income, expenses such as housing, food, utilities, fuel, medical, and miscellaneous expenses must be covered. Although medicaid helps with many of the medical expenses, there are additional charges that the individual must cover himself. The cost of utilities can be a real point of difficulty due to the

fact that some of our people have electricity bills that can run from $40 to $100 per month, further complicated by their poorly insulated homes. And the rates are going up. Along this same line, the price of coal is over $50 a ton and most people use at least six tons each winter. Because few coal companies will extend credit, the elderly are expected to pay over $300 in a lump payment.

But financial problems are not unique to those on Supplemental Security Income. Even if an individual draws a fairly decent income from social security, veterans' benefits, or some other source, there are certain expenses which they, too, can find impossible to meet. For example, the present cost of a hearing aid is $400 or more; dentures and dental care in general are unbelievably expensive. And neither of these items are covered by medicare or medicated in this State. Furthermore, if and when a senior citizen reaches the point where he must enter a nursing home, the costs can be shattering to almost anyone. The costs for nursing home care can run $600 a month or more. Medicare coverage of these expenses is limited. These limitations and high costs can cause such financial burdens, that we know of elderly couples who have been forced to divorce in order to avoid complete bankruptcy. Although medicaid can presently help tremendously with these costs, we are acquainted with the jeopardized position of this program.

We all realize that social security was never meant to be a retiree's sole source of income, but rather as a supplement. But how do we explain that to a 75-year-old widow who does not have money to buy fuel or food? What do we do with these elderly individuals who could not or simply did not save or plan for their retirements? Can we just turn our backs on the lady in Bristol who was burning her shoes for fuel, or the man in Kingsport who eats nothing but peanut butter? Do we just say that we are sorry they didn't understand the rules? And why do we penalize those over 65 who want to work to supplement their income by decreasing their social security payments if they earn over the established amount?

The answers are not going to come easily. But answers must be found because the condition of the elderly is not going to get better, it is going to get worse. And it won't disappear if we close our eyes.

ITEM 3. STATEMENT OF HOWARD N. HINDS, COORDINATOR, LEGAL SERVICES FOR THE ELDERLY, FIRST TENNESSEE-VIRGINIA DEVELOPMENT DISTRICT, JOHNSON CITY, TENN.

I. DELIVERY OF LEGAL SERVICES TO OLDER AMERICANS

The Older Americans Act Amendments of 1975 (Public Law 94–135) was signed by President Ford on November 28. This new law contains a number of provisions specifically referring to legal services and counseling which demonstrate beyond doubt the congressional intent that the program of legal services for older persons be expanded substantially.

Section 103 adds the following to the definition of social services to be provided under the act: "Services designed to provide legal and other counseling services and assistance, including tax counseling services and assistance and financial counseling, to older persons."

Section 106 of the act is entitled "National Priority Services." It provides that a minimum of 20 percent of the funds allotted to carry out State plans for social services for the elderly must be used for four priority services; transportation services, home services, legal and other counseling services, and residential repair and renovation programs.

Section 110 of the act strengthens the provisions dealing with training personnel in the field of aging. It authorizes the Commissioner on Aging to make grants to assist in paying all or part of the costs of "(1) the training of lawyers and paraprofessional persons who will (A) provide legal (including tax and financial counseling) counseling services to older persons. . . ."

The Older Americans Act Amendments were enacted too late to be included in the current Labor-HEW Appropriation Bill. It is expected that the spring supplemental appropriation bill will include appropriations for the activities authorized by the act. We respectfully request support of appropriations needed to implement the activities of this act.

II. FOOD STAMPS FOR OLDER AMERICANS

One of the more visible issues on the national political scene involves the modification of the food stamp program. In fact, several bills are now before Congress which would significantly alter the current administration of the food stamp program. These include President Ford's proposal, S. 2357, and the McGovern-Dole proposal, S. 2451.

The effects that changes in the food stamp program can have are illustrated by USDA's recent proposals to modify the food stamp allotment procedures. The Agriculture Department based its new proposals on a "new" thrifty food plan and the amount of nutrients needed by individuals based on their sex and age. The results are disastrous for senior citizens, particularly older women living alone (nearly one-third of all older women do live alone), and older couples on SSI.

In meeting senior citizen nutritional needs, Congress and USDA must be encouraged to consider the immobility of seniors, their physical illnesses which result in higher medical expenditures and the need to purchase special diets, and their inability to purchase the low-cost food. Congress, in section 701 of the Older Americans Act, has clearly recognized the unique nutritional problems of seniors:

". . . Many older persons do not eat adequately because (1) they cannot afford to do so; (2) they lack the skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; and (4) they have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone. These and other physiological, psychological, social and economic changes that occur with aging result in a pattern of living which causes malnutrition and further physical and mental deterioration."

To meet these special needs of our senior Americans, USDA and Congress must compensate the elderly by providing additional bonus stamps each month for every senior citizen. The importance of food stamps to our Nation's elderly poor cannot be overemphasized.

III. SSI: FOSTER CARE AND DOMICILIARY CARE PROGRAMS

In looking for ways to cut costs, the SSA is "reinterpreting" its policy governing SSI payment to older Americans living in the household of another.

The SSA has proposed to cut one-third ($52.56) the SSI income of every person living in the home of another—foster care domiciliary care, or with friends or relatives. Under this new "interpretation," there is no provision for the older person to prove that he or she is paying his or her share of the household expense.

This move will cause older Americans to become financial burdens to friends and relatives who have cared for them in their homes. Many may not be able to continue. Each of these living arrangements offers supportive community care so that institutionalization is not the only alternative for the older person who can no longer live alone.

There may be time for SSA to rescind this "interpretation." We request this committee's support in insisting on a rejection of this "one-third" regulation.

IV. COMPREHENSIVE HEALTH CARE OF OLDER AMERICANS

Recognizing, with gratitude, Senator Brock's bill to place hearing aids under the coverage of medicare, we submit these additional reforms in the area of health care for older Americans. Legislation is direly needed to greatly expand medicare coverage to include:

1. Unlimited inpatient and outpatient hospitalization;
2. Skilled nursing home and intermediate care services;
3. Outpatient prescription drugs;
4. Eyeglasses, hearing aids, and walking aids;
5. Physical and speech therapy; and
6. All emergency and some nonemergency transportation.

In view of the present economic situation and the improbability of the passage of a health care bill for ALL citizens, the health care of older Americans must be top priority.

It is time to change medicare from a *limited* health care program to one which can serve as a pilot project for national health insurance.

V. TAX REFORM

We urge passage of Senate bills 2401, 2402, and 2403:

1. S. 2401 would reinstate the full deduction for unreimbursed medical costs for older persons.
2. S. 2402 would update the retirement income tax credit to give it full and permanent parity with tax-free social security income.
3. S. 2403 would excuse taxpayers 65 and over from filing declarations of estimated tax on pensions, annuities, dividends and interest, if such income is $2,000 or less.

ITEM 4. STATEMENT OF ERNEST McKINNEY, ASSISTANT PRINCIPAL, SCIENCE HILL SCHOOL, JOHNSON CITY, TENN.

HOUSING CONDITIONS FOR THE ELDERLY IN THE TRI-CITIES AREA

Senator Brock, Congressman Quillen, and other visiting dignitaries, it is my pleasure to talk with you at this time about the conditions of housing for the elderly in the areas of upper east Tennessee and southwest Virginia.

One can look at the poster displayed before us here and get a bird's-eye view of conditions as found the areas aforementioned and readily see that the housing conditions are far, far from good.

The U.S. Census of 1970 showed a population of 55,815 persons of age 60 and over living in the areas covered by the First Tennessee-Virginia Development District.

Housing needs for the elderly in the Tri-Cities area were pointed up in a survey done in 1973 by the research staff of the FT–VDD and we have reasons to believe that because of the inflated costs of building and the economic crunch of the last couple of years, very little has been done to change the findings, hence they are being presented here today.

The Johnson City Housing Authority had 246 units for the elderly and a waiting list of 98 couples or singles. According to a spokesman for the authority, the need for housing for the elderly is much greater than the aforementioned waiting list since many of the elderly do not apply for housing when they find that the waiting list is so long.

The Elizabethton Housing Authority had 80 units built especially for the elderly with 26 units under construction in Carter County. There were 92 individuals on the waiting list. The director expressed a lack of concern for public housing for the elderly in his area and felt that more units were vitally necessary.

The Bristol Housing Authority had 152 units with 118 of these located in a highrise apartment. They had 115 persons on the waiting list. A great need was expressed by the Bristol Authority for more units for the elderly.

Greeneville Housing Authority had 80 units with a waiting list of 30 people. The director there also expressed a great need for more public housing for the elderly. If more public housing for the elderly were available, those living in the family units could be moved and those on the waiting list could be housed.

In Kingsport, there were 36 units for the elderly—all one-bed room apartments. Forty-four tenants were living in family units for the elderly. There was a waiting list of 90. There was an expressed need for more public housing for the elderly since the project had a long waiting list and many elderly couples were occupying two-bedroom apartments in the family unit.

Sneedville has 10 units for the elderly with 14 persons residing in public housing. There were seven on the waiting list. The director explained that applications are not made because the elderly know that units are unavailable.

In Erwin, there were 30 persons living in public housing. There were a total of 20 units designed for the elderly. At that time there were 10 elderly on the waiting list.

In the town of Jonesboro, the mother of the great State of Tennessee, there is no public housing at all for the elderly or any other persons. If it were

not for a few apartments privately owned and a few nursing homes, that are overcrowded with long waiting lists, they would have to go to Greenfield Farms. Greenfield Farms is also overcrowded, though now being revitalized.

The question may be asked as to why the concentration on public housing as a means of providing the relief needed for shelter for the elderly.

A survey for the Tri-Cities area by the personnel who administer the nutrition program for theh elderly revealed that the average income, nonfarm, for heads of household 65 years and over was $2,532 for males and $2,516 for females. For farm families, male heads of households was $2,154 and female heads of household $2,141.

This says to us that with that kind of income, they are unable to pay rent for privating housing and, those who are fortunate enough to own their homes find it difficult to pay taxes and keep their homes in a liveable condition.

I believe that we can feel safe in saying that while some few retired elderly live off both income from a retirement program and social security, a large majority must live off the social security income alone.

This report of the availability of public housing for the Tri-Cities area is typical of the conditions of housing in the entire upper east Tennessee and southwest Virginia area.

These briefly described facts gathered by the research staff of the First Tennessee-Virginia Development District as expressed by the many housing authorities, are the basis for my belief that housing is one of the foremost problems of those living in, and others of us who are facing, retirement years.

Thank you for the opportunity for this presentation.

HOUSING AUTHORITY UNITS FOR ELDERLY BY CITY

Housing authority	Number of units for elderly	Number (couples or singles) elderly on waiting list
Bristol	152 units, 176 occupants	115
Elizabethton	80 units, 112 occupants (26 units under construction)	92
Erwin	20 units, 30 occupants	10
Greeneville	80 units, 125 occupants	30
Johnson City	246 (40 units under construction)	98
Kingsport	36 units, (+44 in family units=130 elderly tenants)	90
Morristown	10 units, 14 occupants	7

ITEM 5. STATEMENT OF EVELYN STULTZ, DIRECTOR, ERWIN SENIOR CITIZENS CENTER, ERWIN, TENN.

TRANSPORTATION NEEDS OF THE ELDERLY

The need

Unicoi County and surrounding counties has a high population of over-65 citizens. Unicoi County has 11 percent of its residents in the over-65 category. The age of its residents continues to climb toward this grouping.

Due to the loss of vision and other physical handicaps, many of them have lost their confidence and ability to drive their own cars. Many no longer have a car nor any other means of transportation for the day-to-day activities we of the younger group take for granted.

Many of our citizens have doctors in neighboring towns, as we have but a few doctors in Unicoi County. Many come to the Watauga Mental Health Clinic for treatment. Without the limited transportation of the Easter Seal bus these would not get even this far.

Easter Seal transportation is but a drop in the bucket. Many older people do not like to call a day ahead and make a reservation for the bus. They pay from their meager incomes for some of their neighbors or friends with a car to take them to town.

No program for the elderly will be successful if they have no transportation to and from your facility.

We have a new meal site at the Unicoi Community which would be much more successful if we had some transportation to and from. Many of the programs would be better attended if the people they are meant to inform could get to them.

Unicoi County has no public transportation of any sort. Trailways Bus Co. does come from Asheville in the morning and goes to Johnson City. No bus station to serve its customers. One bus runs from Johnson City late in the evening toward Asheville, N.C. If you ride any of these buses you may get a connection and you may not. My main concern is the day-to-day needs for some form of public transportation in our boundaries. When millions are being spent for supersonic transports to carry 100 passengers, people in my county cannot get to the grocery store or the doctor by public carrier.

We are continually looking for ways to transport our members of the senior adult center to and from various events. As we look about, you may see hundreds of schoolbuses sitting idly by from 9 a.m. in the morning until 2 p.m. in the afternoon . . . waiting for children to be transported home from school Why could not these same buses be used in the meantime to take senior citizens to and from various centers of activity, on short shopping trips and to volunteer activities, meal sites, and to senior centers for much needed contact with others?

The barrier is the insurance and some laws at the State level. . . .

These same schoolbuses are paid for by the taxes of these senior citizens as well as the younger parents. This seems to me to be a waste of tax dollars.

Another avenue is the rows on rows of church buses sitting idly all week waiting for Sunday. . . .

Again there is the insurance problem. . .

We here at the Clinchfield Senior Adult Center are lucky in that the church bus of the First Baptist Church is ours for some of our activities We must pay the gasoline and the driver fees. Without this means of transportation we would be as housebound as if we were tied to a bedpost.

We will be better able to serve our senior citizens when we give them some means of travel that they can use on a regular schedule and pay for it. They want to pay their way in everything. I think they should be encouraged to pay when they can. After all, this increases their dignity and self-esteem.

Thank you for this opportunity to express my opinions and view about transportation needs.

ITEM 6. STATEMENT OF LLOYD MILLER, FIRST VICE PRESIDENT, STATE FEDERATION OF CHAPTERS, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, JOHNSON CITY, TENN.

Retirement. God bless our forbearers for the creation within our society that provided for our retirements.

It matters not if you are the weather-beaten farmer, the talked-out teacher, the ether-laden hospital orderly, or the flat-footed letter carrier. It doesn't make much difference if your retirement is from private life, public, city, State or Federal. Trying to keep food on the table, clothes on the back, and stay warm has, is, or can be, a problem to all of us.

Retirement is not meant to be a time when we just add years to our life but the time when we would add life to our years. Such is not the fact today

The man or woman who retired 20 years ago, on what at that time, was a good retirement, now finds it more difficult each passing day to accomplish the aforementioned necessities. There are no luxuries for them unless given.

I am sure that many of you here today are living with just such problems in your home. If you are not experiencing this now you might before too long with the ever-increasing inflation, the never-ending demand for more and more taxes, and the lack of competition. What do I mean by lack of competition? What has become of the small farmer? The man who once came by your door security benefit plan already have their Retirement Income Exemption. This is have had to hire a bookkeeper to fill out the papers the city, State, and Federal people demand. He would have had to hire a lawyer to tell him what he could do and what he could not do. He has quit just as have men and women of other small businesses. There are many varied and contributing factors other than these which I won't go into that are causing the dilemma for the retiree of today.

What will help the majority of the people most? You will notice that I didn't say majority of retirees. By majority I mean all the people of our great Nation. A Retirement Income Exemption is the answer. Not an increase in retirement income credit, but a Retirement Income Exemption of the first

$5,000 of any retirement plan, and at age 60. This of course would be for a married couple jointly. There would be comparable figures for other filees.

We all need to keep in mind that the maximum amount of social security benefits is $6,818.40. We also must keep in mind that all social security benefits are tax free from Federal income tax. So people retired under the social security benefit plan already have their Retirement Income Exemption. This is not to say that these retirement benefits are adequate. I hope to hear someone else testify on this matter.

Now, as I continue, I would have you realize I am now referring to the retirees under private, city, State, and Federal retirement plans. There are a few million of them. They are growing in numbers every day as our society calls for more teachers, more policemen, more workers in the private sector, and in many other fields. I would ask you to further keep in mind that as I give you some figures on these retirees, that I am referring to a married couple filing a joint Federal income tax return. These figures will be as of right now. This man and wife, to receive any retirement income credit, must in addition to filing a form 1040, file a schedule R. At the top of this schedule, in column C, appears a figure of $2,286. This $2,286 figure is not deducted from their annuity and tax paid on the balance. Far from it. This $2,286 figure is carried downward to another line on the schedule R. Here it is multiplied by 15 percent. So doing they will arrive at a figure of $342.90. This amount is all that becomes tax free to this couple.

This is inadequate, unjust, and unfair. I will argue with anyone who disagrees. Give these people the help they need, a Retirement Income Exemption of the first $5,000 of their annuity.

What will the results be? The first thing that comes to mind is this will take a lot of money out of the Federal income tax stream. I ask you to think a bit. Will it? These people are not in a position to bank this money. They are going to spend it. The way taxes are today, four or five turnovers of these dollars and all is right back into the tax stream. These dollars will create jobs for other people who will also be paying taxes.

Last year, President Ford said that giving people a tax rebate was the best thing for the economy of our Nation. It was done. He was right. The majority of our Senators and Congressmen thought it was right. They only carried out your wishes, so you thought it was right. This $5,000 Retirement Income Exemption will do the same thing, in addition to helping the retiree. So be right again and support such a measure.

Those of you retired need this now. Those of you not retired will need it when you do. Lets do it together.

ITEM 7. STATEMENT OF BEN PEEPLES, FIRST TENNESSEE-VIRGINIA DEVELOPMENT DISTRICT AREA AGENCY ON AGING, JOHNSON CITY, TENN.

The major problems which result in the needs discussed here today, come from the overall designing by our government in providing for services to the less fortunate and to the aging.

One major area of concern stems from the problem of ever increasing amounts of government procedure and policy control. The Federal Government should be responsible to the Nation's taxpayers for the funds they administer. But realizing the necessity of accountability, our government has created an inadequate system based on numbers and forms. Such a system is accountable in many respects, but defeats the purpose of government in other respects. Each agency involved with Federal and State financing has separate forms and policies which govern its operational structure and its degree of flexibility. The Federal Government has created a system in which performance, especially that of social services, is based solely on numbers and not on quality. This inequality is reported o nforms numbering in the thousands. Agencies find themselves more concerned with how many, and which form applies, instead of how well in respect to the services they administer. With all the forms and policies that are handed down by the Federal representatives in Washington, the Nation is soon to be taken over by the paper manufacturers of the world. Surely, they are the ones reaping from the fiscal management and reporting systems of our

government, not the people we originally had hopes of helping. In the same respect, the government preaches coordination but creates an atmosphere of competition for dollars through this numbers game. The services being delivered are second hat to the competition itself. Agencies see the need to coordinate with other agencies, but all is lost in protecting their future as agencies.

This leads to another area which creates problems—that of unrealistic goals with inadequate funds to reach such goals. Each year the government spends many man hours and dollars deciding what is the best way to provide particular services to the people, and such decisions are based many times on the numbers aforementioned The intended goal, that of helping people, is lost in political forum. By the time the legislative goals reach the people there is only a piecemeal amount of funding compared to what is really needed. Our government gives us a dime to do a dollars worth.

Federal Matching System

There is another major concern which inhibits local governments, especially in rural areas, such as east Tennessee from pursuing a better comprehensive service system. This is the problem of the Federal matching system. Each year, our government collects taxes from the working public in order to function as a government for the people. These taxes are used to promote the growth and well being of our country, part of which is to protect its aging population through various Federal programs encompassing many local, State, and Federal agencies. Such programs are available in many cases only if the local community concerned can generate more money from the people. The government offers such services or funds in ways in which many communities cannot afford to partake. This is to say they take money from the public and offer it back if the public is willing to give more money. Our Federal matching system is unrealistic in that people, many of whom pay taxes, are denied services because their community cannot afford to put up additional money. Meanwhile the funds sit and services are needed. The government was designed to help the people it represents through the funds generated by taxes, but yet the policies are designed in such a way that the people are not getting helped in areas that need it most—the areas that are economically starved.

To sum up, the broad spectrum of problems discussed is to say that:

(1) The Federal Government needs to become less quantitative and more qualitative. In other words there needs to be less forms and more service. If some of the bureaucracy could be cut out of the social service delivery system, our government would have enough money to help the people at home as well as in foreign countries. A suggestion would be to change the government's methods of proving the success of services funded in part through Federal sources. Numbers are many times guesstimates and duplicatory and don't really represent the success or failure of anything. Listen to the people—they and only they can tell the real benefits of what the government does.

(2) Our government has to decide whether it is or it isn't going to solve the problems discussed here today. If it is, then go at them with full force and provide the necessary funds to solve these problems. If not, don't waste the taxpayers money with piecemeal programs. A good step in the right direction is to quit forming new services to perform the functions mandated through existing services. The old programs die out due to a lack of continued government support only to be replaced by new programs which must start at the beginning. In the meantime people are in a state of need and confusion.

(3) Our government needs to revamp the matching system in such a way that if communities can't generate local funds, then they are not penalized. The money belongs to the people in every community, and the ones that are not developed as well continue to be left out of the picture while those that have benefited from the present system continue to do so.

Our government has spent millions even billions to reconstruct countries, countries that we have spent millions to destroy and all the while we have people without enough food to eat, clothes to wear, and coal for the stove probably within walking distance of this meeting today. Our priorities must change if our people are to survive—if our government is to survive.

Appendix 2

LETTERS FROM INDIVIDUALS

ITEM 1. LETTER FROM ROBERT ROCHELLE, EXECUTIVE DIRECTOR, SENIOR CITIZENS SERVICE, MEMPHIS, TENN.; TO WILLIAM E. ORIOL, STAFF DIRECTOR, SPECIAL COMMITTEE ON AGING, DATED MARCH 5, 1976

DEAR MR. ORIOL: We appreciate your dedicated efforts in seeking to find the truth concerning the needs of older citizens in terms of income needs in the Memphis area. We realize that in the brief time you have available it is impossible to learn all that needs to be said. It is also obvious that it would take an extremely long letter for me to explain in detail the items which are serious needs in this community. However, I wish to send some recommendations that we feel, from the standpoint of a direct service provider, need attention.

It can easily be documented that one most serious need for the older citizen today is simply more dollars to purchase the items necessary for life maintenance. There seems to be no complete way to hold down the costs of living effectively enough for the older citizen. Therefore, the only viable way to relieve much of the complications of their lives is to increase the amount of money they have available to meet their needs. This means increasing social security, SSI, and other income benefits.

Some of the specialized needs of older citizens could be faced, by relieving those relieve much of the pressures of their existence. One great assistance would be the ability to secure medication at either a reduced rate, or, for it to be subsidized under the social security system.

Medications are a way of life for older Americans. The increasing costs of medical care are prohibiting older citizens from going to see physicians. The burdensome regulations of medicaid and medicare have discouraged many physicians from even treating older patients. Some simplication of the system should be made to allow proper physician care to be available in a way the older citizen can obtain it. Poor health is quite frequently a companion of older years.

ADEQUATE AND SAFE HOUSING

Adequate and safe housing is another serious need of the older citizen. However, the housing should be of such a nature as to be satisfying for the older citizen. The highrise apartment buildings are suitable for many tenants but do not provide nearly the sense of "home" that other types of housing types ranging from the highrise apartment, the single or duplex type family units, group homes in a community setting, the encouragement of personal or foster care home units, the development of convalescent homes, intermediate care and skilled nursing care facilities for seniors as well. It is all too common to find older citizens in a setting that is not suitable for their needs while others who should be in that position are denied that opportunity. Additional facilities would appear to be the only suitable answer.

It is becoming increasingly clear that some control or subsidy for senior citizens' utilities must be provided. Increasing utility rates are becoming intolerable for most older citizens. Utilities are a problem which face all citizens, but the oldster is particularly hard hit.

The problem of nutritious food will inevitably plague senior citizens. The congregate meal sites have been a blessing to the older citizens. One of the reasons most older people are not eating properly is the lack of desire to eat when a person is alone. These group meetings for meals have stimulated many older citizens into a new stream of life. Home delivered meals are a dire necessity for many home bound elderly in order to receive nutritious food. This valuable component will enable other citizens to remain in their own homes far longer.

Home health care, particularly homemakers, can be a valuable tool in eliminating unnecessary or premature institutionalization, which is within itself a great demand on public dollars. When home health care can be provided for 25 percent to 40 percent of institutionalization, and yet still provide the needed care, the additional funds could be diverted into other programs which would help meet other categories of need. Sometimes a service provided can be as valuable as dollars to provide the alternative.

Need for More Service Aides

We have several social workers helping meet the needs of older citizens within the Memphis community. However, we see a serious need for a number of additional social service aides who can help secure food stamps, obtain eligibility for service, and in general assist the older person to meet their social needs. These aides would be less expensive than the social workers and can provide the less skilled type time consuming jobs.

One direction that appears needed is the development of funding sources to assist multipurpose senior centers in their operation. Currently the Older American's Act and its amendments do authorize these services but without an appropriation to fund them. These service provision centers would be valuable units within the communities where older citizens primarily reside. Multiple services in a single setting of high accessibility and recognition would initiate much needed service.

One of the things needed on the local level is better cooperation with government agencies in their provision of services to the specialized groups of persons called senior citizens. Not only are eligibility requirements too stiff and demanding but the procedure of securing service can be prohibitive. The income situations of older citizens seldom change for the majority. But eligibility still has to be done, often every three months for many of the services. Annual recertification seems more reasonable.

It becomes almost impossible for the senior citizen to spend the time and energy it takes for a 6-hour trip to the food stamp office in order to secure a rather menial amount of supplemental dollars. Most senior citizens just will not go to the trouble to receive these much needed stamps. A solution would appear to be providing specialized times and lines for older citizens who do not have the energy to meet the demands of the current process. The same holds true of securing service in other government programs.

Transportation is essential for older citizens. Their needs are unique and it demands unique approaches. Public mass transportation is highly valuable, but transportation from a particular location to another particular location has to be provided to the older citizen who has no other means of mobility. This means to medical facilities, social and recreational activities, shopping, religious activities and general transportation. Careful planning could provide a good deal of this service with money currently being used on a general scattergun approach to mass transportation. Providing the services is not a real solution unless adequate transportation is provided for the senior to get to that service. Economically the drain on the citizen's income for transportation can be a tremendous loss in terms of their monthly income. Thus another interaction enters the whole picture.

It should be clear by this time the needs of the senior citizen's income needs are so interwoven that they are difficult to separate. The need is for more than just additional dollars, although that is imperative, the need is for services that meet real needs and accessibility to those services to help alleviate some of the problems. It is a complex situation and will demand complex solutions. If government agencies would work cooperatively at the local level to meet the specialized needs of senior citizens these could be more easily met.

I am afraid finding the problems can be simpler than finding solutions but I will be happy to work with your staff at any time on any of the specific issues mentioned here, or others. We appreciate your interest in resolving these needs and look forward to hearing from your office in terms of what is being done as your efforts progress.

Yours truly,

Robert Rochelle,
Executive Director.

ITEM 2. LETTER AND ENCLOSURES FROM ROBERT ROCHELLE, EXECUTIVE DIRECTOR, SENIOR CITIZENS SERVICE, MEMPHIS, TENN.; TO WILLIAM E. ORIOL, STAFF DIRECTOR, SPECIAL COMMITTEE ON AGING, DATED APRIL 27, 1976

DEAR BILL: Enclosed are three examples of specific cases in which homemaker services were of value. In each case the client signed a form indicating permission to use their name as a personal reference in whatever document you choose consistent with propriety. This number could be multiplied considerably and explained in much more detail if time and space allows it.

Getting to the problems involved in the provision of medicaid and medicare services to the elderly becomes a complex matter. I will try to briefly state some of the problems faced.

In this community some physicians are rejecting the treatment of medicaid patients. The burdens and regulations are such that the medical sources can no longer bear the cost of providing the service. Thus, the patient may be unable to locate a doctor when necessary, or may be terminated as a patient, or has a limited selection of physicians. This may mean that the medicaid patient receives a lesser quality care, although this is not evident.

In many cases the medicaid patient must pay their charge in advance in order that the physician's office will not have to go through the burdensome problem of retrieving cost. Once the claims are filed by the patient if the charge is refused the patient pays the entire cost. If the charge is paid then that patient still has to have the out-of-pocket expense during the interim regardless of what kind of hardship it may cause. This seriously discourages medical treatment.

In a recent discussion with a medicare provider, some of the same, though not all, of the problems were evident. In the medicare program in this State, certain insurance companies are used as intermediaries. These intermediaries use quite broad arbitrary bases on which to make payments for claims. Apparently they make rather strict requirements in terms of reporting and case definitions and then at times will change their decisions as to what they will in the end pay. At times, charges paid previously will not be paid when billed. It then becomes a guessing game for medicare providers as to what charges are in fact billable.

A companion agency here in Memphis recently began to make the transition from a fee for service home health program to a medicare provider. Just to meet the reporting and monitoring requirements for medicare his actual cost doubled. Our cost under a federally subsidized program through title XX is about half of the average cost in the city for the same type care under medicare and/or medicaid, and in some cases the difference may be as much as three times our cost. We operate also, under Federal control, requirements, and monitoring, and yet our service is acceptable and certainly productive for the clients. However, we do not have the complex and discouraging reporting procedures that medicare and medicaid now demand. No doubt the concern for quality service must be ever present but a less demanding system surely could be designed. I am sure physicians and home health care providers are providing you with more than adequate amounts of complaints regarding these items.

I hope the assistance of persons like myself and our agency are of help to you in your efforts. I will be happy to assist further if and when our services may be beneficial.

Most sincerely,

ROBERT ROCHELLE,
Executive Director.

[Enclosures.]

Mrs. Gladys White, Memphis, Tenn.

Mrs. Gladys White has received homemaker care since December 1975. Mrs. White, age 61, is an obese woman who lives alone in a public housing development. She is a diabetic and a stroke victim.

Upon first contact with this client it was noted that she was dirty and her hair was matted for lack of shampooing. Her apartment was in need of cleaning, urine was visible on the floor, and the odor was very offensive.

Mrs. White is paralyzed due to her stroke and was having to pay someone to get her out of the bed each day and put her in her wheelchair, as well as paying someone to cook for her. This took a large portion of her income of $157 a month.

Her situation was complicated by the fact that she has aphasia as a result of her stroke. It was frustrating to her to try to communicate with neighbors and paid help who did not always take the time to try to understand her.

Since beginning service Mrs. White has received personal care, housekeeping, and meal preparation service. She is now clean and neat. Her apartment is clean and free from offensive odors. The homemaker and social worker take the time required to communicate with her. This has added quality to her lonely and difficult life.

Mrs. White has no family and probably will someday have to enter a nursing home to which she is very much opposed. This service has made it possible for her to stay in her home and maintain some degree of independence.

Mrs. Hattie B. Neely, Memphis, Tenn.

Mrs. Neely is 82 years of age, primarily bedridden and mentally inactive. She has an elderly brother living in the home, but is not really dependable and responsive to the needs of his elderly sister. Aside from the fact just mentioned, the brother has a drinking problem.

The social worker and the homemaker have been and still are a tremendous asset in retaining this senior citizen in her own home. Several months ago, Mrs. Neely's SSI check was discontinued due to the fact she failed to report the necessary information to the Social Security Administration. Oftentimes Mrs. Neely's mail is disregarded or misplaced, and is never seen by the social worker or the homemaker. So Mrs. Neely had to suffer the consequences. For 2 months the client was without income. Due to the efforts of her social worker, Mrs. Neely was donated groceries. The social worker also contacted several other resources concerning this case. On a couple of occasions, nighttime pampers were donated to this bedridden client in her turbulent times.

Recently the social worker has assisted Mrs. Neely in making preparations for her will.

If it were not for the homemaker and the social worker, Mrs. Neely would very well face the possibility of being placed in a nursing home.

Mr. and Mrs. George Nash, Memphis, Tenn.

Mr. and Mrs. George Nash are an elderly couple, who were referred to us by Mrs. Nash's sister. Mrs. Nash is slightly retarded and is rapidly losing her vision due to an untreatable disease. She has fainting spells fairly often. Mr. Nash has suffered a stroke and was confined to a wheelchair at the time Senior Citizens Services, Inc., started to send in a homemaker. The homemaker assisted with household errands and housekeeping tasks. The social worker helped to obtain food stamps for the family and helped with several business matters.

Mr. Nash then had several more strokes and was then confined to a hospital bed. The homemaker helped with the personal care and encouraged him to eat. Nursing placement seemed necessary and the family began applying for placement for the Nashes. The homemaker continued to help the couple in many ways and Mr. Nash has recovered to the point that he can now sit up in his wheelchair again. With the home care assistance the family has received nursing home placement no longer seems necessary. The couple is very happy to remain in their home and hope to maintain their independence for as long as possible.

APPENDIX 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR BROCK: If there had been time for everyone to speak at the hearing on "Future Directions in Social Security," in Memphis, Tenn., on February 13, 1976, I would have said:

The following replies were received:

LOUISE CHIPLEY, MEMPHIS, TENN.

Much, much is being said and some things being done about the physical aspects of our social life, but absolutely nothing about the moral and the ability to clean up the slum element places from which they insist people be moved.

First, I would say get the slums out of the people—and there would be no problem of getting people out of slums. If these people could be really taught to clean up themselves and the place in which they live and help them do it and make it a requisite for moving to better housing—the new places would not become insect and rat filled immediately.

What the NAACP and other such organizations need to do is to care for peoples' souls instead of their own power—not one among today's peoples are poorer than I was as a child—there were no welfare agencies or food stamps—but the associated charities paid rent to the landlord and gave us a grocery list to take to the store to be filled as it appeared on the list. Thats' all we had most of the time.

CASSIE DOTSON, MEMPHIS, TENN.

When will help come that will help get some of us back on the God's big world, where we can raise the food that is on our diet sheet with five cups of corn; one-half dozen stalks would supply that item. One stalk of beans, and so the diet sheet goes. Also it would give the senior citizen a conversation piece and something to look forward to, say a feeling that I haven't got all helpless.

I have a small piece of land and pay $90 per year taxes, without a house, but would be glad to live there along with other senior citizens. But there seems to be a lack of funds to build several houses, all of which we could pay for if given a chance. We wouldn't lose all of our strength.

I would like to borrow enough from Congress to build at least one double tenant house, please.

HAZEL FORRESTER, MEMPHIS, TENN.

Homemaker-home health aide services are not sufficiently provided in Shelby County for those ineligible for medicare. These low-income persons have no relatives or monetary resources and certainly no influence to bring such services in their home when sickness and disability strike.

Broader funding beyond title XX (wherein 10 percent required) needs desperately to be applied to this vital service, entitling the poor to care by homemaker-home health aides. HHHA service should be mandatory nationwide and prevent not only early institutionalization, but highly expensive care in hospitals, which, for the poor, necessarily *has* to be borne by taxpayers.

I understand the welfare department offers some care, but Senior Citizens, Inc., under a title XX grant is now serving 415 sick oldsters with HHH aides—their waiting list is 150 and they don't even publicize.

Please expand this care for homebound.

EDWARD L. FREDERICK, SAVANNAH, TENN.

Taxes for the elderly should be eliminated on earnings or pensions over a certain livable amount, at least $1,000 per month. Medicare should be increased or administered more efficiently without all the redtape and duplication—more and better coverage. Also, provisions to help either in lowering rates on public utilities for senior citizens.

Right to work for all senior citizens, if able, without being penalized by more taxes.

Able to get in trade schools to learn a new trade, etc.

Help anyway possible to help others to have a happier healthier and eventful life.

Telephone committees to the elderly and a way to bring them to doctors, stores, food, and drugs. No food wagons, unless necessary; people need to get out and meet others if possible.

BESSIE MILLER, MEMPHIS, TENN.

How much more are they going up on our social security? It takes all I get now to live on. I do not get anything else but my retirement and I can hardly *make ends meet now* for I have so much to pay out on my doctor bills and medicine I have to take so much. I was sick all last year, had two operations on my breast which led to removal of both with cancer pneumonia. Twice I almost did not make it, now I am taking a kind of medicine. I cannot get help with my medicine, which I need all the time. They will not help me with medicaid—said I was getting $1 too much to be eligible to receive a medicaid card. I would appreciate it if I could get some kind of help with my medicine if I could. Anyway, I tried, and they told me I had to have $135 in unpaid bills. I have two doctors to pay beside my medicine.

Are there any other way I can get some help? I would appreciate it if you could let me know. I don't know what I will do if they keep going up on it.

WILMA W. MONTGOMERY, MEMPHIS, TENN.

Tell Congress and this committee the things you've been told today and especially tell them: "There, but for the Grace of God, will go you and I."

And what you heard is but the tip of the iceberg.

JANE S. WHITE, ELIZABETHTON, TENN.

There are 75 elderly alone in substandard housing in Carter County (or living with families in crowded conditions).

We need another public housing for elderly development for Carter County—not a highrise (which would be an unnatural home for these people and also difficult to evacuate in case of emergencies).

We need another nursing home in Carter County—preferably one that accommodates medicare since none of ours do now.

Multipurpose senior citizens centers are the hub of life for the elderly. Why do we have an approved title X legislation and yet no money allocated for it? Our own center is in three parts—a small cottage for offices, lower part of a garage apartment for ceramics, and cafeteria of a condemned junior high school next door.

Revenue-sharing has been a farce for the elderly who certainly paid their part all thru years.

Telephone costs should be less for the sickly who often can't even have one now.

RUSSELL F. VIZZI, MEMPHIS, TENN.

This is a problem I have written to you before (and you were kind enough to respond), regarding the *Federal Register* proposed regulations on advanced approval for home health services.

Nationwide, nearly every major organization is opposed to same—yet, it is my understanding that HEW intends to implement that program; in fact it will be an item of discussion at the annual meeting of home health agencies in March (I believe the 15th and 16th, to be held by DDR (direct dealing reimbursement.)) This is the agency that a home health provider must deal with when they elect social security as their fiscal intermediary. DDR is an arm of HEW. As far as we know, no public hearings were held.

HEW attempted similar regulations through the *Federal Register* which would have required hospitals to call and secure *permission* to admit a patient (medicare) to the hospital. This regulation was tied to UR (utilization review and PSRO's), was stayed through in injunction by Judge Kaufman in Chicago. (AMA brought suit.)

We have almost if not the identical situation occurring for home health services. My earlier letter outlined in detail, our objections to same.

Can you and the other Senators help.

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FUTURE DIRECTIONS IN SOCIAL SECURITY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 24—PROVIDENCE, R.I.
Impact of High Cost of Living

JANUARY 26, 1976

Printed for the use of the Special Committee on Aging

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Future Directions in Social Security:

Part 1. Washington, D.C., January 15, 1973.
Part 2. Washington, D.C., January 22, 1973.
Part 3. Washington, D.C., January 23, 1973.
Part 4. Washington, D.C., July 25, 1973.
Part 5. Washington, D.C., July 26, 1973.
Part 6. Twin Falls, Idaho, May 16, 1974.
Part 7. Washington, D.C., July 15, 1974.
Part 8. Washington, D.C., July 16, 1974.
Part 9. Washington, D.C., March 18, 1975.
Part 10. Washington, D.C., March 19, 1975.
Part 11. Washington, D.C., March 20, 1975.
Part 12. Washington, D.C., May 1, 1975.
Part 13. San Francisco, Calif., May 15, 1975.
Part 14. Los Angeles, Calif., May 16, 1975.
Part 15. Des Moines, Iowa, May 19, 1975.
Part 16. Newark, N.J., June 30, 1975.
Part 17. Toms River, N.J., September 8, 1975.
Part 18. Washington, D.C., October 22, 1975.
Part 19. Washington, D.C., October 23, 1975.
Part 20. Portland, Oreg., November 24, 1975.
Part 21. Portland, Oreg., November 25, 1975.
Part 22. Nashville, Tenn., December 6, 1975.
Part 23. Boston, Mass., December 19, 1975.
Part 24. Providence, R.I., January 26, 1976.
Part 25. Memphis, Tenn., February 13, 1976.

(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

FUTURE DIRECTIONS IN SOCIAL SECURITY

MONDAY, JANUARY 26, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Providence, R.I.

The committee met, pursuant to notice, at 10 a.m., in the Providence Public Library Auditorium, Hon. Frank Church, chairman, presiding.

Present: Senators Church, Pastore, and Pell, and Congressman Beard of Rhode Island.

Also present: William E. Oriol, staff director; Diana L. McIver, professional staff member; Mike Wetherell, administrative assistant to Senator Church; Peter Harris, legislative assistant to Senator Pell; John Guy Miller, minority staff director; Patricia G. Oriol, chief clerk; and Donna Gluck, resource assistant.

OPENING STATEMENT BY SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. Ladies and gentlemen, the hearing will please come to order. I am Frank Church, the chairman of the Senate Committee on Aging. I am delighted to be with you, and I am very pleased to see such a good turnout this morning. I have a prepared statement that's just full of all kinds of wisdom, you understand, but it's too long for me to give because the purpose of this hearing is to learn from our witnesses here this morning, from you here, what the problems of aging may be in this State and to get recommendations from you as to how conditions can be improved.

So I am simply going to introduce the statement that's been prepared for me into the record and not take your time in reading it.

This hearing is one of a series of hearings that we have been conducting in many parts of the country dealing with the future direction of the social security program. The hearings have been very productive, and I know that this will be no exception. From them we are going to prepare recommendations that we believe will help to close the gaps in medicare, that will further improve our efforts to keep social security inflation-proof, and which will delve more effectively than we have in the past into the special problems of housing and transportation that cause such serious troubles for so many older people, and other subjects, too, relating to the direction that the social security program shall take in the future will naturally be the subject of these hearings. We expect to get testimony on all aspects of the case throughout the course of the hearing today.

[Prepared statement of Senator Frank Church, chairman, follows:]

PREPARED STATEMENT OF SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. Good morning. I'm Frank Church, and I would like to welcome you to this hearing of the U.S. Senate Committee on Aging on the subject of "Future Directions in Social Security: Impact of the High Cost of Living."

I'm especially pleased to be joined by several of your elected Rhode Island officials in this examination of the special problems of elderly persons in Rhode Island. With their help, perhaps we will leave here with good, solid Rhode Island ideas for solving these problems.

And the problems, as we have had them described to us by elderly witnesses across the country, are severe. 1975 was a year of sacrifice for older Americans, and a year of hard choices. A couple of years ago, one choice might have been whether to have hamburger or no meat at all for dinner; today that choice is often whether to forego a meal altogether in order to pay for a needed prescription drug, or an overdue utility bill.

Inflation has dealt the hardest blow to elderly persons on fixed incomes. The items they need the most—health care, food, housing, and utilities have increased faster in cost than other items. Testimony before this committee, in fact, has made a strong case for early action on my bill to establish a separate Consumer Price Index for the elderly, and to base social security cost-of-living increases on this special index.

Medical costs are of special concern to me and to many of the witnesses who have appeared before this committee in California, Iowa, New Jersey, Oregon, Tennessee, and Massachusetts.

And, here in Rhode Island—the home State of Aime Forand and John Fogarty—I can't help taking a moment to talk about what is happening to medicare.

COSTS GO UP AS COVERAGE GOES DOWN

Statistics tell part of the story. In 1970, the average out-of-pocket costs borne by elderly persons for health care costs amounted to $270. Last year those personal health care expenditures had gone up by $145 to $415. And this does not include their payment for part B premiums. Everything is going up in medicare: coinsurance, deductibles, premiums. But medicare's coverage is going down. It now meets only 38 percent of all health care expenses for the elderly.

Older persons have told the committee what these numbers mean to individual people: the widow who can't find the money to pay for the prescriptions that medicare doesn't cover, the person who must go to a nursing home because medicare discourages home health care, the physician who knows of malnutrition cases which become hospital cases.

And yet, despite the growing burden of medical costs upon the elderly, President Ford's state of the Union and budget messages propose to cut medicare still further.

Mr. Ford called it catastrophic health insurance for everyone covered by medicare. He said nobody would have to pay more than $500 a year for covered hospital or nursing care or more than $250 for doctors' bills in 1 year.

That sounds good, doesn't it? The President makes it look as if there is a limit on how much older people may have to pay for health care. But the President also says that "fees for short-term care will go up somewhat."

And this, my friends, is exactly what Richard Nixon offered twice and President Ford offered last year. He called it "cost sharing" then, but what is really involved? He is proposing that the costs paid by the vast majority of people who use medicare should go up. Now, when a person receives hospital care under medicare, that patient pays $104 of the hospital bill for covered services and nothing else until the 61st day. Under the latest version of cost sharing, medicare beneficiaries would pay the $104 and then 10 percent of all charges on covered services above that. There would be increases in the deductible and, in the coinsurance charge on certain services under part B of medicare. And even the ceiling on a patient's liability has a loophole in it. It would rise whenever social security is raised. In other words, there would be a built-in penalty for every social security increase from now on.

Senate Concurrent Resolution 86 Is Unacceptable

I tell you here and now that I find this proposal to be totally unacceptable and I have asked the Senate to join with me in expressing our total rejection of this proposal and the philosophy behind it (S. Con. Res. 86).

It's a shame that the so-called experts who devised this so-called catastrophic health insurance scheme couldn't have gone out and heard directly from the real experts on medicare: the ill, elderly persons who are trying to make use of that program. Quite often, they are helped, and in major ways. But they can't help asking: why are there so many holes in the coverage? Why does the executive branch in Washington keep trying to do medicare in?

One of the problems in Washington is that high-salaried executives like to think of the hypothetical or "average" person. They want people to fit the categories, and not the other way around. In Boston a few weeks ago, a witness described a local initiative in congregate housing and said that the Federal Department of Housing and Urban Development never would have approved this kind of housing because it was suitable for only 15 to 20 percent of the elderly population. To HUD, the answer is an answer only if it is a "big" answer for a majority of people, and even then HUD won't really do what's needed to make a program work. HUD refuses to recognize individual solutions for individual people.

I think it's only sensible, if you are building housing for the elderly or a senior center, to talk to the experts, the people who will use that center. And if you're putting together a nutrition program, find out what older people want.

In our democracy, now 200 years old, it is always time for government to listen, to hear what people are saying. And that is why we are in Rhode Island today. I'm looking forward, with Senator Pell and other of your elected officials, to your testimony.

[End of prepared statement.]

Senator CHURCH. It's my special pleasure to welcome to the committee this morning the senior Senator from Rhode Island whom I have known for nearly 20 years. I have been a pupil of John Pastore's, as all of us have, and I think that it's remarkable that even though he now plans to retire he is still on the job, and he is with us this morning, and we are very pleased to welcome him to these hearings. It is a privilege.

STATEMENT BY SENATOR JOHN O. PASTORE

Senator PASTORE. I am not a member of this particular committee, but indeed I am very much concerned and interested in the functioning of this committee. I particularly want to pay my compliments to Mr. Church and Mr. Pell for arranging these regional meetings. Mr. Church, these are some of our State's finest. They are the ones who produced the sons and the grandsons who fought for this country. They are the ones who did the menial work at best in order to make this country great, and now when they are within the twilight of their careers they look around, and they see a country that does so much for other people all over the world. We have spread our largess all over the world. If there was ever a national disaster, we were the first ones to be there to help people, to feed people.

We have had a food for peace program. We have had a tremendous amount of money spent for foreign aid, and yet when it comes to our own American golden agers we just don't do enough.

These are not the affluent people. These are not the people that can come to Washington, and I am so happy that you could come to them, and I wish you every success. I merely want to call to your attention, Mr. Chairman, an editorial that appeared in yesterday's *Providence Journal* which I think is very provocative, and merits the consideration of the entire Congress. The title of it is, "Social Security Needs Total Review," and I would hope that you would make this a part of your record.*

Senator CHURCH. I will do so, Senator.

Senator PASTORE. There is another article that appears in today's paper. It is entitled, "Greenspan Admits Ford's Tax Plan Hurts the Poor."

Senator CHURCH. That's no news.

Senator PASTORE. I want to hear from these fine people. I want to make another observation. I am the only golden ager on this platform.

Senator PELL. I will take exception to that statement, because I too am a golden ager. I am only 55. What's your definition?

Senator CHURCH. You're getting there, Senator.

Senator PASTORE. You can't collect social security until you're 62 if you're female and 65 if you're male. That's what makes you a golden ager.

Senator PELL. But the movie theatres and privileges apply when you're over 55.

Senator PASTORE. I don't go to the movies.

Senator CHURCH. We are going to end this quarrel between the two Senators from Rhode Island. I would like to welcome Senator

* See appendix 2, item 1, p. 2136.

Pell, who has done work through the years with the golden agers. I have watched him, and he was especially anxious that we should hold these hearings in Rhode Island, and I would like to call on him.

STATEMENT BY SENATOR CLAIBORNE PELL

Senator PELL. I, too, have a very wise and lengthy statement that I will ask the Chairman's permission to put in the record. What we are here to do is to learn and listen. What we really are here to do is to learn what happens when senior citizens are faced with problems that come to us with inflation. This is the cruelest tax there is, the increasing cost of living, the fact that the dollar that you have today will purchase 90 or 95 cents of goods a year from now. This is the worst tax the State and local government can have. It would be much more honest were we to raise taxes if we could stop inflation, because inflation is the thing that really bites and really eats. You know that when you have to pay 60 cents a pound for bread, or 89 cents a pound for hamburger, and $1.29 a pound for fish.

Senator CHURCH. You'd better get your wife up here to tell you about the present prices.

Senator PELL. Speaking of the "spice," that's the plural of "spouse," wives, I would like to introduce Senator Church's wife, who is tucked away in the audience. Bethine, will you stand, please? There she is. Also, my own wife, Nuala, she is here. These are the other golden agers under my definition, but in any case you know the suffering that goes on. You know the needs, and I think what one doesn't really know as regular citizens is the miserable, the sick, the poor, the old. You don't see because they are not out on the streets. The people out on the streets are healthy, and well, and working, and it's a concern of ours, the people that you don't see.

I would like to also pay credit to Eleanor Slater who has done a magnificent job with our excellent State Division on the Aging and has been a tremendous help, which is apparent, for this hearing. I would like Eleanor Slater, if she would, to stand up.

Then we are particularly honored today, because some of you who may have read the morning paper may have read the article about Mrs. Sodonie Brown who has lived in these shores for better than 90 years, and she has been helping her neighbors, and out of sheer curiosity came to see what her younger neighbors were doing. Mrs. Brown, will you stand up?

It is my prediction she will be standing up very vigorously a good many years from now, and I am delighted that she could come. Finally, I would like to put in a plug for my own Social Security Recipients Fairness Act. The purpose of this hearing is to focus on the problems of the elderly in which the Federal Government can provide help or a remedy. It is not a hearing concerned with State problems or local problems. It is concerned with Federal problems.

SPEEDIER REPLACEMENTS NECESSARY

One of the things that is necessary is to make the Social Security Act provisions fairer, and my act will provide for speedy replacement

of lost, stolen, or delayed checks once they are 3 days late at the most. We provide that disability payments should take no longer than 110 days to process, and there could never be any more than 25 percent maximum deletion from a person's benefit check to compensate for accident benefit over-payments. I think this would make the whole social security system fairer and be a real advance, and greater use to you, the beneficiaries of it.

I thank you, Mr. Chairman, for allowing me to make a brief statement and I look forward to the hearing today.

[The prepared statement of Senator Pell follows:]

PREPARED STATEMENT OF SENATOR CLAIBORNE PELL

Senator PELL. Mr. Chairman, as a member of the Senate Special Committee on Aging, I am delighted to welcome you and the committee to Rhode Island. I recall that our committee last visited Rhode Island in September 1971, to consider problems with medicare and medicaid. In the 4½ years since that hearing, and indeed throughout your tenure as chairman, the Special Committee on Aging has built a distinguished record of action and advocacy on behalf of our senior citizens, with much of the fine record attributable to your work. I am certainly proud to have been a member of this committee during that period and to have worked with you in the Senate on many issues related to aging. I know that my fellow Rhode Islanders are aware of the long hours you have put in, and the excellent job you have done as chairman of this committee. You are, indeed, the spokesman for senior citizens in the Senate.

I would also like to welcome our distinguished guests and witnesses, as well as the many Rhode Islanders who have joined us today to explore, on the grass-roots level, just what is happening to senior citizens in these very hard times.

This hearing will examine the personal stories and experiences of senior citizens who must live every day with high inflation, low incomes, and the special problems and frustrations of being elderly in America today.

Our witnesses represent the 118,000 people over the age of 65 who live in Rhode Island today and who make up 12 percent of our population. A recent study by our State Division on Aging projects that in just 4 years, by 1980, one out of every seven Rhode Islanders will be over 65 years of age.

This State, and this Nation, must be prepared to acknowledge the implications of these statistics, and to direct our resources in a more effective manner to the needs of this group of older Americans.

SENIORS LEFT TO STAND ALONE

Right now, we are not marshaling our efforts very well. We leave many of our senior citizens to stand alone, like frail trees at the edge of the forest, with little protection from the harsh elements.

Preliminary efforts in many fields have been made. Congress has initiated programs to help with insuring access to health care, and all of us in this room take great pride in two Rhode Islanders, Aime Forand and John Fogarty, whose enormous personal efforts made national health care insurance a realistic goal.

Congress has also made real efforts to insure proper nutrition, adequate income, decent housing, and basic transportation, for this country's 21 million seniors.

However, as today's witnesses will describe, our efforts have too often fallen far short of our goal.

Of course, some problems cannot simply be legislated away: The isolation and loneliness of many older Americans is not only the result of poor housing and crime ridden neighborhoods. It is also, to some extent, the consequence of recent patterns of family development, and of the dissolving of close family ties.

But many of the harshest personal problems of today's senior citizens can be helped: In instances where we have not yet done all we can, we are here to see what more must be done, and offer to do what we can.

In some cases, the Ford administration has been directly responsible for holding up the delivery of badly needed benefits and services already approved by Congress; such a case was last year's attempt to put a 5-percent ceiling on the social security cost-of-living benefit increase, an attempt that we in Congress overrode. The present veto of the Health, Education, and Welfare budget is another instance of "administrative neglect" directed toward our senior citizens. Last year Congress successfully opposed the benefit increase ceiling, and I hope that this year we will override the HEW veto.

So we are here today to learn where medicare and medicaid can be improved; we are here to learn if the senior lunch programs are working well; we are here to ask if housing is adequate, and if it is not, just what more is needed. We want to know whether senior citizens can afford to heat their homes or apartments or even burn their lights at night. Can they pay for telephones to connect them to their families, friends, or doctors? We are here to learn what it means to a senior citizen when bread is selling at 60 cents a pound; and when hamburger is 89 cents a pound, and fish is $1.29 a pound.

We are here to learn about the very high cost, both personal and economic, of long-term institutionalization, and a possible remedy for that tragic situation.

Most importantly, we want to hear about these situations, ideas, and problems, from the people who are closest to them, Rhode Island's senior citizens.

We will also hear some testimony today on the adequacy or inadequacy of retirement income, especially through the social security and supplemental security income programs.

Solvent Trust Fund Essential

One key to adequate social security benefits must be a solvent social security trust fund; at present the trust funds are about $43 billion in the black, but unless we adjust the tax structure, they will go into the red sometime during 1982, and could be running a $7 billion deficit by the end of 1983. We cannot allow that to happen. Congress must soon decide how to pump new funds into the trusts, and the choices seem to be either to raise the taxable wage base, or raise the tax on the present wage base, or to add some funds from general revenues, or a combination of these proposals.

When we do revise the tax structure, it is my intention to support whatever resolution imposes the least hardship on the average Rhode Island wage earner and his or her family.

Finally, we are here to learn of Rhode Island solutions, as well as problems. We have many people here today, seniors as well as younger men and women, who are working full time, on shoestring budgets, to alleviate the disadvantages which the elderly face.

I believe that they have done an excellent job. They receive far too little praise, and I know their work often entails a great amount of frustration for them, so I am looking forward to learning of the results of their efforts, so that we can take the good as well as the bad back with us to the Senate, and hopefully change things for the better.

[End of Senator Pell's prepared statement.]

Senator CHURCH. Thank you, Senator Pell. I was the first cosponsor on the Pell bill that he has just mentioned. It is a good bill. We are going to do everything we can to get it passed.

Senator PELL. S. 985.

Senator CHURCH. You have a new Congressman. It's been a great pleasure for me to get to meet him and know him. Already we have become good friends, and this is because of his great interests in the problem of the aged. It is natural that we should become close friends as soon as he came to Washington. I am glad he is here as a Member of what is called the other body in the Capitol. Nothing can be done until the two bodies get together, and we have gotten together at this hearing, and I would like to present now Congressman Ed Beard.

STATEMENT BY EDWARD P. BEARD, A U.S. REPRESENTATIVE FROM THE SECOND DISTRICT OF RHODE ISLAND

Congressman BEARD. Senator Church, Senator Pell, Senator Pastore, Mayor Cianci, Lieutenant Governor Garrahy, and ladies and gentlemen. I have a statement that I will submit for the record. But I would like to just make a few remarks. As I see some of the major problems of the elderly, Senator Pell has mentioned he has introduced the Social Security Recipients Fairness Act in the Senate. I introduced the same bill in the House. I have certain hopes that in 1976 that there could be some action taken on this bill. Congressman James Burke, the chairman of the Social Security Subcommittee, has indicated to me that there would be some action on the House side on this legislation.

I know, for example, there are elderly people who have their checks stolen or who have lost them, and they have to wait an awful long time before the checks are reissued.

This has been a tremendous burden on the elderly. Not only here in Rhode Island, but all over the country, we have thousands upon thousands of elderly people waiting in lines trying to get into public housing, and that has to be addressed in the Congress.

Of course, we have an administration that has been more or less down on public housing for elderly; but I think in some way this can be changed. We have to meet that obligation, and in the areas of national health insurance it's the mandate of the people that we have national health insurance. This will not only help the elderly

people, but it will help our working people all over the United States. I am very, very highly honored that I have been invited by Senator Church and Senator Pell to participate in the committee deliberations today. I will do my utmost as Senator Church has said, in the other body, to serve the elderly people, the 22 million elderly Americans in this country and try to help them have a better life in their golden years. Thank you, Senator.

Senator CHURCH. You're welcome. Without objection, your prepared statement will be inserted into the record at this point.

PREPARED STATEMENT OF CONGRESSMAN EDWARD P. BEARD

Congressman BEARD. I welcome the distinguished Senator from Idaho, Senator Frank Church, my own dedicated colleague, Senator Claiborne Pell, and members of the staff of the Committee on Aging.

It is most appropriate that you show concern for Rhode Island's elderly by coming here to listen to the hardships that our people have endured in a period of great inflation and unemployment. Everything has skyrocketed so much that those who have to depend on social security are severely victimized.

One of the most tragic things happens when a recipient of social security has a check misplaced or lost. The consequences are devastating. Anxiety, fear, and genuine difficulties are presented. Because recipients must depend on a fixed income for their survival, their normal way of life is at best marginal. This fact of life made me introduce in the House of Representatives a bill that Senator Claiborne Pell had introduced in the Senate, the Social Security Fairness Act, which would expedite claims where a check has been stolen or misplaced. It would permit the Government to issue a check to the recipient in much quicker and responsible fashion, so that the beneficiary can meet his monthly obligations.

Even beyond that, I believe that the time must come whereby older people can work in part time jobs without paying a penalty if they earn above the present restriction. I see a lifting of that restriction to a more reasonable amount such as $6,000 or so. It is unfair for older people to be discouraged from taking a part time job because of a government restriction on the amount they can earn which is no longer valid in the face of our economy. The only way we can change this is for the elderly people in America to bang on the doors of the Congressmen to tell them it is time for a change. That restriction must be raised to a figure that meets present day standards.

Senator CHURCH. Congressman Fernand J. St Germain is unable to be with us today. He has submitted a statement for the record, and without objection, I will insert it at this point.

[The statement follows:]

STATEMENT OF FERNAND J. ST GERMAIN, A REPRESENTATIVE FROM THE FIRST DISTRICT OF RHODE ISLAND

It is a pleasure to be able to present my views on future directions for elderly programs, with particular reference to social security reform.

At the outset, I would like to voice my extreme concern about the President's proposal for changes in the social security system. I am sure that we are all agreed on the need for change; however, the administration has given us a proposal which can only hinder the development of a program responsive to citizen needs. The Presi-

dent's proposal continues to make demands upon lower income workers to sustain the social security program and is clearly an expediency measure which would cause only short-term relief to the problem of funds for social security. Therefore, the need is to establish a long-term financing program which would not only impact upon lower income persons, but would affect upper income workers as well.

Further, we must look to alternate sources for funding of the Social Security Administration, since the growing number of benefit recipients is fast outpacing the number of workers contributing into this system. It is apparent to me that general revenues must be considered as a possibility if we are to maintain the benefits program we currently have.

I know that my colleagues in the House have been highly responsive to the need for social security law reform and have encouraged the passage of legislation affecting all phases of the social security process. The results have been gratifying, and I am sure we can look forward to comprehensive legislation in the near future.

Leading Provider of Housing for Elderly

While I am in an optimistic vein, I would like to draw attention to the many benefits we are currently providing to our elderly citizens, benefits which are often overlooked in our discussions of future directions. For example, Rhode Island is a leading State in providing elderly housing, transportation and meals-on-wheels services. Further, Rhode Island's Division on Aging has established a hotline for information on any problems or questions our elderly citizens may have. For these reasons, Rhode Islanders may turn with pride to their State as a model in its services to our senior citizens.

However, there is much more to be done, and I am certainly anxious to assist in every way possible to continue the progressive trend of elderly programs in Rhode Island and in the country. National health insurance is a major item which I feel we must address as soon as possible. The establishment of a catastrophic health insurance plan will help somewhat, but this can only be an interim step toward the full coverage which all our citizens desire and deserve. Our elderly particularly need the security which a comprehensive health plan will provide, and I am confident this plan will be enacted in the near future.

Ultimately, the problems of the elderly hinge upon the inadequacy of the income upon which they must depend. Although there has been legislation introduced to provide more frequent cost-of-living increases to social security recipients, it is obvious that this is not feasible until the financing of the system is once again stabilized. Therefore, our priorities are clear: Reform of the trust funding formula, increases in the benefits, and restoring the faith of our citizens in the stability of the Social Security Administration.

Forums such as this hearing can only yield positive results in helping us, as Members of Congress, to inform our citizens as to what we are doing for them, as well as to learn from them where the serious problems lie and how to best serve their interests. I am greatly pleased to be able to share in this give-and-take experience, and I appreciate the kindness of Chairman Church and members of this committee in allowing me this opportunity.

Senator Church. This hearing gives me the opportunity to become acquainted with your public officials in this State, and I know of no one about whom I have heard warmer, more enthusiastic remarks, than Lt. Gov. J. Joseph Garrahy. He is here to welcome the committee, and I would like to recognize him at this time.

STATEMENT OF LT. GOV. J. JOSEPH GARRAHY, STATE OF RHODE ISLAND

Lt. Gov. Garrahy. Senator Church, Senator Pell, Senator Pastore, Congressman Ed Beard, Mayor Cianci, I join with our congressional colleagues in welcoming Senator Church here this morning officially. I had a chance to chat with him last night. I know of the work he has been doing on behalf of Rhode Islanders in the Congress. He has taken on the responsibility in a sensitive area of examining our intelligence agencies in the country. He is also looking at the multinational corporations. If you read this morning's paper, you will

see that some of the work that Senator Church has been involved in is crucial to Rhode Island, particularly because of the economic situation here. The Senator, of course, is aware of the high unemployment rate in Rhode Island and the needs that we have here in this State.

I might like to point out that the new budget has been submitted to the Congress by the President. We hope that those particular cuts in that budget will not be shifting the financial burden to the States, particularly to Rhode Island which is already overburdened with economic problems and high unemployment in trying to grapple with State finances during a very difficult time. I want to welcome the Senator, and I know that he is here to listen to the senior citizens of this State as to the problems here having to do with housing, having to do with medicare, having to do with social security, transportation, and all the problems really that affect Rhode Islanders.

RSVP Provides Outstanding Construction

I might like to just put a plug in. Although we are here to talk about different programs and how they affect the welfare and the living of senior citizens, one program that I am particularly excited about, and that I see our senior citizens working with in the State of Rhode Island is the RSVP, the senior companion program. They contribute so much to this community as senior citizens in helping us in nursing homes, in helping us in our instructions, in providing the type of care and compassion in helping people who in some instances do not have anyone to look after them. I want to congratulate those in the RSVP and the senior working program for the outstanding work they have done in the State of Rhode Island. I have seen the results of that work. I might like to say this morning, which is a bad morning, that to see so many people here this morning is gratifying. Senator, it demonstrates that the people wanted to come, and we are delighted to have you with us.

Senator Church. Thank you. Of course, we are the beneficiaries of the hospitality of this city, and here on behalf of the city is the mayor, Vincent Cianci.

STATEMENT OF HON. VINCENT CIANCI, JR., MAYOR, PROVIDENCE, R.I.

Mayor Cianci. Senator Church, Senator Pell, Senator Pastore, Congressman Beard, Lieutenant Governor Garrahy, and all interested people: On behalf of the citizens of the city of Providence, R.I., I welcome you as you conduct your hearings on the impact of the cost of living on the senior citizens of this Nation.

As the Senate of the United States receives testimony from senior citizens on their experiences in trying to cope with high prices for essential goods and services which they require to live according to a decent standard, I wish to join with them in bringing to your attention some of the greatest needs as told to me in my meetings with them.

There is a continuing plea that the costs involved are so high in maintaining a quality of life which seniors deserve, that their fixed incomes are insufficient to provide for just bare and minimum requirements.

Fifteen percent of the people of Providence, over 26,000 people are 65 years of age or older. It is easy to understand why I believe that their case is an important one to be made before this august committee. What is of great importance also is that 80 percent of the 45,000 families in the city of Providence earn less than $15,000 a year.

Senior citizens have told me in a litany of frustration, that: (1) "The cost of living is too high." (2) "Social security benefits don't begin to make it possible for me to eat well and to have my medical problems met." (3) "The cost of food is too high, and all costs, as well." (4) "My own costs for medical care are so high, something has to be done about improving medicare, medicaid, or create a national health insurance program." (5) "Social security checks take too long to be changed when I change my address or lose my husband." (6) "The social security checks that I have directly deposited in the bank are often delayed." (7) "With the amount of money I get, I can't even pay for heat and lights." (8) "Even though we have a free transportation program for senior citizens, I can't always get them when I need them; I can't pay for any other means of transportation when I am sick." And the litany goes on.

I have been told that when Federal social security payments are increased the State and public housing authorities often decrease other payments. There should be clauses in the Federal legislation which will not permit this corresponding decrease in funds, or increase of cost for services.

Senior citizens feel that social security payments have never coincided with the cost of living. Even though there are cost of living increases built into the payments now, the basic minimums are so insufficient, that cost of living increases have little or no effect.

Seniors who are trying to maintain their own homes are often forced to sell because of rising fuel, utility, and maintenance of housing costs. For those who have lived in their homes for many years, and have raised their families in the same neighborhoods, this is a most serious wrench in their lives which public policy should not cause. In fact, Federal public policy should insure that this does not happen.

The demand upon public housing among the elderly is heightened by rising costs.

Medicare Lacks Complete Coverage

The medicare program does not provide complete hospital, doctor, or prescription costs. For many of this program, it is still considered necessary for them to maintain Blue Cross or other health insurance coverage paid by them, in order to supplement their medicare coverage. Private health insurance costs are also rising. This results in an additional reduction in their income for more basis food, housing, and utility needs. Since the State medicaid program only covers those at the lowest economic level, more attention should be directed by the Congress to pass a workable and effective health insurance program for all of the Nation's seniors.

I, too, feel frustrated as does the senior citizen. But I responded as quickly as I could.

Just 1 month after I took office, I called upon the banks to sell food stamps to seniors on every day of the month in the city. Until then, the seniors had to find other places to buy them, which were often inaccessible to them, or were not secure enough for them. By March of 1975 the banks had responded positively to my request.

Shortly thereafter, I appointed a senior citizen task force made up of a senior citizen representative, medical, and social service professionals, and other senior citizen interests. This task force was charged with providing me with advice and counsel on matters relating to the medical, biological, psychological, and social conditions and concerns of senior citizens with a view toward the establishment of programs and services for senior citizens.

The task force has been meeting regularly and will shortly provide me with a report which will recommend the development of a city-government-based capability to deal with all issues relating to senior citizens.

Task Force Studying Needs

In all the years that the needs of the seniors in city of Providence have been growing, the former administration only responded with a recreational activity. I have re-staffed this program and have charged them with working with my task force in outlining what the city should do to meet the needs of those 60 and older.

Heretofore, there has been little coordination of existing public and private programs. In the past no one in city government had tried to pull together all untapped resources. With a few short weeks the task force will deliver its report to me, and I expect to immediately establish priorities in this area.

Senior citizens are an integral part of the total Providence community, and as such are entitled to the benefits of all the resources which the city has at its disposal and the creation of new ones, if necessary.

The winter of 1976 will not pass until I recommend a city government course of action which will lessen the impact of finances on the city's senior citizen.

I urge the U.S. Senate to respond to senior citizens as well. Thank you, Senator.

Senator Church. Thank you, mayor. The mayor has certainly given us many of the problems that face people, and it is obvious that we are going to have the level that these hearings must at the State level of government and the local level.

Now, let's hear from the senior citizens. That is what we came for, and we have our first panel. Let me say this. That there will be an opportunity for all of you who want to offer us recommendations or to tell us about problems that you personally face to do so. You can do it in two ways. We have got to cover a lot of ground this morning.

First of all, we are going to feature some panelists, and we will hear from the panelists. Second, we will distribute, make available to anyone who wants it, a special form, an easy form. This is the first Government form you have ever seen that's easy to fill out. It's practically a blank sheet of paper with space for your name and address. So if you want to write us something that you think

we should know, these forms will be available for you to do so, and you will be sure that they are read, because we carefully review them after the hearings.

Third, as time permits, depending on how quickly we can move along, we will call upon individuals in the audience who wanted to say something, if they will promise to limit their remarks to just a minute, or—well, two, so we can be sure that we spread it around as much as possible.

First of all, we go with the panel, and, remember now, we are going to discuss the role of the Federal programs, the role of the Federal Government today, and our first panel consists of Clifford Shaw, Fred Creighton, and Dorothy Craighead.

I am told that Mrs. Jennie Jacques has the flu this morning and could not be with us, so our panel is reduced to three.

STATEMENT OF CLIFFORD SHAW, CRANSTON, R.I.

Mr. SHAW. I am Clifford Shaw, and as the opening speaker I should like to take the privilege of thanking Senator Church and Senator Pell for including Rhode Island in these hearings and giving us a chance to put this on the record. It is a little challenging to find that even before we, the representatives of older citizens, start to speak, most of our problems have already been touched upon.

Perhaps we can give them a little bit closer focus. Two concerns impel me to speak on behalf of older citizens. At 74, I guess I qualify as one of them.

My first concern is the effects of inflation and the second is a more productive use of the time and talents of the retired.

I speak for a group of retired people not generally thought of as being in need. The needs I present certainly are not as urgent as those of the really desperate. But as long-range goals, I think they are vital to the future of millions of retired people and the country as a whole.

Today I speak for myself, but what I have to say could well represent the views of one group with which I am actively associated—Cranston Leisure Learning. More than 300 retired people hold 6-week sessions twice a year to stimulate the concerns, skills, and participation of anyone who still wants to be active. We are self-supporting. The group is ecumenical. It is not unique. There are 5 or 6 similar programs in Rhode Island.

INFLATION IS PRIME SPECTRE

Inflation is one of the prime spectres in the lives of retired people in this category. Their incomes are admittedly above the poverty level, but still are fixed and inelastic. Some say needs diminish when you retire. After 40 or 50 years of married life, however, material things begin to fall apart. A range you bought 20 years ago for $100 has to be replaced, and now you discover something similar costs $500 or $600. The same for refrigerators, sweepers, all household needs.

Many of us are property owners. Taxes take a bigger and bigger slice from the family dollar. If the roof goes or the cellar wall springs a leak, repair costs are astronomical for us. We are no longer do-

it-yourselfers. And where, 20 or 30 years ago, we could float a loan to meet such costs, now we worry that the loan will last longer than we will.

I am not saying that the government should consider financial aid to people in this category. What I do urge is that this committee and every government agency make control of inflation a basic objective, to be weighed and involved in every step they take.

Second of my concerns is the way our society wastes the capabilities of the millions of retired. Any man or woman who leaves a job after 40 or 45 years in good health represents an asset in skills, experience, and tested knowledge that should be used for the good of the entire community.

I know there are many efforts today to harness these resources, but these efforts are largely local and limited. SCORE, for example, provides management aid for small businesses, but this is only one aspect of the infinite variety of experience available.

What I am suggesting is a committed philosophy for government, business, industry, the professions that will make continued use of the retired part of our society's operation, just as we expect the young worker starting his or her career to go on to achieve success. It need not be a financial burden. These are people who can earn their own way in services that will increase the productivity and the stability of our economy.

Older Citizens Shaping Direction

Older citizens are seen as becoming a major factor in shaping the direction of our society. But oldsters lack the solidarity to shape society to their needs. Society itself must understand the potential of these millions and put them to constructive use before we deteriorate into a generation of disgruntled has-beens whose only effectiveness will be to slow down and misdirect the progress of our civilization.

To paraphrase President Kennedy: "We ask not what our country can do for us. We ask what we can do for our country."

Those of us who have lived through the vicissitudes of this century, and those who are going to retire with the same kind of invaluable preparation in the future ask only the opportunity to do something for our country and for the society of which we are still a potentially creative part. Thank you.

Senator Church. Mr. Shaw, that was not only a very fine, but a very commendable statement. Thank you. Let's hear from all the panelists here. Fred Creighton.

STATEMENT OF FREDERICK W. CREIGHTON, PROVIDENCE, R.I., LEGISLATIVE CHAIRMAN, RHODE ISLAND COUNCIL FOR SENIOR CITIZENS; MEMBER, GOVERNOR'S ADVISORY COMMITTEE ON AGING

Mr. Creighton. Thank you, Senator Church, Senator Pell, Senator Pastore, Congressman Beard, and all the distinguished people here, and also my friends and neighbors, senior citizens.

I happen to be one of you. My name is Frederick W. Creighton, and I am also legislative chairman of the Rhode Island Council for

Senior Citizens which is affiliated with the National Council, and I am also a member of the Governor's Advisory Committee on Aging. I am an advocate for the elderly.

As an advocate of the elderly I became very much interested in the SSI program. That was passed on October of 1972, and it actually became effective on January 1, 1974.

The way the bill was passed, the State could either keep it the way they had it, or they could turn it over to social security. Well, that meant that I had all kinds of meetings and letters of correspondence with the State, finally with the Governor, and 2 weeks before it became effective they turned over about 9,000 people to social security, and what a mess it was—they didn't know what to do with the programs because it was new. They didn't have the people to really get the program going. We still have a problem because these people—I can't understand why—after we find these people, and they apply to social security, why it still takes 2 or 3 months before they get their checks.

This is one of the problems, and in the meantime these people, they are very low income. They don't have the money to live, to exist, pay the rent, and so forth.

Door-to-Door Search

Now, I really think that we have a program that actually may show results. The Division on Aging, they had a meeting with the Social Security Administration. This was in April before the Information Privacy Act was enforced. They received about 10,000 names, but the real problem is this. It now becomes a door-to-door proposition to find the little old lady, the little old man on the side street, the little old lady or little old man in the suburbs. They don't know exactly what's going on. I do a lot of speaking all over the State to organizations, and I find even there these people won't come forward for the simple reason they don't want to let their friends know that they are on low income.

So it has to be done in the homes on a friendly basis. The Division on Aging has had CETA workers. I believe they started off with 30, due to the fact of getting other jobs and so forth, they are down now to about 17. But this is time-consuming work. Besides, they have caseloads after they find these people, and therefore now they only have about two people to go out and find these people. The Division on Aging went to social security and they got the names before the Privacy and Information Act became effective.

We have about 9,000 more people to see. I am going to give you a breakdown of what actually happened. Today there are 934 names that have been screened, and 700 completed—with questionnaires and have been returned to social security. Of the 700 it was noted that 86 elderly were potentially eligible for SSI. It is further projected that of the 86, 75 percent should be actually eligible for SSI. Only 2 percent of these people contacted were already receiving SSI.

Of the 700 people contacted, 127 or 20 percent are in need of various services, and will be added to the direct service caseload.

Division Lacks Manpower

There are other things besides money. There are people we find that really should be entitled to food stamps. They should be entitled to medicaid. I don't know what SRS is doing to find these people. I can understand why they don't do it because unfortunately they do not want to increase their caseload; but they have to be found because these people are really in need. Now, in order for the Division on Aging to continue what they have started, the success of the project depends on CETA aides. As of this date we only have about 17 working, and about 2 actually trying to find these people.

It would need about 15 more people, and that is something that CETA aides should be doing. Instead, they are probably in some office doing nothing and getting paid for it. This is actually very imperative that we find these people.

Thank you very much.

Senator CHURCH. Thank you, Mr. Creighton.

Senator Pastore?

Senator PASTORE. Mr. Creighton, I noticed one time while watching television in Washington, when I had a little time to do it that there was an ad on the screen advising people who were entitled to food stamps and who were not getting them, to go ahead and apply for them. I quite agree with you. There are a lot of people who are entitled to these food stamps that are not getting them. One case may be because they don't know how to apply while in some other cases, they are too proud to apply. What is your answer? What is the best way to bring it to their attention?

Mr. CREIGHTON. I really think these old people—I am old, too.

Senator PASTORE. So am I.

Mr. CREIGHTON. But my brain is active. I am physically in fair shape. I think what the problem is that a lot of these people do not know how—they see these ads in the paper. Possibly, also, they see it on television. It is a fast 90-second deal, and they soon forget all about it. They have to be really counseled. They have to be talked to, telling them what it's all about. If they become an SSI recipient they are automatically entitled to food stamps.

Needy Must Be Found

That is one of the good things about it. Of course, what we really have to do is find that person that's entitled to SSI. I can say this: Any person here or wherever, if their income—that includes all income—social security or whatever in this State as an individual would be less than $209.14 should apply to social security. Now, if they are a couple, it's a different story. In other words—I am talking now if they have social security. It would be $315 if their resources should be no more than $1,500—but if they don't have social security, it is a different kind of a deal.

As an individual it's $189.14. As a couple it's $295 because with social security there is a $20 disregard. If people, in their later years really want to become active, and they can find themselves a part time job, even though they have SSI, they can work. Because the first $65 a month is disregarded, and 50 percent of the balance of that is disregarded.

So if their social security check or their income, is around $125 or so, they can still work.

I want to thank you. Any other questions?

Senator CHURCH. No, I am going to stop right there, because you see when Senator Pastore wants to ask a question he can ask a question any time he wants. He's my senior in the Senate; but I am going to enforce the rules where the others are concerned.

Actually, Senator Pastore has to leave at 11 o'clock, and I wanted to be sure he had a chance to ask what questions he wished beforehand, and it may be that our next panelists will not have finished by the time the Senator has to leave.

Senator PASTORE. May I have 1 minute? I will leave at 11 o'clock because I have another commitment. I will repeat again—I am not a member of this committee; but I am very much interested in the workings of this committee, and I have pledged to the members of this committee all the assistance I can give.

Senator CHURCH. Thank you very much, Senator Pastore. Our next and last member of the first panel is Dorothy Craighead. Dorothy, we want to welcome you this morning.

STATEMENT OF DOROTHY CRAIGHEAD, WARWICK, R.I., MEMBER, PROJECT HOPE AND NUTRITION COUNCIL TITLE VII PROGRAM

Mrs. CRAIGHEAD. Thank you, Senators, and good morning, ladies and gentlemen. I am Mrs. Craighead, a member of Project Hope and Nutrition Council Title VII Program. I am mainly interested in good nutrition for senior citizens, and I believe that good nutrition is very important for senior citizens.

Having a well-balanced meal adds to the joy of living, promotes good health, and cuts down on medical bills.

As we grow older, our eating habits change, and we find that we do not eat as much as we did when we were younger. That is why it has to be a well-balanced and nutritious one. I would like to give a sample of meals that are served 5 days a week in the Greater Providence area by Project Hope. This is just a sample: Vegetable soup, baked chicken, mashed potatoes, squash, coffee, and, milk.

Now all the vitamins are in this one meal. As you know, there are many seniors living alone on fixed income, and because of the cost of food they buy the things that are cheapest and not all seniors are able to receive food stamps. There are some seniors I find that are eligible for food stamps who do not receive food stamps.

The food stamps cost the seniors more to receive, and with the cost of food the way it is, the food stamps don't go as far as they should. So we find that a lot of seniors, they are unable to afford the kind of food that they should buy. There are also seniors who are unable to get out and do their shopping, and someone has to do the shopping for them, which is a pretty unstable thing for them because they can't get the things they want. They just write a list, and somebody gets it for them.

The stamps don't go as far as they ordinarily could go. So Project Hope is trying to help and assist them by delivering a hot meal to shut-ins. They are delivered by meals-on-wheels. I wish I could explain to you gentlemen the joy that people have with the different

food, eating their meal in a social setting. Some seniors have enough to take home for their evening meal, and this is a savings to them.

Co-op Programs Aid Seniors

I would like to say that food co-op programs started by Project Hope at the different centers helps seniors to buy food at a lower cost than they would in the market. Also, they can buy it at a great savings. They can buy cuts of meat, vegetables, produce and staples, all at a savings. This program is very important, and we are trying to reach as many seniors as possible. All these things help with the budgets, and the well-balanced meals, and physical well being of senior citizens.

We hope that these programs will be able to continue because good nutrition keeps the body in condition, and the mind functioning properly. Senior citizens can participate in all phases of the center's activities, and I just hope that Congress will continue to have this available so more seniors may be reached with these programs. Thank you, again.

Senator Church. Thank you very much. I certainly do agree with you about the importance of the nutrition program and the whole effort that's been made on meals both with respect to those that are served at the senior centers and those that are served as shut-ins who can't leave their own homes.

I have two announcements to make before we go to questions. For those of you who are standing, I can hardly see beyond the light, here, but every once in a while I have a sense that there are people standing here in the back of the room, and there are still a few chairs, a few seats here that are not occupied. I wonder if those who are sitting next to an unoccupied seat will put their hand up and give some of the older folks a chance to come and sit down. Will you do that, so people can see where the few empty seats remain? Come on down. Don't behave like you're in church and have to sit in the last pew. Come down to the front. There are a few seats down here.

One other announcement. This is a splendid public library. I hadn't had a chance to see it. You people in Providence should be proud of it. Just outside the door, I am told, the library has provided, on a table, pamphlets, books, and other information of special interest to senior citizens. So if you have the time, you might want to take a look at the library materials that have been set out on that table.

Instead of leading off with the questions, I would like to defer to your Rhode Island Senator and Congressman, and let Senator Pell commence with the questions.

S. 352 To Protect Retired Homeowner

Senator Pell. Thank you, Mr. Chairman. In connection with a point that Mr. Shaw made about the increasing cost of maintaining one's residence. It's a very valid point, indeed, and I have introduced a bill, S. 352, Retired Homeowners Protection Trust Fund Act. You have to have a study; sometimes you have to have two studies, and then eventually you will get the bill through, and what this does is to authorize the study of this bill, keeping the Social Security

Trust Fund separate from others to enable retired homeowners to retain their home. I think if you would examine that bill sometime, Mr. Shaw, you will find this would meet that problem.

Maybe you could generate some support for it from across the country. I think this would be a very specific help to that problem. That was more a statement than a question. I would like to ask one further question of Mr. Creighton. The question is, how can we go about this outreach a little bit more? Who should pay for it, and what more specific suggestions do you have to make sure that those who are eligible for food stamps and SSI are informed?

Mr. CREIGHTON. I think really the Social Security Administration should pay for it. But I don't think they are about to do it, because I don't think they want any more clients. I also think SRS, if you know what I am talking about, would pay for it, too.

Senator PELL. What is SRS?

Mr. CREIGHTON. That is the Welfare Department we have. I don't think Jack Affleck would be in favor of it to increase his budget, actually he would have to take and subsidize more people. I think what has to be done—and I also think there should be a law passed by Congress that when these costs of living increases come about—increases such as in social security and SSI—the full amount is passed on to the recipient. On SSI, the last time around, there was an 8-percent increase but the State only came up with 4 percent.

I think that it should be mandatory that there should be a law with your Federal Government that they would have to pass this full amount along to the people.

Senator PELL. Mrs. Craighead, I wonder if you could describe to us a little bit what a typical meal would be under the program. Incidentally, as to the prices I gave as to the hamburger and so forth, those are the prices in the butcher shop in Greenville, R.I. They are not prices pulled out of thin air. Let me assure you of that.

Mrs. CRAIGHEAD. Well, Senator, I gave you a sample of the meals that we do serve at the different centers. They start off with a soup.

Senator PELL. What kind of soup?

Mrs. CRAIGHEAD. They have different soups. There is a vegetable soup, chicken soup, pea soup, or chowder.

Senator PELL. Are they canned or fresh?

WELL-BALANCED MEALS

Mrs. CRAIGHEAD. No, these are fresh soups made in the kitchen. I would like to say these are cooked on the site. They have their own cooks; all centers have their own equipment, their own refrigeration, their own storage, and all these things are cooked on the site. The other meals are brought in in containers and served hot. These meals are well balanced because they consist of meat, a vegetable, and a salad. The seniors therefore have meat and two vegetables, and they have dessert and coffee, and they have milk which is all the vitamins that they need.

Senator CHURCH. That sounds like a good balanced meal.

Mrs. CRAIGHEAD. Well, it is a good balanced meal.

Senator PELL. Are you concerned with the question of cholesterol and the dietary content of the meals?

Mrs. CRAIGHEAD. Yes, that is all taken into consideration for the senior citizens.

Senator PELL. Thank you very much.

Senator CHURCH. Congressman Beard, please?

Congressman BEARD. Thank you, Senator, distinguished panelists. I would like to tell you that in considering the Older Americans Act, I had the honor to serve as a conferee along with Senator Pell. Meals-on-wheels will go on. That was highly emphasized in the legislation. It's very, very important. I also notice from Fred Creighton's testimony, one of the things is sending a message home to the thousands not only in Rhode Island but throughout the country who are not aware of the programs they are entitled to.

I think if the Government, in my opinion, was as efficient in trying to get information to the elderly as they are to the citizens with their income tax forms, we would be a lot better off in this country. I have a question for Mr. Creighton. In the time I have been here this morning, I haven't heard transportation discussed. I know senior citizens have been issued identification or transportation cards. Through the surveys that I have taken in one area in the State, they only have a card which entitles them to free transportation, but there are no buses. So what is the situation there?

Mr. CREIGHTON. Well, actually, I think we are very fortunate to get what we do have. The mass transit, free bus service for people 65 and over, we have been fortunate to get this.

Senator CHURCH. I don't know of any other State that has that. Do you?

Mr. CREIGHTON. Rhode Island and Hawaii have it.

Senator CHURCH. The first State and the last State leading the way.

Mr. CREIGHTON. They didn't want to give it to us; but we had to fight for it. Really, what Congressman Beard is talking about I believe is where the mass transit doesn't exist. Now, I think that the State should subsidize the local bus companies so that the senior citizens could ride for free. Otherwise, they should put their buses on those lines because they say it's statewide; but as Congressman Beard says, it's not for the whole State because they don't cover the whole State.

FREE BUS TRANSPORTATION

Congressman BEARD. Mr. Creighton, Senator Church, I believe the record would be interested in my recent trip to Hawaii with the Select Committee on Aging in the House. There is a similar problem in Honolulu where they have free bus transportation on off-peak hours. On the islands of Molokai and Oahu the senior citizens have their cards for transportation. Under the Older Americans Act we have extended funds to the States for rural transportation. So I would hope that the State officials will take advantage of that. We could have an extension of what we have in Providence, Cranston, Warwick and elsewhere where we have the transit system.

Mr. CREIGHTON. In Newport and Portsmouth, and down in that section of the State around Pascoag, and other sections of South County, there isn't any transportation. These are the people that should be taken care of.

Senator CHURCH. Why don't we look to the provision of the new law that Congressman Beard is referring to and maybe there would be some opportunity there for Federal involvement which might be helpful.

Mr. CREIGHTON. But I am going to tell you it would take some doing in the State to get them to do it, even though the money is there.

Senator CHURCH. My turn—Mr. Shaw, first of all, you spoke of something, and that is the talents, the experience, the wisdom that older people have, and how we should try to keep them engaged, keep them interested. Of course, there are some that would like to continue to work at least on a part-time basis who may be able to work and have something to contribute, some skill, and an opportunity to work except they are very severely limited under the social security system as you know as to how much they could earn.

Do you have any recommendation to make there.

Mr. SHAW. I think, Senator, this may have been over-emphasized. I think there are a great many people who have these talents, these skills who aren't too much concerned about how much they would lose from their social security if they could continue to use their talents. I am afraid what I was talking about this morning is the least interesting of the problems that are to be discussed here, and so I didn't want to take too much time. But my feeling is that the way to approach this is not to set up another government agency to dispense funds, but to try to get some kind of program where industries, for instance, and government could work together, so that industry would set up some kind of program to use these talents within the context in which they have been used for years. This I think is a great field, and I don't think it is the amount of income that would worry the people who could do this sort of thing. It's just a chance to continue to be useful.

Senator CHURCH. Just an opportunity.

Mr. SHAW. I think a lot of us are suffering from what I call the "Shaw retirement syndrome." The less urgent things there are to do, the less urgency there is to do anything. We are victims of that, and we would like to get away from it.

Senator CHURCH. Fred Creighton has mentioned a number of people who may be eligible for the SSI benefits who are not getting the information, who do not know. Fred, could you give us an estimate? You know a lot about this subject in Rhode Island. Could you give us an estimate of about how many people you think are living in this State who should be getting the SSI benefits who are not getting it?

Mr. CREIGHTON. That would qualify?

Senator CHURCH. That would qualify, but people who would qualify just don't know, and aren't included.

DON'T WANT WELFARE

Mr. CREIGHTON. I would really think there could be, I am not talking about the people who have already qualified and are being taken care of. I think out there wherever they are, I don't know, probably on some third floor, someplace there might be at least 1,500

or 2,000 people. I think that would cover it. There may be a little less; but you have to talk to these people because the old people are out there and really, they want to keep their dignity. You see these people are not like young people. They don't want welfare, and they won't admit that they need it. This is the problem. There is one more thing, Senator, I want to say before I leave here. Being the legislative chairman in Rhode Island here, I have had a bill, what they call the generic drug bill. I know if you could pass that federally, it would be a wonderful thing for these people. I have had it about 4 or 5 years in the State here; but the lobbying against it is pretty tough. In other words, the AMA, the pharmacists association, and the legislators that we have, as a matter of fact are lobbying against it. The legislators that we have happen to be either lawyers or pharmacists, and they are there for their self-interest. Now, what we need actually is a Federal bill, and then they would have to do it, and I think that is very important, the generic drug, and also a circuit breaker. You know what I am talking about?

Senator CHURCH. Yes, I know what you are talking about, and we are looking at both of these subjects very, very seriously on the committee. I want to say one other thing on the subject of drugs or medicines. I think that the limitation in the present medicare program, that prevents anyone from having medical bills covered except when they are hospitalized is one of the most serious gaps in medicare.

I know so many people on very limited incomes who have a chronic illness of some kind that requires prescription drugs, not just one bottle of medicine, but every week or every month or every 6 weeks they have to replenish the supply, and they have no way of getting reimbursement under medicare, and in some cases that will come to 20 or 25 percent of the total income of the person, and I think that one of the things we should do as a priority in filling the gaps of medicare is to take people who are on prescription drugs or in that fix and see to it that medicare gives them help for the medicine that they have to have.

INFLATION FAR MORE SERIOUS TODAY

I want to say one other thing. I agree completely with what Clifford Shaw has said about the importance of getting inflation under control. That is critical. I also have to recognize that that problem hasn't yet been solved by any means. The inflation is far more serious today than it used to be. In the last couple of years we have had inflation of 12 percent 1 year; 7 percent this year; 7 percent is twice as high as the average in this country over the years. So inflation remains a very serious problem, and until we get the answer to it, and get it back under control again, then for goodness sakes let's make this cost of living passthrough work as efficiently as possible. When I first proposed the passthrough in an effort to make social security inflation proof, I was thinking about 3, or 4, or 5-percent inflation, not 7 or 12 percent inflation, and it's a big difference.

So we made it an annual passthrough, and when people are faced with inflation as serious as the recent years have been, that annual passthrough is a hardship. You can't wait 12 months before you catch up with what's happened. So I have a new bill in. I wish

you would get as much support for it as possible which would improve this. It would make for a passthrough each 6 months which can be done under the computer system as easily as 12 months, so this adjustment can come without people having to wait for 12 months, and it would adopt a new cost of living index that relates to the kinds of cost that older people face.

They have a different budget than ordinary people. You are not buying a new automobile. You are not doing that kind of thing. So we need a cost-of-living index that is adjusted to food and rent and fuel and medicine, the kind of things that make up the major components of the typical budget of an older person. Make that the basis for the adjustment in social security, and apply it also to SSI, and do it every 6 months if the inflation hasn't been whipped, and that would be a great help.

Mr. SHAW. Could we take time to ask for a question or two from the audience?

Senator CHURCH. It's a good idea. Do we have the microphone? I have this light in my face.

Mr. REGER. I am very glad to be here.

Senator CHURCH. Would you use the microphone over here, sir?

Mr. REGER. I have been a resident of New England all my life.

Senator CHURCH. Would you identify yourself?

STATEMENT OF ERNEST REGER, PROVIDENCE, R.I.

Mr. REGER. Ernest Reger. There has been a blueprint to solve the inflation problem in front of your nose all the time for the last 35 years. Our revered President Franklin D. Roosevelt had it, OPA wage and price control, an example of this is when President Nixon instituted an emasculated form of OPA or price control that worked. It worked too well, because it was a namby-pamby-type of thing. If you went back to Franklin Roosevelt and studied the NRA and the OPA which I lived under, I was in business, and I know how it worked. I couldn't sell what I was selling for more than I sold before the war. I could have gotten three and four and five times what I was selling it for if the OPA was not there.

The person who worked, that was the wages he got; but he was able to get along. There were many more shortages. People of that era should know that. There were many more shortages than we have now during the war. You couldn't get anything, yet we made out. Everything was controlled to the point that the working man, the working people on whatever salary they had seemed to get along very well. I know I got along very very well. I had no trouble. The only trouble was that, well, I couldn't get a new car. Well, it's too bad. The old Chevy went for 110,000 miles, and when the war was ended I got a new car during the year. Thank you very much.

Senator CHURCH. Thank you. I would like to say that I wasn't involved in the second world war, but in the Korean war I was involved in the price stabilization. I know something of what you speak.

STATEMENT OF ANNA BEARD, PROVIDENCE, R.I.

Mrs. BEARD. My name is Anna Beard. I am Congressman Beard's mother. The only thing I have to say is this: Every time social security

goes up—I live in public housing, and I notice everytime Social Security goes up our rents go up. So what are we gaining? We don't gain anything that way.

Senator CHURCH. There is a gentleman that would like to speak—are you speaking—we will let you both, one at a time.

STATEMENT OF BRUNO HOFFMAN,* PROVIDENCE, R.I.

Mr. HOFFMAN. I am Mr. Hoffman from Providence. I am active in senior citizens groups. I only want to make one remark to Mr. Shaw's statement about people working who are over 65. There's a limit to how much you can make without losing social security. I don't see any reason for this limit because it is not necessary anymore to keep senior citizens off the labor market and, if they work they pay income tax. The original idea is not valid any more. On the other hand there is a provision that came in under the Eisenhower administration: Somebody could collect social security in any month he doesn't make more than $230; but in 1 or 2 months he could make $5,000 or $10,000 and still collect in the other months. This is a waste of money and helps rich people. It should be eliminated and used to increase the $2,700 to $5,000 or $7,000, or eliminate the limit altogether.

Senator CHURCH. Will you speak into the microphone?

STATEMENT OF VINCENT VESCERA,** PROVIDENCE, R.I.

Mr. VESCERA. My name is Vincent Vescera. I had money before Roosevelt was elected; but I followed with the NRA. I lost $500. I had to go to WPA myself; but I was proud. There was a time when the administration, they wanted to vote for the people, and the rich people, the Republicans, they ashamed. That's why we leave the country. Let's get the country going like it was when Roosevelt was in office.

Senator CHURCH. Folks, we are going to hear from two more. Just two more, and we will have the next panel, and then we will give you another opportunity to speak.

May we hear from this gentleman?

A VOICE FROM AUDIENCE. You made a remark, Mr. Chairman, that I am only allowed 1 minute. I have something here that I have kept a secret for 14 years, and I thought that today would be the proper time for me to expose this. But I can't do it in 1 or 2 minutes.

Senator CHURCH. Let's wait and see how much time remains when we are finished. We will do our best.

Mrs. TRITENDI. He can talk. I am Rose Tritendi.

Senator CHURCH. You are going to speak from the panel?

Mrs. TRITENDI. Yes.

Senator CHURCH. Let's go to the next panel. Dr. Mary Mulvey, Madeline McKiernan, Jim Keegan, and Janet Lewis are the members of the second panel. Before this panel begins, I want to tell many of you who may not know about it, that Dr. Mary Mulvey has been promoted to vice president in the National Council of Senior Citizens which is a great recognition for the work that she has done.

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* See additional statement, appendix 1, item 2, p. 2127.

** See letter, appendix 1, item 9, p. 2135.

STATEMENT OF DR. MARY MULVEY, PROVIDENCE, R.I., VICE PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Dr. MULVEY. Thank you, Senator Church, Senator Pell, Congressman Beard, other distinguished guests on the platform, our senior citizens and guests. I have a lengthy written statement. I will streamline it now; and I respectfully request that the full statement be included in the record.

Senator CHURCH. Of course.

Dr. MULVEY. I am also State Chairperson for the National Health Security Committee. I am convinced the only way to solve the health problems for all Americans is the Health Security Act (S. 3 and H.R. 21), the Kennedy-Corman bill. President Ford promised a national health insurance program for this year in his 1975 state of the Union address; and he now declares that we cannot afford national health insurance. Yet, 20 million Americans have no health insurance, and another 30 million have inadequate insurance.

MAJORITY FAVOR NATIONAL HEALTH INSURANCE BILL

The way is not through the catastrophic health insurance proposed by President Ford, which would require the elderly to pay $500 out-of-pocket for qualifying hospital expenses, and a $250 limitation annually to qualify for medical services. These amounts would increase proportionately with cost-of-living increases in social security. It is important also to note that the prestigious Cambridge Survey revealed recently that 57 percent of our population is for a national health insurance bill at least as comprehensive as the health security bill.

Kennedy-Corman makes everyone in the United States eligible for coverage. The program would pay nearly all personal health care services including catastrophic coverage.

Preventive care would be an important aspect of that program. It points toward organized arrangements for patient care and would support HMO's—Health Maintenance Organization—and other prepaid group practice plans, such as the Rhode Island Group Health Association (RIGHA).

Mrs. Lewis, who is on this panel, is going to talk about RIGHA, this morning. We have had medicare for 9 years, and we are grateful for what it has accomplished. But it covers only 38 percent of health care expenditures for older Americans; and Mrs. McKiernan, on this panel is going to talk about medicare.

National health security is the answer; but even if enacted now, it could not become fully operative for several years. Therefore, I recommend prompt changes in medicare, not only to close the loopholes, but also to conduct a mini-health security program for the older segment of the population as a prelude to, and demonstration for, extension to all segments of the population.

Our recommendations are to merge medicare and medicaid in a federally administered program covering all persons, 65 and over, and all other medicare and SSI beneficiaries. Part A and part B would be combined so that premiums now charged under medicare part B would be terminated.

Benefits now under medicare would be expanded and payable without co-insurances or deductibles. Nursing home services, re-

gardless of prior hospitalization, would be covered up to 120 days, and without limit if furnished in a nursing home affiliated with a hospital. Other benefits would include out-patient drugs, care of eyes, ears, and feet.

Many sources have labeled President Ford's medicare catastrophic health insurance proposal a fraud perpetrated on the elderly. He proposes to increase the out-of-pocket payments for medicare beneficiaries by requiring them to pay a co-insurance charge of 10 percent of all daily hospital charges, following the first day for which they pay the full cost; to impose a 10-percent co-insurance charge on hospital-based physician and home-health services; and to raise the part B supplementary medical insurance deductible from $60 to $77 in 1977, increasing thereafter proportionately with social security cost-of-living increases. These measures would wash out future social security cost-of-living increases.

Proposed Changes "A Hoax"

These changes are a hoax on the elderly. For example, under present law, the patient pays $104 the first day in the hospital and no more for 60 days; but the President's plan would increase the cost for the medicare patient upwards of $250 for an 11-day stay, which is the average medicare patient hospital stay. Medicare patients will pay 10 percent of hospital costs day after day until they spend $500.

It is estimated that this proposal would not offer a savings until after a patient had been hospitalized for 75 days since, under the present program, medicare patients would have to be in the hospital 75 days in order to spend $500 out-of-pocket. Yet, only 1 out of 1,000 remains 75 days in a hospital, so the President's plan will benefit only 1 out of 1,000 Americans under medicare, not the millions of senior citizens who are sick and infirmed.

Actually, the President's program imposes upon the elderly $2 billion more than they are paying now and provides a paltry $500 million rebate in the form of catastrophic coverage, the result being a Federal budget saving of $1.5 billion at the expense of the elderly, sick, and disabled. Implications are that the Federal budget will be balanced on the backs of the elderly, sick, and poor.

We urge the U.S. Senate Committee on Aging to prevail upon Congress to oppose the medicare catastrophic health insurance proposal of the President and to consider our recommendations for improvement of medicare until such time as the national health security is enacted. We congratulate you, Senator Church, on your initial step toward this goal through the submission of Senate Concurrent Resolution 86, "Opposing Increases in Medical Costs for the Elderly."

Equally objectionable is President Ford's proposal to lump medicaid with 15 other Federal programs, and give the States only $10 billion in block grants with no strings attached for State matching funds. This revenue-sharing plan represents less money than before for those who need it the most since, under the present program, the Federal Government now provides $11 billion and the States must provide $8 billion in matching funds.

If medicaid costs should increase at even half the rate of last year, with only a $10-billion budget for all health programs for the poor, serious cutbacks in some programs and elimination of others would result.

Revenue Sharing Has Drawbacks

Revenue-sharing could seriously affect such categorical programs as community neighborhood health centers which serve the poor of all ages, SPOC, which is the Special Project for Older Citizens that you will be hearing about on this panel, and other programs. Older persons have never received their rightful portion from revenue-sharing and other consolidated programs because they have had to compete with more vocal programs in the power structure; and this is the basic reason for our establishing categorical programs, including elderly housing, medicare, medicaid, the Older Americans Act, and subsequent amendments, et cetera. Incidentally, the President already proposes cutbacks in the nutrition program for elderly under title VII of the Older Americans Act.

The logical solution is to scrap the patchwork approach to health care through enactment of S. 3, H.R. 21, the Kennedy-Corman bill, not only for the elderly but for all Americans. We are the only industrialized nation which still makes adequate health care a privilege of those who can pay for it.

Comprehensive health care for all our people must be established as a matter of right, like the right to education and the right to vote. Thank you.

Senator Church. Thank you. I had some remarks here about Mr. Ford's state of the Union proposals; but Dr. Mary Mulvey has summed it up so beautifully that I am just going to associate myself with her position because it says it all, and it says it well.

Dr. Mulvey. Thank you.

[The prepared statement of Dr. Mulvey follows:]

PREPARED STATEMENT OF DR. MARY MULVEY

Senator Church, Senator Pell, honored guests and senior citizens of Rhode Island. As vice president of the National Council of Senior Citizens (NCSC) and director of the Rhode Island Council (RICSC), I am very much involved with issues concerning a better life for seniors. And, the cost of maintaining good health directly relates to the quality of life.

I am deeply moved by the plight of the senior citizen living on a fixed income in these inflationary times, who can be financially devastated when faced with overwhelming health problems. Hospital and medical costs are soaring faster than all other items in the Consumer Price Index.

As chairperson of the Rhode Island Committee for National Health Security, I am convinced that the only way to resolve health care problems for seniors, indeed for all Americans, is through passage of the Health Security Act (S. 3, H.R. 21), the Kennedy-Corman bill.

President Ford promised a national health insurance program for this year in his 1975 state of the Union address; and he now declares that we cannot afford national health insurance. Yet, 20 million Americans have no health insurance, and another 30 million have inadequate insurance.

The way is not through the catastrophic health insurance proposed by President Ford, which would require the elderly to pay $500 out of pocket for qualifying hospital expenses, and a $250 limitation annually for medical services. These amounts would increase proportionately with cost-of-living increases in social security. This would be catastrophic—indeed a disaster for most of our elderly.

STATEWIDE SUPPORT FOR KENNEDY-CORMAN BILL

The Rhode Island Committee for National Health Security has statewide support for S. 3, H.R. 21, the Kennedy-Corman bill. With us are: the entire Rhode Island congressional delegation, the State administration, leaders of community action and senior groups, labor, civic, student, and religious organizations.

It is important also to note that the prestigious Cambridge Survey, conducted by Patrick Caddell, and released quarterly, revealed (*Parade* magazine, November 30, 1975) what many of us have known for a long time: "The people of this country are fed up with the usual way of paying for health care."

We are finished with the old approaches. The Cambridge Survey asked for a response to four different health proposals. The results present such dramatic evidence of public thinking, I will read the four proposals and the percentage for each one as reported in the Cambridge Survey.

1. Keeping things as they are today—only 13 percent.

2. A small system where poor people are given medical insurance and everyone is protected against sudden major illness, 23 percent.

3. A system of national health insurance which guarantees every person as much care as he or she needs, 35 percent.

4. An amazing 22 percent lined up behind the most radical alternative—a totally nationalized system where not only is everyone guaranteed as much health care as he or she needs, but doctors and hospitals are taken over by the government and prices are regulated, 22 percent.

Yes, the people of this country are overwhelmingly in favor of a big change in health care—"a system of national health insurance which guarantees every person as much care as he or she needs"—and that would be the Kennedy-Corman bill. Fifty-seven percent of the population (totaling items No. 3 and No. 4) is for a national health insurance bill at least as comprehensive as the health security bill.

Kennedy-Corman makes everyone in the United States eligible for coverage. The program would pay nearly all personal health care services including catastrophic coverage. Covered would be physicians' services, inpatient and outpatient hospital services, home health care, optometry and podiatry services, devices and appliances, prescription drugs, some psychiatric services and nursing home care. It would cover, at the outset, dental care for children up to age 15, and eventually the entire population. And, most important, it would establish pilot projects to determine the feasibility of home maintenance care for the chronically ill or disabled. Remember, even if a nursing home is good, most people can be better rehabilitated in their own homes with proper care.

EMPHASIS ON PREVENTIVE CARE

Preventive care would be emphasized, as well as early diagnosis and medical rehabilitation through a vastly improved health care delivery system—pointing toward organized arrangements for patient care, such as HMO's (health maintenance organizations) and other prepaid group practice plans, such as the Rhode Island Group Health Association (RIGHA). RIGHA is unique and has received national recognition for its innovative practices.

Other national health security aspects include: Administration by the Social Security Administration: financing through a health security trust fund created by a tax on employers, employees and the self-employed, with the amount matched by Federal general revenues; a quality control commission to develop cost control features, including national standards for health care providers; consumer input in policy, administration and development of health security on national, State, and local levels; public accountability; and a resources development fund to support innovative health programs in manpower, education, and group practice development.

We have had medicare for 9 years; and we are grateful for what it has accomplished. But medicare covers only 38 percent of health care expenditures for older Americans. National health security is the answer; but even if enacted now, it could not become fully operative for several years. Therefore, I subscribe to the position of the National Council of Senior Citizens for prompt changes in medicare, not only to close the loopholes, but also to conduct a "mini" health security program for the older segment of the population as a prelude to, and demonstration for, extension to all segments.

Our recommendations are to merge medicare and medicaid in a federally administered program covering all persons, 65 and over, and all other medicare and SSI beneficiaries. Part A and part B would be combined so that premiums now charged under medicare part B would be terminated and beneficiaries would no longer have to meet these payments out of limited and fixed incomes.

Benefits now under medicare would be expanded and payable without coinsurances or deductibles. Nursing home services, regardless of prior hospitalization, would be covered up to 120 days, and without limit if furnished in a nursing home affiliated with a hospital. Other benefits would include out-patient drugs, care of eyes, ears, and feet.

Some portion of the cost of coverage would be borne by general revenues, and the remainder by payroll taxes—the same for employee and employer.

The need for these changes in medicare is great because of the ever-increasing costs to medicare beneficiaries—the latest being from $92 deductible charge to $104 for the first day of a hospital stay up to a 60-day period—plus increases in copayments. No! Poor, sick, elderly, and disabled people cannot bear additional out-of-pocket payments for medical treatment such as those proposed in President Ford's medicare catastrophic health plan.

Many sources have labeled President Ford's medicare catastrophic health insurance proposal a fraud perpetrated on the elderly! He proposes to increase the out-of-pocket payments for medicare beneficiaries by requiring them to pay a coinsurance charge of 10 percent of all daily hospital charges, following the first day for which they pay the full cost; to impose a 10-percent coinsurance charge on hospital-based physician and home-health services; and to raise the part B supplementary medical insurance deductible from $60 to $77 in 1977, increasing thereafter proportionately with social security cost-of-living increases. These measures would wash out future social security cost-of-living increases.

PRESENT CHANGES A HOAX

These changes are a hoax on the elderly. For example, under present law, the patient pays $104 the first day in the hospital and no more for 60 days; but the President's plan would increase the cost for the medicare patient upwards of $250 for an 11-day stay, which is the average medicare patient hospital stay. Medicare patients will pay 10 percent day after day until they spend $500.

It is estimated that this proposal would not offer a savings until after a patient had been hospitalized for 75 days. Yet, only 1 out of 1,000 remains 75 days in a hospital; so the President's plan will benefit only 1 out of 1,000 Americans under medicare—not the millions of senior citizens who are sick and infirm.

Actually, the President's catastrophic program for medicare beneficiaries must be looked at within its devious context; in reality it imposes upon the elderly $2 billion more than they are paying now, and provides a paltry $500 million rebate in the form of catastrophic coverage, the result being a Federal budget saving of $1.5 billion at the expense of the elderly sick and disabled. Implications are that the Federal budget will be balanced on the backs of the elderly, sick, and poor.

We urge the U.S. Senate Committee on Aging to prevail upon Congress to oppose the medicare catastrophic health insurance proposal of the President and to consider our recommendations for improvement of medicare until such time as the national health security is enacted. We congratulate you, Senator Church, on your initial step toward this goal through the submission of S. Con. Res. 86 "Opposing Increases in Medical Costs for the Elderly."

Equally objectionable is President Ford's proposal to lump medicaid with 15 other Federal programs, and give the States $10 billion in block grants with no strings attached for State matching funds. This revenue-sharing plan represents less money than before for those who need it the most since, under the present program, the Federal Government provides $11 billion and the States must provide $8 billion in matching funds. Furthermore, the administration has expressed alarm over the 25 percent rise in medicaid costs last year; but, if medicaid costs should increase at even half the rate of last year, with only a $10 billion budget for all health programs for the poor, serious cutbacks in some programs and elimination of others would result.

CATEGORICAL GRANT PROGRAMS COULD SUFFER

Revenue-sharing could seriously affect such categorical programs as community neighborhood health centers which serve the poor of all ages, SPOC (Special Project for Older Citizens) which specializes in resocialization and de-institutionalization of older hospitalized persons, and other medical services to meet the needs of those who can least afford the costs—the poor, the elderly, the medically indigent, the under-served, and those who require mental health care.

Categorical grant programs were established to define problem areas, furnish Federal support to help deal with the problems, provide direction and control of funds as Congress intended, and establish priorities and standards of administration to assure

quality and responsiveness. So, President Ford's proposal to consolidate categorical programs is a giant step backward.

Older persons have never received their rightful portion from revenue-sharing and other consolidated programs because they have had to compete with more vocal programs in the power structure; and this is the basic reason for our establishing categorical programs, including elderly housing, medicare, medicaid, the Older Americans Act of 1965 (authored by the late Rhode Island Congressman, John E. Fogarty), and its subsequent amendments. Incidentally the President already proposes cutbacks in the nutrition program for the elderly under the title VII of the Older Americans Act. Again, as in the proposed medicare cutbacks, the President's proposal is a well-planned method of cutting health care specifically designed to help the underprivileged to survive in the abyss of poverty.

The logical solution is to scrap the patchwork approach to health care through enactment of S. 3, H.R. 21, the Kennedy-Corman bill—not only for the elderly but for all Americans. Our objective is a better life for everyone. It is everyone's right to have the best of health care in our society. We are the only industrialized nation which still makes adequate health care a privilege of those who can pay for it.

We speak of our freedoms in this country. If we are to hold up our heads among other industrial countries in the world, we must affirm one more freedom—the freedom from fear of ill-health and its financial consequences for the old and the young, poor and affluent, employed and unemployed. Comprehensive health care for all our people must be established as a matter of right—like the right to education and the right to vote. Thank you for giving me the opportunity to present this statement.

Senator CHURCH. Now may we hear from Mrs. Madeline McKiernan?

STATEMENT OF MADELINE McKIERNAN, PROVIDENCE, R.I.

Mrs. MCKIERNAN. Honorable ladies—I did see Eddie Beard here; but I guess he is gone.

Senator CHURCH. Eddie is coming back.

Mrs. MCKIERNAN. This is a pretty tough act to follow. I have no prepared text. I can show you there is a list of these going back, but this is a combination of medicare and Blue Cross, and I have the two top ones which are treatments, and we got this one c.o.d. I call it. It's $104.50 each treatment.

Senator CHURCH. Could you pull the microphone a little closer, please? You're doing fine. We just want to hear you.

Mrs. MCKIERNAN. I am not going to argue with medicare, inasmuch as we have used it. I am very, very delighted; but we have been in a position where Blue Cross is taken out of my husband's pension, and this is $21.26 a month, and we have medical bills. I have one here, one druggist alone I ran into this morning is $71. I have also been taking a continuing treatment and medication for my blood pressure, and that I have been able to get at cost.

I can only agree with everyone here that understands what it is for people, as I say, I don't want to use the word "retired," because I don't feel I am retired. I had to leave my position because of the budget. I worked for model cities. But I still am continuing in that vein for many, many people that used our services, and I can hardly turn these people off. But I have had to listen to people speaking about food stamps, and I will jump away from medicare for a moment and make the suggestion that when people do go on medicare and social security that food stamps become involved, even if it's at a maximum, but they should also be tied in with medicare—food stamps. I don't believe it's so at the present time, but also I feel that Mr. Shaw said there are so many people that are giving their time because they can't turn people off in their own positions that they have held.

We could use so many senior citizens to teach people that can't read or write, and you would be amazed at the people that we have had to help to make out forms, to read letters for them. SSI—here is a country that pays social security. Is that supplemental? I don't know. SSI—they can't read or write.

Senator CHURCH. SSI?

Mrs. MCKIERNAN. It hands them a check for $189 and gives me one for $169, and they don't take any effort to see that these people know how to spend it, to shop, to pick up the ads in the paper. They are not even able to do this.

To get back to medicare, I would like to see the Kennedy-Corman bill passed as soon as possible.

Senator CHURCH. Thank you, very much. I would like to underline what you said by pointing out when we passed the medicare program, and it took a long fight to do it, when we finally got it passed it took care of 50 percent on the average, 50 percent of the cost of medical care for the elderly.

MEDICARE LOSING GROUND

Today it takes care of 38 percent. So we are losing ground with the medicare program, and instead of getting proposals to reverse the trend we are getting the opposite kind of proposals that are going to stick the people with a $1 billion or $2 billion more of out-of-pocket costs. So that the coverage will drop to 25 percent or less. That's the direction we are going in. It's just the wrong direction.

Mrs. MCKIERNAN. Just one more thing, if I may, Senator. I have a bill here. This bill is for office visits and treatment which is for $104.50, and you pay this as you get the treatment. Well, I have called and talked to Blue Cross. I think medicare doesn't care, but Blue Cross said, "Yes," they think they will review it and take care of the percentage. I am wondering about the doctors. We get 100 percent, and we that can't afford it only get a percentage back of what we paid, and I think that's something that should be looked into.

Senator CHURCH. Would you just restate that? I missed it.

Mrs. MCKIERNAN. That's all right. I said that I called medicare offices. I called Blue Cross on this $104.50 which is every month. They said they felt they could review it, and very possibly they would pay a percentage. But do I understand we pay 100 percent? We are hoping we will get back a percentage; so it's the consumer that's being hurt, the patient that's being hurt all the time. That's all. Thank you, Senator.

Senator CHURCH. Thank you. Could we hear from Jim Keegan next, and then we will finish up with Mrs. Lewis. Senator Pell would like to introduce Mr. Keegan.

Senator PELL. This is a slightly separate subject, but one of the most important purposes of this hearing was to explore Rhode Island's solutions to national problems, and the effects of institutionalization upon the human spirit and in economic times having an individual institutionalized as opposed to being out in the general community. This morning we visited a fine project in Warwick* which is a day

* For additional information on the Warwick program, see appendix 3, p. 2139.

care center for seniors that provided an alternative to institutionalization. Everyone of those individuals probably would have been institutionalized had it not been for the day care center. In Cranston there is a special program appropriately named the special program for older citizens (SPOC) which has conducted work in deinstitutionalizing and resocializing old people. We have Mr. Keegan who is a participant in the special program for older citizens designed for deinstitutionalizing and resocializing of elderly patients at the Institute for Mental Health.

Senator CHURCH. Thank you, Senator. Mr. Keegan.

STATEMENT OF JIM KEEGAN, CRANSTON, R.I., SPECIAL PROGRAM FOR OLDER CITIZENS (SPOC), INSTITUTE OF MENTAL HEALTH

Mr. KEEGAN. My name is Jim Keegan. I am from the Institute of Mental Health, and I am a participant in the (SPOC) special program for older citizens.

What we do at SPOC is an actual—we do cooking. We have mutual activities, field trips, and we go around visiting with other groups. The question is, "What does SPOC do for me or for people there?" And it's hard to answer because you don't know until you finish it. I am about, I should say, in about the middle of it. I think it has helped me mentally, physically, and spiritually.

I would recommend the program to anybody that's interested in furthering their own self interest. That's it.

Senator CHURCH. Thank you, Mr. Keegan. Our last participant on panel No. 2 is Mrs. Janet Lewis.

STATEMENT OF JANET LEWIS, WARWICK, R.I.

Mrs. LEWIS. When I was asked to participate in this panel I asked exactly what I should do, and what information I was supposed to bring to you, and I was told, "Tell it as it is." "Tell it from your own experience," and this is what I plan to do. RIGHA, the State's largest and first maintenance organization, became the first and to date the only certified HMO in Rhode Island on February 7, 1975.

Later in the year RIGHA also received national certification.

Senator PELL. Could I interrupt for a minute? Actually RIGHA has been the first federally fully qualified HMO, not only in Rhode Island, but in the United States.

Mrs. LEWIS. I received that word when I was on a trip to Hawaii. People knew that I was interested. They mailed me the article, and I didn't have it to follow. I have been a member of Rhode Island Group Health Association for 4 years. My husband and I chose to go into this program because we felt the coverage was more complete than that of any other health insurance we previously had, and that the cost would be less expensive.

This has proved to be true, especially after my evaluation of the benefits received so far from our membership in this health maintenance organization referred to commonly as HMO.

Appointments Every 3 Months

Appointments were scheduled for us every 3 months for a doctor, and medicine, and much more often if necessary. Emergency calls are handled 24 hours a day. If your own physician is not available, there is always another physician ready to consult with you who has ready access to all your files. Services are available for all types of emergencies. I woke up one morning with a very painful eye. RIGHA was called, and by 8:30 a.m. I was examined by one of their staff doctors who immediately referred me to an opthamologist who diagnosed the injury as a corneal abrasion. In simple terms, I had cut the cornea of my eye. Proper treatment was given immediately, and within 3 days my eye was back to normal, and was followed up by frequent appointments.

My husband's condition became more serious over a weekend when normally it is hard to get in touch with a doctor. On calling RIGHA I was advised that our physician would meet us in an emergency room at the hospital where following an examination he was admitted as a patient. After major surgery, complications set in. So he was hospitalized for 3 weeks. During this time I was able to see and to talk with our physician daily. Following the death of my husband I was deeply impressed by the expressions of genuine sympathy extended to me by many members of the RIGHA staff.

At no time have I ever felt I was just a number in such a large organization. I was always treated as a person, as a real, human being, which I am sorry to say was not my experience at some of the hospital clinics which I attended with my husband previous to our affiliation with RIGHA. There was no additional expense for my husband's surgery or hospitalization or for specialists who attended both of us.

As of January 1, this year, the total health care for me now costs $10.75 for RIGHA and $6.70 for medicare per month. I have total coverage for $17.45 paid on a monthly basis. The RIGHA Building is located at 210 High Service Avenue, North Providence, adjacent to Our Lady of Fatima Hospital.

RIGHA is not a part of Fatima Hospital. It is a separate HMO facility. The complete unit for HMO's is in one building, on one floor, with ramps at every entrance. Laboratories are housed in one section, so all testing can be done on the premises. A pharmacist is available for the filling of prescriptions at a reasonable cost. Throughout the building are the waiting rooms, reception desks, and offices of the professional staff.

Nursing care is available at home if needed after hospitalization, or if your illness is not chronic a nurse will call at your home once a day if the necessity arises. Doctors will also make house calls when needed. Preventative health services include physical examinations, immunizations, and also periodic vision and hearing tests. All these services are included in your monthly charge. Additionally, you are covered for emergency care outside Rhode Island, but you must notify RIGHA at the time you receive the care.

There are many other advantages too numerous to mention, but which are listed in the RIGHA health care benefits. At the age of 65 all hospital blood transfusions must be paid for, or blood used must be replaced on a 1-to-1 basis up to the first 3 pints used.

If 10 pints are necessary, you are still only responsible for replacement of the first three pints. Under the age of 65 it is the policy to replace all blood used on a 2-to-1 basis. This was the only thing that I had to do above the cost of being a member. I replaced 3 pints of blood for my husband.

Most of the information I have given you is from my own personal experience over a period of 4 years. I feel that I can truthfully say I have used 90 percent of the benefits available with this health maintenance organization, and all these benefits were included in my monthly payments. Thank you.

Senator CHURCH. Thank you. It's good to hear about something that's working.

Mrs. LEWIS. It is working.

Senator CHURCH. First, I would like to recognize Senator Pell for whatever questions he may have of the panel.

Senator PELL. Thank you, Mr. Chairman. Dr. Mulvey, you really are the successor of Congressman Forand and Congressman Fogarty in carrying the torch for the elderly in our State, and just as they did, acquiring a national reputation and consistency in carrying it, so I think that everyone of the people who are in this room owe a great deal of credit to you for what you have done.

COST OF DRUGS

I would like to get to a rather hot subject. That is the question of the cost of drugs. Generally speaking, are the older citizens able to get drugs at reasonable costs, or what is the situation in this regard?

Dr. MULVEY. No, they are not. In hospitals, of course, the drugs are paid for. When they get out of the hospital they buy their own, and they have to buy the brand name drugs which are about 5 to 10 times the cost of the generic drugs.

The generic drug is provided in the hospital to the patient, but when they get out and have to buy their own, they have to pay the price of the brand name. Am I answering your question?

Senator PELL. Exactly.

Dr. MULVEY. And certainly, as Senator Church has mentioned before that one of the first things that we should do is to put prescription drugs in the medicare program because in many cases the cost of prescription drugs annually for the average medicare beneficiary is more than the medical costs for the year.

Senator PELL. Is there any place in Rhode Island where a citizen can buy drugs under the generic labels.

Dr. MULVEY. I think that RIGHA does carry the generic drugs.

Senator PELL. Is this only open to people enrolled in RIGHA?

Dr. MULVEY. Yes.

Senator PELL. What about the citizens here?

Dr. MULVEY. No, not unless the doctor writes the generic name on the prescription label; but then the patient may have the problem when he gets to the drugstore that the drugstore does not stock the generic labeled drug, because there isn't as high a profit on the sale of the $2 generic drug as there would be for a $10 drug by the brand name, which is exactly the same thing as the generic drug.

Senator CHURCH. What a racket.

Senator PELL. Isn't it true now where you can read the hieroglyphics on the prescription, if you get through the hieroglyphics, that the drug is usually identified by its content, or does the doctor usually prescribe it by brand name?

BRAND NAME VERSUS GENERIC

Dr. MULVEY. The doctor almost always, I would say 99 times out of 100, prescribes the brand name, because in most cases that's the only name he knows. The generic name is this long, and the brand name is about this long. We in Rhode Island supply the members of the Rhode Island Council and many other senior citizens with a list of the generic equivalents of the brand name drugs. As Fred Creighton has mentioned, for 5 years in the State legislature, we have not been able to pass the generic drug law which would require the physician to write the generic name on the prescription. If he did this, the patient could shop around for the generic drug, although it is difficult for the elderly to shop around, but if he were able to buy the generic drug it would be helpful.

Many States have the law, and I know Massachusetts has run into this problem. They passed a law about 6 or 7 years ago, and the pharmacists as a rule did not stock the generic drug. So a consumer group has arisen to take measures to require the druggists to stock the generic drug.

Senator PELL. How do you think somebody might go and buy this on a mail order basis where you could write or send a check or money order for it?

Dr. MULVEY. Again, the physician has to write the generic name, because the pharmacist cannot substitute.

Senator PELL. What is the name of the nearest mail order place where they can get generic drugs?

Dr. MULVEY. First, I want to mention that the National Council of Senior Citizens has a mail order service in Philadelphia. The AARP has a mail order house in Hartford, Conn., and in Boston too. They have them in various places.

Again, the constraints are that the physician must have written the generic name on the label. The National Council drug service does carry generic drugs.

Senator PELL. Thank you. I would like to ask Mr. Keegan a couple of questions. Thank you, Dr. Mulvey, very much.

Mr. Keegan, what activities are you doing now, or do you participate in or do you help with?

Mr. KEEGAN. I do general—I call them household chores. We clean up. We do our own cooking. Everybody participates in activities, such as music. We work. We generally help out.

Senator PELL. What is the difference between the program you are in now and what you were in a year ago?

Mr. KEEGAN. A year ago I was doing nothing and I am not being funny.

Senator PELL. Thank you very much.

Senator CHURCH. Congressman Beard?

Congressman BEARD. Dr. Mulvey and distinguished panelists. You know we have covered quite a few topics here today. We have talked about the transportation. We have talked about food stamps, and we have heard excellent testimony on national health insurance and problems of health.

You know it seems to me that here it is, 1976, and we have done so little for the elderly. We have legislation we have introduced for 5 years in the Rhode Island General Assembly trying to get generic drugs, the equivalent, in trying to get something done for the elderly on their medicines, so they could have the chance to have a choice whether to purchase the brand drug or the generic drug which is 9 or 10 times cheaper and still has the same effect. Yet, over the same length of time we have spent billions on wars. In 14 years of Vietnam we spent $150 billion. Here we are talking about transportation to areas in our own State where there is no transportation for elderly people.

"A ONE-WAY STREET"

Hawaii, as I mentioned earlier, was built as a great resort, yet there are elderly people there who are not even aware of social security. I have had a chance to talk to them. In this country where we have all the money and all the riches that we have, all the emphasis is on major commitments overseas in helping this country and that country, but no one in the world is coming to the United States offering to help the United States to give us economic assistance. It's all a one-way street.

So here we are, in 1976, with all the modernization, the cars, television, and everything that we have, and we can't solve the problems of 22 million elderly Americans.

Let me tell you something. We are lucky that we have fellows like Senator Church, Senator Pell, and other Members of Congress who have done a good portion of work in this area. They have spent their entire legislative careers trying to solve the problems of the elderly. But take a look at the U.S. Congress. Take a look at the Senate, and you take a look at the House. Most Presidents, most of them are senior citizens, and I say, "Shame on them that in 1976 we don't have national health insurance. Shame on them." These are elderly members who lead the committees, in most cases. Most of them are senior citizens in the Congress. You take a look at the age bracket in the Senate or in the House, and you will find that the chairmen are the members who have the most authority, the most push, they are in the elderly bracket. I say, "Shame on them that they haven't taken care of their 22 million elderly Americans in this country." Now we have a balance. Maybe there is a ray of hope. There are good young Democrats and young Republicans who are working for a new concept of serving the people first, serving the people first. We have a balance in the House and Senate. I think the fact that Senator Church has traveled to Rhode Island, is testimony to you people that have come out on a lousy day like this. But this is a problem all over the country, and it's a shame. I think it's important.

Senator CHURCH. Go ahead.

ELDERLY DESERVE EQUAL CONSIDERATION

Congressman BEARD. I think it's very, very important that this Congress and the Senate and this will be recorded, and I will be able to read this, that the Members who have the authority, the Members who have the seniority, and the Members who have the push, if they would only take a look at that minority of population, 22 million elderly Americans, and give them the same commitment and the same consideration as the President and the Congress give foreign countries.

If we did that we wouldn't have to have this meeting here today. I would like to congratulate Dr. Mulvey for her years of service and the distinguished panelists and members who have testified today. This is what it's really all about. We are here to serve you. Sometimes I might get up tight, and you wonder why I get mad. I have seen the bureaucracy of government. I see an administration that pushes one thing and yet when he was a Member of Congress voted against medicare or medicaid. That's the truth. We have got to get together in this country and eliminate the problems of health that we have where people cannot get decent services, and that is necessary, and we have got to have guarantees that we won't have to worry about pensions.

People are losing $1 on every $2 they earn; they take a dollar out. That is ridiculous. You paid your dues, and we need not only transportation, but we need services on every level, for the working people, middle aged, and our youngsters.

If this is an indication of the way we treat our elderly today, what is going to happen to us later on? We better set an example. I am telling you this whole country better set an example.

Too many people are willing to shove their relatives into the nursing homes, and institutions, and lock the door and forget about them. That's a matter of fact.

I hope the time will come that I will be able to say, "Senator Church, Senator Pell, there is no need of having hearings in Rhode Island or anywhere else in this country. The elderly people are considered No. 1." They should treat you the same way as they treat you on election day.

Senator CHURCH. You can see why Ed Beard and I get along well. Let me just add one word about this problem. The committee that I head up, the one that Claiborne serves on, when it was set up it wasn't given any legislative power. All it was given was the right to go out and find out what the problems were and to make recommendations.

We have been making recommendations. Some of them have gotten enacted into law; but I find myself over and over again doing the kind of thing that Mary Mulvey mentioned, trying to play a defensive role.

REAR GUARD ACTION

We have a new recommendation from the President of the United States which is in the name of doing something for improving medical care for the elderly which in fact does just the opposite. It increases the charges on the elderly by $2 billion and gives only $500 million back. You see, I have to go to the Senate and say, "Here is a

resolution to reject." Let the Senate express its sentiments that they are opposed to this program, and let them vote to reject the program so that it gets no further. But that's not doing anything affirmatively. That's a rear-guard action to prevent things from getting worse, and until you get somebody in the White House who is willing to work toward making things better, that's all you're going to accomplish.

May I say to the panelists how much I appreciate their contribution. We have a third panel, and we want to give you people out there a chance to speak up again before we finish. So let's give this panel a hand.

We are going to the floor, again, and let's turn that microphone around. Would you first give us your name; identify yourself for the record, please?

STATEMENT OF BROTHER CHARLES WINN, PROVIDENCE, R.I., SENIOR CITIZEN AND REPRESENTATIVE, SENIOR CITIZENS OF RHODE ISLAND ACTION GROUP

Brother WINN. I am Brother Charles Winn, a senior citizen and the public relations representative of the Senior Citizens of Rhode Island Action Group.

I would like to speak to the subject of generic drugs. The availability of the drugs was brought up by Dr. Mulvey. Some druggists do not stock them, but I want to underline the fact that clinics, the Veterans' Administration, and animal hospitals use the generic drugs. They are available in quantity, and I had the personal experience of going to a clinic for an emergency and being given a sample or a temporary supply of generic drugs with a prescription for the same drug, and I remember very distinctly the scowl on the druggist's face when I handed him the prescription with the generic drug. I have been using that drug ever since. That is 3 or 4 years ago. It has proved effective, and there have been no complaints as far as my health is concerned. So I wanted to give that specific testimony that the drugs are not only available; but they are consistently used by clinics, public health clinics and hospital clinics, and the Veterans' Administration, and if it's good enough for the U.S. Army, I think it's good enough for me.

STATEMENT OF MRS. CURLEY, PAST PRESIDENT, RHODE ISLAND COUNCIL OF SENIOR CITIZENS

Mrs. CURLEY. Mr. Chairman, Congressman Beard, Senator Pell. I am Mrs. Curley, past president of the Rhode Island Council of Senior Citizens, and also a member of Congressman Beard's advisory council, and I am also a senior aide in Dr. Mulvey's office, and we all work for our money in Dr. Mulvey's office, the chairman and volunteers on the SSI, and I would like to say my last figure was 1 out of 8, regretfully, we reached in Rhode Island on that program.

May I say a word about President Gerald Ford. He is now known as Nixon's revenge. He established the record of voting against everything to help the elderly, and now he is trying for a veto record. We have a candidate right here who I think is ready, willing, and able to replace him. So I am voting "No" against an elective term for President Ford, and to use a play on words. Remember that old saying, "See you in church, Senator." Well, Senator Church, we'll see you in the White House.

Senator CHURCH. That wasn't a put-up job, folks. Here comes another gentleman. Let's hear from 1 or 2 more, then go to the third panel. Then there will be still another opportunity for others to speak.

STATEMENT OF ROBERT BURNS

Mr. BURNS. My name is Robert Burns, and I would like to ask a question. In reference to a generic drug, when a patient goes to a doctor, and he asks the doctor to prescribe it in a generic term instead of the brand name, can a doctor refuse? Now, the doctor might say he is not familiar. If the patient is familiar with the different setups where he can get the generic named title, could he present that on an authorized paper to the doctor so the doctor could verify it, possibly not right at the moment, but within a short order in the future?

Senator CHURCH. You asked the question. I will have to give you a curb-stop opinion. I am a lawyer, you see, in addition to everything else. So I love to give curb-stop opinions. This advice is just as good as what you are paying for it, which is nothing. But my guess would be in answer to your question that in the absence of a law on the subject, the doctor could do just what he pleased. He could either cooperate or not cooperate, and I think that's probably the situation in most States. Isn't it ironic that it's harder for people to find out how to get generic drugs, and thus avoid getting charged 3, 4, or 5 times as much as you should, than it is to get generic drugs for animals? There is no problem there. You can get it for your dog; but you can't get it for yourself unless you can figure out the system, and not many people have been able to figure out the system. It's just that complicated.

Mr. BURNS. May I say one more thing on this? The reason I raise this question is too many people when they go to the doctor or the druggist are more or less like ashamed or face-down, so that they will take the brand name.

Senator CHURCH. Yes, I think that's true. May we have this young lady; this gentlemen; and then we will go to panel three.

STATEMENT OF BETH TAYLOR, NEW ENGLAND ELDERLY DEMAND SOCIETY

Miss TAYLOR. Thank you, Senator Church, Senator Pell, Congressman Beard, members of the committee. My name is Beth Taylor, and I represent the New England Elderly Demand Society, and I have a short prepared statement that I would like to read to you.

The New England Elderly Demand Society is working with the institutionalized elderly toward nursing communities with proper medical and now psychiatric care. As an advocacy group for the elderly, we are concerned that the treatment that they receive, particularly in institutions, is dehumanizing and does not adapt to the real needs of the elderly. Medicare is just another institution which consists of a lot of redtape and eats up the taxpayers' dollars with administration, and ingores the proverbial saying, "Treat the cause, not the symptoms." It does not insure that the elderly will receive quality health care. That problem is especially true among institutionalized elderly. An inmate is normally considered less than a normal person. For

the elderly the attitude is often compounded by misunderstanding of geriatric illnesses. This leads to misleading treatment because they are too old.

We should stop putting too much energy and investigation into programs which do not interest the needs of the elderly, and start building programs for the elderly so they can live out their lives with the dignity and respect they have earned. Thank you very much.

STATEMENT OF MICHAEL BODAY, CHAIRMAN, GRAY PANTHERS

Mr. BODAY. Mr. Chairman, Senator Pell, Representative Beard, I happen to be Chairman of the Gray Panthers that fought for elderly in the State of Rhode Island. We don't have to go any farther. We are in the State of Rhode Island still fighting for the handicapped, for busing, we are still fighting for the elderly, and I have been a resident of the State of Rhode Island for 72 years, living here, almost 73. We are still fighting for the elderly of the State of Rhode Island. We wrote a wonderful letter to Beard. We wrote a letter to Pell this morning. We wrote to Congressman Beard first, and we got a wonderful answer that he is supporting the handicapped. Here we are fighting the State of Rhode Island. We have about 30 percent of the elderly that have transportation. We have people out in the town of Westerly, and all through Burrillville, Warwick, Warren, and up to Newport where there is no transportation. They went around the State to get and snap the pictures of the elderly at a dollar apiece. Now, this is awful. The State of Rhode Island goes out and takes a dollar off the people who have no transportation, and I am ashamed to be a resident of the State of Rhode Island. I am ashamed that the handicapped have no transportation in the State of Rhode Island, and we are talking about the drug bill. The House has passed it, but what did they do in the Senate? They pigeonholed it right in our own Senate. We've got to clean house right here in our own State. Our own State has got to be cleaned up. We have got to find out who is with the elderly and who is against the elderly, and we have a wonderful Congressman sitting right here, and Senator Pell. We are thankful we have people like that in Washington fighting for the elderly. We have people in the State House that we are dissatisfied with, and we absolutely should have them working with us, or else we are going to go out and clean house.

Senator PELL. What we are focusing on here are the Federal issues, not the State or local issues.

Mr. BODAY. That's a Federal issue, also, Senator Pell, and I also was in conventions when we heard Senator Church speaking, and I am going to tell you, he will get our support. As far as the elderly go, I think he is a wonderful man, and it's good to have somebody like him. I want the Senators out of our State to know what we are fighting. I know what I am talking about, because I have been all over the State of Rhode Island.

Senator CHURCH. If you are the head of the Gray Panthers and a member, you know what you are talking about. That's a great organization.

Mr. BODAY. We are organized all over the country, and we intend to get something.

Senator CHURCH. Thank you. May we go to panel No. 3, please? The panelists on the next and final panel are Edmund Beck, Henry Graham, and Rose Tritendi.

Congressman BEARD. I would like to present this from the Warwick Community Action Group.

Senator CHURCH. Thank you very much. I will be happy to accept it.

You have been wonderful and very patient. It's a crowded room. People are still standing in the back. There are some seats in the front now. If anyone wants to come forward, they are invited to do so. Let's give this last panel of the morning our attention. First of all, may we hear from panelist Edmund Beck?

Mr. BECK. Thank you. I have a statement that will be read for me, Senator. But I would like to ask permission to let Mr. Graham present his statement first.

Mr. GRAHAM. My name is Henry Graham. First of all——

Senator CHURCH. Do you have Mr. Beck's statement to read?

Mr. GRAHAM. No; I have a statement of my own which I would like to make at this time, with your permission.

Senator CHURCH. You may proceed.

STATEMENT OF HENRY GRAHAM, EAST GREENWICH, R.I.

Mr. GRAHAM. Thank you. I will now start, Senator Church, Senator Pell, Congressman Beard: You have listened to a great many dignitaries and others discuss the various problems of the aged. I trust we might show our appreciation in some small way for your help. Some time ago I was invited to attend a meeting in the office of the State Division on Aging on the subject of the problems of aging. At that time I stated that the No. 1 consideration of my organization was tax relief for the elderly. Maybe passing it to the Federal Government is what I am going to propose in some instances later. I was called by Mr. Harris, and asked to participate in this hearing.

I might also advise Senator Church that the letter you dictated on January 16 asking me to get in touch with Mr. Harris on the 23d arrived at my house on Saturday the 24th.

Senator CHURCH. That is the Post Office Department.

Mr. GRAHAM. I don't know where we pass the buck; but that's a Harry Truman expression.

The issue in my organization is actually tax relief for the elderly. Now, it can be done through the State, or we can get some assistance from the Federal Government in my opinion. I would like, therefore, to just dwell a moment or two on taxes locally. The taxes on my house have risen in the past 13 years 240 percent. I am sure that the same thing applies to you. This then says to me there is only one answer to tax relief for the elderly, and this is by legislation that would freeze the tax rate and the property evaluation on homes in which we reside. There are admittedly many factors that must be taken into consideration, however, such as tenure, income property, exemptions granted for other purposes, and so forth. Incidentally, I had to spend Saturday afternoon in the library because of short notice, and it shows that the exemptions are now being granted to the very poor, $1,000 to $4,000. Personally, I will sell any income property. However, if there has to be such a requirement that real

estate could be sold. A man works for many years contributing social security, and reaches a maximum for the entire period. This money was taxed on income at that time. They are now retired and collect jointly $650 monthly or $7,800 annually from social security. In my opinion, this money is theirs, bought, taxed, and paid for. It should not be included in any calculation for income purposes.

If you now want to calculate income, let us not forget that there are a great many frugal people in these United States.

There are also many people who spend every dollar they get, and more. Should the frugal person be penalized because he was frugal? Because he saved a few dollars? There is also the person who is retired, maybe because he had to, who can't live on what is coming in. So he and his wife get a part-time job and earn money within the limit of social security, $4,000 or $5,000. If this was added to their $7,800 social security, should they be penalized for it? It's obvious to me that at least any income factor used in calculating earnings for income tax purposes should be $15,000 or $20,000. At this point gentlemen you may say that this sounds well, Mr. Graham, but where is the money coming from? Before you get to that, may I point out to you that 60 to 70 percent of my town's tax dollars go to the support of public schools. The taxpayer has been asked to pay more and more, and I believe we are getting less and less for our dollar. We have high school graduates unable to read and write. Despite the increase in educational costs, a great deal of this comes down from Federal Government, therefore more juvenile delinquents, rapes, thefts, and all sorts of crimes.

The elderly are being assaulted along the streets. In my opinion this has reached a point where people are so educated that they won't accept a job with minimum wages. These jobs go vacant. If anyone wonders what this has to do with them, let me remind you. It's your taxes that support this, whether you do it through the Federal Government or whether you do it locally, and I ask you what are you getting for it? Why do schools only operate 180 days a year? It's a known fact that anybody that operates a program 5 or 6 days is operating more economically.

Enormous Waste of Tax Dollars

I believe the Federal Government should be reviewing the tax dollars it pours into the educational system. A lot of it in my opinion is wasted money. I might add, a short time ago I read the *Providence Journal*, on January 19, great big headlines on the first page, "Inmates Paid $120 a Week To Get Degrees." Fifteen inmates were involved and it was spread out over a period of 2 years. This isn't my idea of educational money. I don't think we should be paying them $120 a week after they have committed some crime to get into prison. Personally, I think my figures are $120,000 off, but I still contend that nearly a quarter of a million dollars is a bundle of money. I don't object to preparing a prisoner for re-entering civilian life; but I think such spending is outrageous. I will call your attention to another article in the *Providence Journal*, January 16, that quotes Representative Alphonso Bell of California. I presume that our friend, Congressman Beard probably knows him. I suggest you read it in

its entirety. The thing I want to point out to you is that in the last 20 years when the population was increasing by 30.5 percent, and the inflation was ruining our dollar by 83.4 percent annually—pardon me gentlemen—the cost of running Congress has increased by 560 percent according to an article in *Time Magazine*, June 2, 1975, "A New Way for the Aging." There are approximately 22 million Americans 65 years of age or over. You realize that there are more or less the same number of people employed by the various Federal, State, city, town, and municipal governments. To say it another way, for everyone of them, there is one of us.

I recall reading that 200 years ago, 1776, the cry was "Taxation Without Representation." We now have "representation," and I think it's time that we took a hard look at our "taxation."

The entire system needs overhauling. Where moneys are spent in the State, someone should be policing the expenditures and if that be the case then a quarter of a million dollars wouldn't have been spent at the State institutions. They should have a watchdog in their office for moneys which are appropriated that they voted for which they in all probability asked for. When it comes in there, it runs rampant. It is obvious. It must be obvious to you that I feel there is a great many dollars being spent by the Federal Government. I think many of them are spent unwisely. I think if there were less politics and spending and more thrift there would be moneys for better health care, such as medical health insurance.

I would like now to revert back to the subject of taxation for the elderly. A person 65 years old has in all probability been paying taxes to the school system for 45 years. I think it's now time that he be relieved of that responsibility.

FREEZE ON TAXES SOUGHT AT AGE 65

I recommend that towns and cities freeze their evaluation of real estate and freeze his tax rate beginning at the time of his 65th birthday. I would further recommend that the loss of revenue be passed on by the Federal Government.

This evening after writing this article I picked up the Sunday *Providence Journal*. I took a look at an article referring to the boat show. I saw boats selling from $2,000 to $150,000. It occurred to me that I have to pay a tax on my 1971 car, and I need this car to get around in. Why then don't the affluent who can afford these expensive toys pay taxes on them?

For the record, I would also like to refer the committee to the *Readers Digest*, July 1974, page 135; and also *Readers Digest*, February 1975, page 73. Both of these articles refer to ways of saving money by the government. Thank you, gentlemen.

Senator CHURCH. Thank you very much, Mr. Graham. When I first introduced Mr. Edmund Beck, he had a prepared statement, and that statement will be included in full in the record,* and Mr. Beck, if you have anything further you would like to add to your statement please feel free to do so at this time.

Mr. BECK. Not to the statement, Senator, but I do want to thank you and Senator Pell for introducing or rather supporting S. 1183

*See p. 2112.

which is the disability bill. I am sure Senator Hartke must be frustrated because you supported it for 6 years, and passed the bill; but the House didn't do as well.

I have written to Congressman Beard, and I hope he will be able to help us in the House; because that's where it has fallen down. Senator Pell, we want to thank him for S. 2478 which is the Bill of Rights for the Blind, which he introduced last year, and of course we all appreciate it very much. I am sure Senator Church will cosponsor or support the bill.

Senator CHURCH. I certainly will.

Mr. BECK. The local legislators have received a lot of flak here this morning, and I am not here to defend them. I am sure they can do that themselves. However, we do have some legislation, I am sure, Congressman Beard is aware of it. He is a former representative of the State House. That will enable him to alert the Federal legislation; the catastrophic law bill was mentioned quite a few times today.

We have that in Rhode Island, and many other laws that we can't get federally, so I would like to point that out. I wouldn't want Senator Church to go back to Idaho or Washington and think that poor little Rhode Island can't do anything.

Senator CHURCH. Actually, I have had a very favorable impression of Rhode Island in every way, and I will take that back with me. This has been a very good hearing. I have problems with a plane because of the weather. I am told, and I hope to hear from each member of the panel; but after that if I have to leave please accept my apologies. Senator Pell and Congressman Beard will complete the hearing so everyone who wants to be heard will have a chance. I am running out of time, so that's my problem.

Mr. BECK. I had hoped that someone would read my statement, and then I could add something to it, but except for that I don't have anything at the present time to add to it.

Senator CHURCH. Thank you very much for your statement, Mr. Beck, and we will come back to you again later if you think that you would like to have your own statement read.* But let us go on at this time to——

Mr. BECK. Excuse me. I would like to say something else. I am greatly privileged and honored to be on the same panel, on the same platform with Senators Church and Pell and Congressman Beard.

Senator CHURCH. Thank you. We are pleased and honored that you are here. Rose Tritendi, please. Rose? I have an announcement here. Evelyn LaBonte should go to the back of the auditorium where a member of her party is waiting for her, if she is here in the audience.

You may begin, Rose.

STATEMENT OF ROSE TRITENDI, PROVIDENCE, R.I.

Mrs. TRITENDI. Senator Church, Senator Pell, Congressman Beard, I am very happy to be here to testify for the seniors. One of the big problems in Rhode Island, and I guess it covers the whole national country is the utilities, and I am going to speak on utilities. One of the biggest problems of the elderly in Rhode Island is utilities. Many of their utility bills have increased by more than 100 percent in 2 or 3 years. These fixed, low-income people cannot pay their

utility bills except by doing without food, clothing, and medicine. A lifeline rate may make it possible for them to have a basic supply of a vital necessity at a price they can afford. Why should utility companies get bigger and bigger profits while elderly people are freezing in the dark?

Poor people are using less fuel and paying bigger bills so the investors can keep getting their high rate of return, and the utility companies get bigger and bigger corporate profits and pay smaller and smaller corporate taxes.

Shut-offs of utilities is another serious problem of fixed income elderly. There is a need for a more human treatment of people who cannot meet the rising cost of energy. The companies should set up their policy for their offices that would make it easier for elderly people to catch up on heavy winter bills or pass due bills. For instance, a woman in Pawtucket, for example in her seventies owed $150 to Blackstone Valley Gas. She was shut off in the summer. When winter came again she could not afford what the company demanded to have it turned on again. She had to move. That is the biggest problem we have here in Rhode Island, and I think the whole Nation has it. I have some bills here which compare to last year, and all the fuel adjustments and the rates that we got for this year——

Senator CHURCH. Rose, I have a suggestion to make. I hope we can find a way to do this nationally everywhere. I don't know yet just how to approach it; but I can't make any sense out of the fact that here we are talking about the energy crisis, our increasing dependence upon foreign oil. There is a big monopoly called the OPEC cartel that sticks us with this provision, and this was 6 years ago, and that has nothing to do with the cost of oil. They are raising the price of Saudi Arabia, and we are paying $13 or $14 a barrel, so we talk about conserving energy. Yet we have a rate system that operates just the other way around. The less you use, the more you pay. The more you use the less you pay. Why can't we turn that around? People that are limited in their income and who have got to watch their bills, those who turn off the lights and use only as much as they need to get by on—they ought to be charged the cheapest rate. People who can be extravagant with their electricity and don't care how much they use—they ought to be charged with a higher rate.

We just have it upside down, and we ought to be able to turn that around. It would make sense from every standpoint.

TELEPHONE A BASIC NEED

Mrs. TRITENDI. Another item which is affecting the elderly is the telephone—many elderly cannot afford a phone. That's a must. An elderly person has got to have a phone. As you know, Senator, they may get sick. They are up in their third floor room. They are all alone. If they have a phone whenever they get sick they could call. But a lot of them have to go without it because they cannot afford a phone.

Another thing they have trouble paying their bills. After the general assembly amended the general laws, chapter 256, to authorize the Public Utilities and Common Carriers to give free or further reduction

rates to elderly, that was H.R. 2035, that was passed in 1971. New England Telephone gave a $1-a-month discount to the elderly. The law is still on the books, but the discount was taken back. This is a question that I have been asking myself. Why? Why have they done this? Special application forms were provided by New England Telephone and for a while some elderly got a little relief. Some people who must have phones have to do without. Better communications are needed between consumers and utility companies. There should be at least two low-income people on the board. This is what they are not doing. They have their own people, the big shots, you know, the stockholders. They have nobody from the low income, the elderly, which they should have being represented.

Fuel adjustment charges which are automatic should be outlawed. The utility companies should have to justify any increase in prices, and the Public Utility Commission should regulate fuel adjustments the same as they do the rate of use for services. The consumer should not have to pay the whole cost of fuel price increases. This is what's happening. They have to pay the whole price, which should not happen, especially for the elderly. They are not giving them any relief at all. There is plenty of evidence to show that the utility companies do not in good faith try to get cheaper fuel for themselves, and there is good reason to suspect that with the price of fuel charges, utility charges. The consumer pays the highest price possible with the fuel adjustment charge. We should do away with all fuel adjustment charges, or at least change the law so they are not automatic.

Senator CHURCH. Thank you very much, Mrs. Tritendi. Congressman Beard?

ROYALTIES ADJUSTMENT WOULD LOWER FUEL COST

Congressman BEARD. You mentioned the fuel adjustment charges. This has been a tremendous drain on not only the elderly people but really on all the people of the State as well as around the Nation in various degrees. I think if the major corporations, like Gulf Oil and other major corporations had a royalty adjustment of what they pay to foreign countries to extract this oil, we would be a lot better off in this country. For example, $500 million to the country of Angola as a starter. If there was an adjustment to royalties of what they pay in order to extract oil, we would be better off.

Mrs. TRITENDI. Congressman Beard, I am going to ask you one question. Would you see to it that the dollar discount that they did take away from the elderly in Rhode Island, will you see to it that there is something done about that? The law is still on the books.

Congressman BEARD. That would be a State issue now. It is out of my jurisdiction; but I supported you the last time on that. I am very sympathetic on that issue. There is not too much I can do. That's up to the telephone company.

Senator CHURCH. Ladies and gentlemen, my time has run out. I am sorry I cannot stay; but the whole time you have been awfully nice to me. I appreciate the hospitality that you have greeted me with in Rhode Island.

Senator PELL [presiding]. Is Bill Lynch here?

Mr. LYNCH. I am here. I will get Senator Church down there.

Senator CHURCH. All I can say is I am leaving Rhode Island in very competent hands. Thank you very much for attending.

Senator PELL. This has been a great hearing. I want to make sure that everybody has an opportunity to express themselves that would like to, and in this regard, I am referring to Mr. Beck's statement. He is an old friend of mine. I will put his statement into the record. He might like to digress and just make a few points himself. I think it would mean more if you said what was in your heart. The statement will be inserted in the record.

Mr. BECK. All right, Senator Pell, thank you. What I have in the statement is in reference to the handicapped as well as the elderly. The cost of institutionalizing handicapped are 4 times as much as if they were in low-income housing. They have a housing project. It is called Highland Heights which is in Fall River and is for the elderly and handicapped. They have nurses, doctors, all sorts of health care, quality treatment, and food, which of course is on the premises for those who want it, and don't want to use their own facilities and apartments. It is so much better for the people to be in this environment than it is to be in an institution.

They made a study of 26 people that were transferred from nursing homes and institutions into Highland Heights for a whole year. They studied them and found that they have done so much better at Highland Heights living in independence and freedom. Here they are able to socialize with other people and are able to go out and do things as other people do. Here in Rhode Island we are very fortunate to have Lieutenant Governor Garrahy interested in the elderly, the handicapped, and the people in the State, and he has conceived the idea for Rhode Island, and we hope we will have such housing here in the State.

I think that about covers it, Senator Pell.

[Mr. Beck's prepared statement follows:]

PREPARED STATEMENT OF EDMUND BECK

Historically, when decisions were made concerning the need for housing the public, disabled people were not considered. Their needs usually did not enter into the calculations of the developers, the designers or the officials of the various levels of government. Consequently, millions of disabled people have had to find their shelter somehow, somewhere, often in most uncomfortable and undesirable situations. Many disabled people have been forced to live out their lives in dull and dreary institutions because no alternatives were available. For many years, the establishment of institutions was accepted as being the best and most economical means of doing something for and with the handicapped. Consequently, many young and alert young people have been forced to spend their lives in nursing homes surrounded by ill and elderly people.

There exists a need for 10,600 elderly public housing units in the State, and 2,750 moderate-income units. These figures come from the 1973 Department of Community Affairs report, "The Elderly and Their Housing."

Approximately 15 percent of Rhode Island's population (represents the noninstitutionalized population) are physically handicapped.

Approximately 26 percent of Rhode Island's physically handicapped citizens (represents the noninstitutionalized population) are 65 years of age or older.

Approximately 11 percent of Rhode Island's physically handicapped, permanently disabled population are 65 years of age or older. The majority, 77 percent are between the ages of 45 and 64 years. These figures come from Summary of Findings of Rhode Island Department of Community Affairs.

Care, whether good or bad is most frequently custodial rather than restorative and goal-oriented. Eventually, most of these patients are sequestered in institutions or isolated in their homes, no longer considered "patients" with short and long-

term therapeutic goals, but rather regarded as invalids requiring only supportive care with occasional crises intervention.

LOW-INCOME PUBLIC HOUSING

The Independent Living Authority, a nonprofit corporation of Rhode Island was formed for the purpose of developing low-income public housing specifically designed to meet the special needs of the elderly and handicapped individuals and families. It will be a 14 story building containing 200 one and two bedroom apartments. Each apartment will be a private unit containing all of the facilities one would anticipate in a public housing development. Architectural barriers will be eliminated.

A nurse on the premises will respond to an emergency alarm system originating in each apartment. Routine nursing services will also be available on the premises. We will seek cooperation from the community and agencies to help furnish nursing, homemaker services, occupational and physical therapy, social services, entertainment, and recreation and other services.

It would be to the advantage of the occupant to live in an environment of freedom and independence. They are also expected to have easy access to public transportation, doctors' offices, hospitals, shopping center, etc.

Independent living is not merely a pipedream. Due to the foresight and imagination of Dr. David S. Greer, associate dean for medical affairs at Brown University, there is a model residence already functioning, a few miles outside of Rhode Island in Fall River, Mass., at 100 percent capacity, since September 1970, with a waiting list of eligible tenants.

The tenants of Highland Heights range in age from 21 to 95 years although 75 percent of them are 62 years or older.

There are no architectural barriers there. The elevators are large enough to accommodate multiple wheelchairs. Everything in the kitchens and bathrooms are designed at suitable heights to accommodate people in wheelchairs.

A significant point is that a project such as Highland Heights satisfies both housing needs. The handicapped can live independent lives, free of institutional restrictions and architectural barriers. The elderly are also provided for far better than many would be in conventional public housing, since so many of the elderly are also handicapped.

Senator PELL. Thank you very much. Congressman Beard, you may have some questions.

CONGRESSIONAL PRIORITIES TWISTED

Congressman BEARD. I think your point is well taken. Again, I am kind of embarrassed the House hasn't done as well for the legislation you referred to earlier for the handicapped. I can assure you that as I serve on the Select Committee on Aging the needs of the handicapped and elderly will be served, we are certainly doing the best we can. Unfortunately, sometimes the priorities are twisted in the Congress. I have stated earlier that with so many senior citizens in this country, and a majority of the Congress almost, individual members who are senior citizens, we should have a lot more progress. Perhaps that will help not only the elderly but the handicapped people.

But one thing—I did have a change, and you will certainly appreciate this. Again, for the handicapped children we did pass legislation in 1975 that would eliminate some of the architectural barriers in schools and to give youngsters who are handicapped, disabled, an equal opportunity for an education.

I was very, very happy that we had that chance, and I participated again along with Senator Pell on that legislation.

Mr. BECK. There is no reason for you to apologize, Congressman Beard, because you have not been in office that long. We have a bill in there, H.R. 821 which was introduced by Representative Burke from Massachusetts, and I am sure you will do everything in your

power as well as Congressman St Germain who has already told us he would, and with your good work there I am sure we will get it through.

Senator PELL. As I think back 4½ years ago when we had the last hearing of this committee in Rhode Island, I realize that conditions are still very poor, but they are better than they were, and they are improving, thanks to the work of many officials at all levels of government, and we should also bear in mind the situation throughout the country is worse than it is here. There are very few States, for instance, which even have off-hour busing, public transportation. Our programs are in advance of the Nation, and our job is to try and improve it on a national level. I received a letter from Mrs. Susan Tomasso describing the work that the RSVP program has done, and I will insert this in the record.* Now, we will hear from the interested citizens who are on the floor. This lady was first, and if you will identify yourself.

STATEMENT OF SUSAN TOMASSO, WEST WARWICK, R.I.

Mrs. TOMASSO. Senator Pell, I am from West Warwick, and I am very proud to be in RSVP and Community Action of Warwick. I am glad to get out and proud of what you are doing, and I hope you keep us going by appropriating money for more buses and all that.

Senator PELL. You are Mrs. Tomasso, are you not?

Mrs. TOMASSO. Yes.

Senator PELL. Thank you very much, indeed. Your letter will be part of the record as well.

Mrs. TOMASSO. Thank you very much.

STATEMENT OF BARBARA L'HEURAULT, PAWTUCKET, R.I.

Mrs. L'HEURAULT. My name is Barbara L'Heurault from Pawtucket Inner Cities Senior Citizens Group. The program is too limited a coverage, and too expensive, because the deductions that must be paid before coverage begins. Part A, hospitalization coverage costs $39 monthly unless you are covered by social security, in which case it is free.

Medical coverage, part D, costs $6.70 per month. If you are hospitalized you must pay $92 before coverage begins. If you are hospitalized for over 60 days you must pay $23 per day for days 61 through 90. Medical coverage, part B requires a deductible of $60 before coverage begins. Many services are not covered. Medicare will not pay for nursing care in the home, drugs, and prescriptions, homemaking service, eyes, ears, for glasses or hearing aids. For those reasons our group urges your support for comprehensive Federal health programs as would be provided for in the Kennedy-Corman bill.

Senator PELL. Thank you very much.

STATEMENT OF LOLA GENDRON, CENTRAL FALLS, R.I.

Mrs. GENDRON. My name is Lola Gendron from Central Falls, and I am interested in legislation which relates to the Social Security

*See appendix 1, item 10, p. 2135.

Administration policy of collecting overpayments when it is clear that the recipient is not deliberately at fault.

Since 1971, I have had several problems with the Social Security Administration regarding overpayment benefits. I have with me copies of correspondence dealing with these problems which I shall give to the committee.* During the year 1971 I had several disputes with the SSA about the amount of my benefits.

I even contacted Senator Pell's office for help. On January 13, 1972, I received a letter from the SSA stating that I had received $164.80 more than I should have. The reason for the incorrect payment was in their words caused by a special action which was to expedite payments to me. The letter explained that I must send a check for that amount within 30 days which I did. I sent the check even though the mistake was entirely the fault of the Social Security Administration. In May 1973, I received a letter from SSA pointing out that I was overpaid $500 because I had worked in 1971. Since they did not withhold enough in 1971 they would withhold $500 from my checks of May through July of 1973. This was 2 years after this mistake on their part. In August of 1974, I received another letter from the SSA. The letter claimed that they overpaid me $5.30 a month for a period of over 1 year.

Administration's Blunders Cause Hardships

These overpayments continued from January 1973 through May of 1974. This overpayment was entirely the fault of the SSA. There was no way I could have known that these checks were higher than they should have been, but the letter said they would recover the money by taking it out of my next few checks. With the help of Project Hope, Central Falls, I protested this action. No money was taken from my checks, and I assumed that the matter had been dropped. In November of 1975, I received another letter regarding the same, old, alleged overpaid benefit. The letter said that they would withhold my January 1976 check and take $98.78 out of my February check. This would mean I would repay $365 because of a $105 mistake made by social security. With the help of Project Hope I once again protested. I filled out several forms, answered many questions, and signed several statements.

I was told by Mr. Kempf of the Pawtucket Social Security Office that there was a possibility the SSA would waive its recovery of the benefits paid me.

It was almost 3 years ago, and I believed paying it back would be a hardship. I feel anyone living on a fixed income should not have to pay for a mistake made by social security. I still have not heard about my request for a waiver. I request that this system of harrassment of innocent recipients of mistakes made by SSA be discontinued.

In each of the instances I told you about the SSA has not denied that it was their fault. At no time did I know that the social security checks reflected errors made by the SSA, but I was expected to pay for these errors.

*Retained in committee files.

I am only 1 of millions of social security recipients, and I am sure that many others have similar problems. I feel it is up to Congress and this committee to develop legislation which will protect social security recipients from this needless aggravation. Thank you.

Senator PELL. Thank you Mrs. Gendron. Also, the Social Security Fairness Act that I have introduced and Congressman Beard has cosponsored and Senator Church has cosponsored, if it is passed it will resolve some of these problems that you mentioned.

Mrs. GENDRON. Thank you.

Senator PELL. Sir?

STATEMENT OF CHANDLER W. JOHNSON, PROVIDENCE, R.I.

Mr. JOHNSON. Thank you very much, Mr. Chairman. My name is Chandler W. Johnson. I am an elector of the State of Rhode Island, and Providence Plantations. I am a resident of Providence, and I appear here without presuming to represent anybody else but myself alone. I am what has been recently labeled as a senior concerned citizen, and you, Senator Pell, more importantly in this respect, it is necessary, Congressman Beard and I have known each other for years, beginning with his activities in the local general assembly before he went to Washington.

So that if any representations or whatever regarding me without going to the CIA, I hope they haven't caught up with me yet. I don't have a telephone so I am not afraid of having it bugged now, and that's another reason why I am glad I don't have a telephone. Without being repetitious of what I have already heard, I have these very few short observations to make. But with your indulgence I would like to add a short prefatory remark.

Senator PELL. I would get on with your observations, and also talk right into the microphone.

Mr. JOHNSON. I can't do it, and with all due respect I would prefer not to do it until I have expressed my appreciation to you and your colleagues on the committee for the opportunity afforded here, and I am sorry that Senator Church had to leave before I could give it to him straight from the horse's mouth, and I appreciate the service that you three gentlemen have been doing during your service in the Congress.

Now, for the few points. In connection with the facilities afforded to some of us senior citizens in the housing facilities, I am accustomed to appearances at hearings like this, and I have been informed that it is the members of the committee that are supposed to be the beneficiaries. I am not used to these modern technological contraptions. I have been accustomed in attending such hearings as this that the members of the committee are the individuals who are supposed to be the beneficiaries of whatever contribution the people want to make. So as far as I am concerned I am addressing my remarks respectfully to you gentlemen on the committee, and through you to your colleagues in the Congress. I am a resident of one of the housing authority facilities for the elderly, and I had an experience just last night that I feel should most respectfully be brought to your attention for whatever influence you may have in straightening the problem out, and I am one of those political heretics who believes that whatever is good for Rhode Island and its citizens, if it is good, will have its application for the citizens elsewhere in the country.

Tenants Cannot Afford Telephone

There is no pay phone in that facility up there available to the tenants like me who can't afford the luxury of a telephone. So I had to go down and in response to a message delivered to me by the local police department, to put in an emergency call to my son who is serving in Germany, and when I went downtown to try to make the call in response to this message, at one of the pay phones down at Kennedy Plaza, there was nobody that I was able to reach in the telephone company on duty at the time between 8:30 and 9 o'clock who could unscramble the numbers, and I have never indulged in the numbers racket anyway. So I couldn't do it myself. So I decided to go up to the police department headquarters from whence I got the message to see what they might be able to do about it.

And, fortunately, I am very grateful for the assistance that was given me there at police headquarters, Lieutenant Murray, particularly. They have ways and means of breaking through and overcoming obstacles like that. So that in about an hour's time they had the same experience I had; but they were able to overcome all the obstacles the telephone company threw in its way, and I finally got through to my son. So my point is that to me whatever the technical obstacles there are in the way, and it was explained to me that no paid telephone could be installed in that facility because it isn't open 24 hours a day for the public, and I don't care under the circumstances about the public generally with all the pay phones available to them, if they need them elsewhere; there should be a paid telephone in the facility for the likes of the tenants like me who don't have a telephone.

Senator Pell. Thank you.

Mr. Johnson. Just a minute. You aren't through with me yet, with all due respect, Mr. Chairman.

Senator Pell. There are several others that wish to make remarks, and maybe you could digest your thoughts.

Mr. Johnson. I have. Don't worry. I have faith. I hope you have.

Senator Pell. Excuse me. I must interrupt here. The Warwick Community Action Bus must leave, and would Mrs. Greene please come to the elevator or she may be left behind. Mrs. Greene?

Savings At Expense of Health

Mr. Johnson. More importantly, and with whatever national effect it might have, you people in Congress now have the administration's—more particularly the President's—budget before you, and I want to record officially for the record my protest as strongly as I can make it, and through you to your colleagues in the Congress that the priority for savings should not be made in the area of health, education, and welfare in view of all the benefits that is accorded to the Defense Department in preference. And the protest that the President would make about not having money available, the savings in the Defense Department budget since it should not be our concern to look after the people elsewhere in the world before we look after our own here at home. The savings in the Defense Department budget to our side of the budget could more than make up the funds necessa-

ry to continue and improve the benefits in that health, education, and welfare side. Thank you very much, Mr. Chairman.

Senator PELL. Amen.

Brother WINN. I am Brother Charles Winn, again. I want to make a brief comment on the public utility situation. I know from attending many, many hearings, the public utility people, the Public Utility Commission hearings, and a great many other people are aware of Brother Charles Winn as a frequent testifier at the hearings, the rate hearings. I have been to Washington to see Mr. Nassikas at the Federal Power Commission office, and it is to that point that I address the national representatives, Senators and Representatives from Washington. I don't know what influence Congress has on the departments like the Federal Power Commission. I know when we wanted to see Mr. Nassikas, Senator Pastore got on the phone and he said to him, "These people from Rhode Island want to see you now," and after a brief pause he said they want to see you now, so I presume you have some influence in getting through to them. What I am getting at is this. The Federal Power Commission has on several occasions overridden the State Public Utilities Commission in New England, particularly, where the power companies operate a conglomerate that covers the entire area. The electric companies and the gas companies are interstate, and this probably is true in many areas of the country. But the Public Utilities Commission is a State regulatory organization.

COOPERATION NEEDED AT ALL LEVELS

Without cooperation from the Washington office and without regional organization, it is an extremely difficult if not impossible task for the State regulatory agency to make effective decisions.

This is one of the problems of the Public Utility Commissioner to be able to make decisions that will stick, because we are dealing with the electric companies for example, and there are seven of them in New England, all under the New England Power Co. The parent company controls the prices, the charges for services. Rhode Island does not produce but a very small fraction of its electrical power, and for the Public Utilities Commission to make reasonable regulation of Narragansett Electric, or Blackstone Valley Gas, or any public utility that operates outside of the State, is an extremely difficult job. I would say, I would ask the representatives of the Senate and House to use whatever power you have to get the Federal Power Commission to cooperate with areas like New England so that we could arrive at a reasonable decision on rates. This is my main point.

Congressman BEARD. Brother Winn, recently the Federal Power Commission granted an increase for Blackstone Valley and I vigorously protested in my office because I feel that our own case here with the utility being before the Public Utility Commission there is always a chance for the public in most cases to be able to testify.

In this case it is almost impossible for people, unless they read the fine print in the paper to know about it, and, secondly, the only chance would be in Washington, and this would rule out 99 percent of the people in the State of Rhode Island. I am very sympathetic to what you are saying. I have vigorously protested the procedures of the Federal Power Commission.

Brother WINN. At the time we went to Mr. Nassikas; we asked him to hold meetings in Providence, and he said this was impossible, and he left to catch a plane to Montana. That is a long way from Washington and much further away than Boston or Providence.

Congressman BEARD. I agree.

Senator PELL. Thank you very much, Brother Winn.

STATEMENT OF CYNTHIA NEAL, PROVIDENCE, R.I.

Miss NEAL. My name is Cynthia Neal. I am asking for a better clarification of the medicare benefits and limitations. I feel very strongly about this, particularly of the clause dealing with custodial care. My mother is 86. In 1952 she started to carry private medical coverage to take care of her in her old age. She has continued to carry it; but when medicare came, the policies which costs between $400 and $500 a year were tied into medicare, which comes under, as defined, "custodial care." So she is not able to collect any of her insurance moneys, and I think that other people may have this very same problem, and I think it's very important that the medicare benefits be more clearly defined, and particularly the clause on custodial care.

STATEMENT OF RALPH PERROTTA, PROVIDENCE, R.I., FEDERAL ADVISORY COMMISSION ON LEGISLATION

Mr. PERROTTA. My name is Ralph Perrotta. I am a member of the Federal Advisory Commission on Legislation. In fact, I am the only New England representative on that committee. I would like to address myself to the energy policy on New England, because I think what's happened is a much larger share of the burden of the so-called energy crisis has been put on the backs of New Englanders, and on Rhode Islanders in particular. While the Consumers Price Index showed that prices in general went up 11 percent in the years 1973 to 1974, the increase for electricity was 18 percent, and the increase for fuel oil was an astounding 5 percent for New England. When you consider that New Englanders have much colder winters than the rest of the country, that means that we are paying huge fuel bills far out of proportion to what people in the United States generally are paying. At the last meeting of the Energy Administration Committee, I asked John Hill, who is a deputy director, what he is doing to come up with a pricing policy to distribute the burdens of the energy crisis more fairly than they are now, and I think the short answer is "nothing." The administration's policy now is to equalize prices of fuel oil around the country and have different kinds of fuels around the country; but for New England which relies heavily on one of the most expensive fuels, namely fuel oil, as opposed to natural gas, and coal, and so on, that policy is an unfair policy, and needs to be changed. Thank you.

Senator PELL. Thank you, Mr. Perrotta.

STATEMENT OF HAROLD CORRIS, PAWTUCKET, R.I.

Mr. CORRIS. Mr name is Harold Corris. I live in Pawtucket, R.I. I only arrived at 11 o'clock, and if this has been brought up I will retire. Has any question been brought up about page 20 in the social security booklet relating to self-employed persons?

Senator PELL. No.

Mr. CORRIS. I am self-employed as a manufacturer's representative which I set up years ago because I felt that when I reached a certain age if I worked for one company I might be laid off, or retired, and at a certain age would be unable to find another job. I represent three companies. I sell raw materials to the jewelry factories. I work on a commission basis only. I pay my own expenses, receive no pensions, and no one pays my social security except myself.

On page 20 in the social security booklet very few people that I have spoken to know anything about the restrictions on the hours of labor. My doctor tells me not to retire. He said to keep working. If you retire you get sick. What I want to do is as my doctor says—to begin to cut back and work part time—but to work the rest of my life if possible. I contacted social security; but I read the law thoroughly first. A self-employed person like myself, and there are many around the country, and that includes many attorneys whom I happen to know, can only work for 45 hours per month which means if I wanted to drop one of my companies or two and work part time I have been told by social security they will check the time I leave my house. They will call my companies and see what days I report in to the factory. They will check my customers. In other words, I cannot work and cut back and draw social security. As a self-employed person I have to pay both the employer and the employee share of social security. The average person has a job. The employer pays half of it. This past year in 1975 I paid $1,042.80 for social security. In 1976 I will have to pay somewhere between $1,100 and $1,200. I have been paying since social security laws started. I will probably never collect a dime. What I want to know from you gentlemen now is the answer to this question, and I believe I wrote to Senator Lowell Weicker, and Senator Barry Goldwater who both are trying to sponsor it. I want to know why a person is restricted to 45 hours a month if you are self employed, which means approximately 11 hours a week, and no company is going to allow a person, particularly salesmen, to go out and work 11 hours a week.

I want to know why this law cannot be changed so that a person who pays since its inception and it is my money, should not be able to work if he wants to at 65 and draw social security. If I want to work part time and work five mornings a week, it's my money, and I want to have the right to work instead of not working, and I feel that this social security law should be changed. I am directing my question to both of you gentlemen, because I know that some of the Senators, particularly Senator Lowell Weicker, and Senator Barry Goldwater, who happens to be Republican, and Weicker a Democrat, have been trying to get this law changed for years, and have come within one or two votes, I believe, and I feel that this is very important.

I have talked to a lot of other people, other salesmen, and I can't see the sense of making me work only 45 hours a month if I want to work more.

Senator PELL. Two thoughts, two points: First, you will be glad to hear I am a cosponsor of the Goldwater bill. Actually Goldwater and Weicker are both Republicans. It is a darn good bill. I am glad to be a cosponsor of it.

NEW PENSION LAW

Second, there is a new pension law. There are provisions whereby you can set money aside, defer tax payment.

Mr. CORRIS. I am not interested in the money. I want to work.

Senator PELL. I can't promise you any more than I myself am cosponsor of it.

Mr. CORRIS. One more fact, am I taking too much time——

Congressman BEARD. Can I make a brief comment?

Mr. CORRIS. Sure.

Congressman BEARD. Trying to understand without having the material in front of me which you expressed——

Mr. CORRIS. Page 20——

Congressman BEARD. I don't have that. I see what you are saying, because you happen to be a self-employed businessman you are being punished.

Mr. CORRIS. That's right.

Congressman BEARD. As far as I am concerned I will take a look at this legislation. I have always supported legislation that's going to give the elderly person an even break. Just as I have introduced legislation to raise the amount of money to $6,000 before a person is penalized, where they have to pay like $1 or $2.

Mr. CORRIS. I don't care if it's $6,000 or $10,000, you can't work more than 45 hours a month.

Congressman BEARD. There are so many inequities in the law. I support Senator Pell, being a cosponsor; I will be happy to introduce it if you would send me a written statement on that to the House in Washington, I will be glad to introduce that in the House.

Mr. CORRIS. When the social security law was passed it was passed under the assumption that everyone reaching 65 would have a pension, working for someone, he would get out of the labor force and let the young people work. The other bad feature about the social security law which is being evaded by many people, I know many of them, professional people, businessmen, is they take the social security law which says you can have all the income you want from dividends in stock and you can still draw social security. So many professional men and many businessmen take their company, and you can investigate this, they turn the corporation over. They draw themselves off the payroll, draw no money. Someone else runs their business; but at the end of the year they can draw $150,000 or $300,000 in dividends from the company, and they are still drawing social security.

Senator PELL. The reason for that is that they pay into social security.

Mr. CORRIS. So have I paid in. I can't draw. I can't work. I want to work.

Senator PELL. Thank you. Before the next person, if you will forgive me, I would like to introduce Mrs. Brown, who was asked to come here. She is considerably older than you are, she is 92. I thought we ought to ask her to speak. Maybe you could bring the mike over to her. Excuse me. All of you may have read the article about Mrs. Brown. It was in the *Providence Journal* this very morning.*

*See appendix 2, item 2, p. 2137.

STATEMENT OF SIDONIE BROWN, PROVIDENCE, R.I.

Mrs. BROWN. Thank you, Senator. I have been asked to come here today to thank Mrs. Eleanor Slater. She is the lady that's in charge of the elderly, because she had heard that I was an invalid to a certain extent, and that she saw to it that I got material brought to me so that I can sit down all day and work and make all kinds of fancy things, anything at all in occupational work. I do this for the people my neighbors, for the children, and for the elderly that come to me. I have people that send me material. I cannot mention their name because they would probably be invaded with people going up there looking for them, but they bring me the material, and I hook rugs. I crochet rugs. I give them all away. I make them by the hundreds because I am very fast with my hands. If somebody sends me yarn, I take it and make shawls like the one that I have on, and I make all kinds of fancy work. I make afghans. I make booties, and I make bonnets for babies. If they bring me the yarn I make jackets, little afghans for the baby cribs, and anything anybody wants made, if they bring the material. I do beautiful needlepoint which I have learned how to make in Europe. I am Belgian born, but an American citizen, and these people bring me the material. I will manufacture and make beautiful designs for them.

Some people bring me the canvas, buy me the yarn. I make their needlepoint the way it was taught to me in Europe. Anybody that wants to learn to do needlepoint can come to my apartment and I will sit down and teach them to do it, anything, even making oriental rugs which I know how to make, which was taught to me in Europe in occupational work. I thank people very much that come to my house. I will give them anything that I made like bonnets, little booties for children. I make little booties for people. They come. As long as they bring me the material, because I cannot afford it. I live on social security, and I cannot afford to buy the material, but everybody is welcome if they have the material to bring it to me, and I will make it. I will make something, even if it's a half a yard of elastic, I will make something out of it. I thank you very much.

Senator PELL. Thank you, Mrs. Brown. You epitomize the thought that you live and receive by your giving to others over the years in your wisdom and age.

Mrs. BROWN. I don't know what they said about me in the article. I will have to read that.

Congressman BEARD. Mrs. Brown, Congressman Beard. I think what Senator Pell said is true. You know, I notice the newspaper mentions the longevity of your family. I believe your grandmother lived to be quite elderly.

Mrs. BROWN. Yes, my great-great-grandfather was the inventor of the strike-anywhere match. I only have two left. He was a landowner in Belgium, an *Elano*, which in English spells *Elano*. Franklin Roosevelt was a distant relative of my mother. So, therefore, when he came to this country he did not speak English, and when he told the people what his name was, and when Sarah was born she was named not Sodonie because in this country they make mistake. They want to call me Sodonie. I told him I was 11 years old when I landed in America. My name is spoken with a soft "i," not a "y."

He said, what are you talking about? I learned English in Belgium. I learned all my foreign language in Belgium. I have done a lot of work. When I hear people speak in German about something in this country I always reported it to somebody in authority. When I heard in Italian or in Spanish I went right to town on them. Flemish birth, which I am, and I thank you very much.

Congressman BEARD. I am only a baby looking at your longevity. It's tremendous. Let me tell you this, we are working to try to improve all the elderly people's lives in this country, and we will do our utmost. It's wonderful to have a person like you who can come before us. When you read the story, I would suggest everyone get a copy of the newspaper and read the life of Mrs. Brown. I think it's a tremendous life, and it's a tremendous story of what has taken place in your life.

Mrs. BROWN. I sit all day long on my chair, and I am desperate and most comfortable. I don't go out very much. I am thankful to the Jordon School. They allow us to go shopping. They pick us up. It makes it nice. I couldn't carry bundles anyway. Sometimes I go to Mrs. Eleanor Slater's office to see if she's got anything I can use, a little bit different, to make something pretty. They bring me back. They always take me home. They get mad if I take the bus. I should call them up, and they will pick me up to go pick my things out.

As I say, people are good to me.

Congressman BEARD. God bless you, dear.

Mrs. BROWN. As I am diabetic and arthritic, I am ready to sit down. Thank you very much.

STATEMENT OF DAVID MALONE, SOCIAL WORKER

Mr. MALONE. David Malone, and I am a social worker. I deal with the aged on a daily basis. I have found with my experience working with this group of people that they are in need of many things—not only of money. In their economic situation it is a problem. I feel they need help in the medical area, for example, in homemaking. I feel that homemaking services should be paid for by medicare, because a lot of these people have an income of social security which makes them eligible for homemaking payments through public assistance. They have to dish out money for someone to come in and cook and take care of them. So I feel that medicare should include homemaking services to be paid for the elderly or even the disabled who are receiving social security payments. I think it was Fred Creighton, he mentioned one of the problems during the first panel discussion. Many people are eligible for various programs. They don't know anything about these programs. Believe me. I deal with them every day. I feel there is a shortage of staff for private and public agencies.

I think that something should be done, also, with the staffing of these people to go out and see the results of these programs, social workers, aids, just interested volunteers, or whatever. I think title XX of 1972 or 1973 by Congress, services for the elderly, the blind, families under a middle income limit, I feel that the stress in Congress should be to increase funding to the various States to provide more staff for public and private agencies to get to these people, and

seeing that these people are doing all right in the community. Thank you.

STATEMENT OF FLORA WARE, CHARLES PLACE TENANT ASSOCIATION, PROVIDENCE, R.I.

Mrs. WARE. Senator Pell, Congressman Beard, it is my pleasure to be here. I represent a group of senior citizens in an apartment complex. It has been subsidized. It has been of great concern to me, the situations that have existed in this particular complex for the services they pay for, the rents every month. The complaints are ignored to a certain degree. They have been recognized and they have been checked, but it is inconsistent. The checking is inconsistent, sir. They are paying an increase in rent in the past year of $21 to $22, which has been denied them even though they are the most cooperative group of people I have ever met. Our citizens and our people are very cooperative to everything we propose as an organization. I can bring them social activities. They will cooperate and provide great generosity, sir, to any mass that may be brought into the building, which I have unfortunately been able to bring them only twice in the past year. We now have conditions in this building where we have a recreation room which is unusable because of inadequate heat. I ask you—where money is subsidized by the taxpayers in Rhode Island, why do my senior citizens have to be refused activities in a recreation room that has inadequate heat? We have lived in this building, sir, for over a year. I am greatly concerned for my people. I know others in other buildings must have other complaints. I know this; but my concern is with the people I represent, and I have taken this opportunity that you have given me to speak up for them. I am not quite as old as they; but I am very concerned because the time is coming when I, too, will be in their position, and hopefully, God grant that, someone else may be younger than I. Then they will speak up as I am today.

Congressman BEARD. Would you contact my Providence office and explain the dilemma, and I can assure you we will get to the bottom of it?

Mrs. WARE. I spoke to a Mr. Newmeyer. He is in your office. I will check it out for you. If it is a——

Congressman BEARD. If it is a State problem, or if it falls under Federal jurisdiction, one way or the other we will assist you.

Mrs. WARE. Please don't make me start at the bottom, again.

Congressman BEARD. You start with my office.

Mrs. WARE. I am already near the top. I won't disclose the names of the agencies to whom I have approached and who have tried to be helpful; but I have gone through State, city and some Federal, and I would ask that you give me a little extra consideration, knowing that I have gone through these aggravations. Yes?

Congressman BEARD. Right.

Mrs. WARE. I will contact your office.

Congressman BEARD. I am making my office available to you, if we can assist you.

Mrs. WARE. Thank you very much.

Senator PELL. Thank you very much for being a very patient and interested audience and participants. I think this has been a good

hearing. It is only too bad that President Ford's budgetmakers couldn't have been here listening to us before they dreamed up his budget. I completely agree with the gentleman who spoke about the law of priorities in his budget. They should have done this rather than appropriate money for defense in the hardware sector; they should have appropriated more for the human, aging, health educational sectors, and this is the direction that many of us in the Congress will seek to push the budget into, to carve the budget more along the needs and true desires of our people. Congressman Beard, do you have some closing comments?

National Health Insurance Is Goal

Congressman BEARD. Yes, again I am very honored to have been invited by Senator Church and Senator Pell to participate in this committee hearing. I serve on the counterpart in the House, and I think collectively the House and Senate Aging Committees certainly will do their utmost to make sure that the elderly people are given a little better shot in this regard. My goal, and I know Senator Pell's goal, is to see national health insurance implemented in this country.

Senator PELL. Thank you very much and may I add that Congressman Beard in the Congress, just as Senator Church is in the Senate, is noted as one of the most vigorous fighters or participants in all matters to promote the well being of the elderly. There is no more vigorous spokesman than he, which is shown by his patience in sitting through this hearing.

I present the compliments of Mr. Church who would like to have stayed with us. His plane was canceled through Green. The only possible way he could get a flight was to make his way back to Washington and leave by plane from Logan.

This meeting will now be shortly recessed. It was 4½ years ago when we had our last meeting. Maybe we will try to do it sooner next time around. Meeting adjourned.

[Whereupon the hearing was adjourned.]

APPENDIXES

Appendix 1

STATEMENTS AND LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF EMILE DENIS, SENIOR CITIZENS OF RHODE ISLAND ACTION GROUP

A Suggested Plan To Improve Home Health Care by Improving Medicare Benefits Under Social Security

First, as you know there are millions of medicare patients in the U.S.A. that are not completely senile or helpless, but are in institutions or nursing care facilities.

Second, we believe many of above mentioned millions would be happier in their own home environment thereby becoming healthier and recuperating faster. In their own home they would receive T.L.C. (tender loving care) by their spouse and other members of the family if some of the children are still home.

Third, many senior citizens between the ages of 65 and 72 because of their insufficient income and the fact that they do not want to depend on charity look for work, to supplement their income. But with unemployment as it is, sometimes it is impossible to obtain work. They may earn $230 a month without losing the social security Checks.

Fourth, if some plan could be worked out so the government would pay the $230 per month the spouse could then devote full time to care of patient instead of working 30 or 35 hours away from home.

Fifth, we understand that the government, Federal and State will pay the minimum cost of care in the above mentioned care facilities. The cost is $15 per day or $450 in a 30-day month.

Sixth, if some form of home-care payment could be worked out it would save the government money and leave the patients family feeling independent after working all those previous years.

ITEM 2. STATEMENT OF BRUNO HOFFMAN,* PROVIDENCE, R.I.

Social Security

Recently we heard a lot about "Problems of the Social Security System" about a Budget Deficit and about the needs of a review of the system. Since its inception and for many years afterwards, right wing circles of our political spectrum were fighting social security and what it stands for. Now, with President Ford's budget message and his proposal of an increase of the social security payroll tax, we hear all kind of arguments about the health of the system and future dangers.

Social security as insurance.—Originally this was supposed to work like real insurance. Employer and employee would pay annually a certain premium, which with interest earned over the years would guarantee a certain income at retirement age. This was not kept up, first by adding certain welfare aspects, like giving a minimum income even to people who had not contributed to the fund. And in recent years the steady inflation made it necessary to make adjustments according to the increase in cost of living. This was done, for quite a few years by special laws of Congress, always much later than necessary; finally in 1972 Congress passed a law giving automatic increase of the social security benefits according to the Consumer Price Index.

*See statement, p. 2089.

Inflation and cost of living.—Did this law, that supposedly was part of the cause of the deficit really make up for the losses and needs of the old people who had spent a lifetime in honest work? How was it handled? Everybody knows that the cost of living in 1974 went up 12 percent. Our government found a formula calculating it for only 8 percent. And the first payment was made in July 1975.

SSI.—Hardest hit by this system are the very low-income people of the SSI program, who can not make up for the tremendous increases of heating and electricity bills. They buy no cadillacs or frigidaires and therefore their cost of living index is gone up much more than 12 percent. And there the State of Rhode Island found a legal way to withhold half of this increase and use it for other budget purposes. A Federal law is necessary to order States to pay fully to all beneficiaries the increases coming from Federal sources.

Interest of the social security fund.—How much credit does the government give as interest? The inflation caused in the private economy a big increase in the interest rate helping the private investor to make up for some of the inflation (mortgage rate 9 percent or more). Maybe there would be no deficit, if the fund gets the right credit.

REMOVE EARNINGS LIMIT

Earning allowed for people of 65 to 72.—This too, stayed far behind the economic development. $2,760, the new limit is much too low. Why should there be any limit? If the people work, there comes some more income tax in. But a figure of $5,000 would make much more sense. On the other hand, there should be an elimination of the loophole, created under the Eisenhower administration allowing people to earn in one or the other month any amount of money (even $10,000 or more) and to collect social security in all the other months fully, when they don't make more than $230 in those months.

President Ford's proposals for social security taxes.—Again the administration came to the wrong conclusions about the consequences of inflation. Not only has the small income worker the same percentage charged to him as the man making $10,000 or $15,000, but people making more than $15,000 or later $16,500 pay no social security taxes from the amount they make over these limits. How can you justify to charge in round figures a worker making only $5,000 annually, $300 tax, i.e. 6 percent and somebody making $33,000, $990 tax, i.e. only 3 percent. And don't forget it does not make any difference if from the $5,000 he has to support a wife and children. Mr. Greenspan, the President's economic adviser was in a television interview yesterday speaking out against an increase of the taxable base of income. He gives the old excuse, it would change the insurance system and bring more obligation in the future. I showed before that the insurance principle has been given up long ago. And why should Congress not have anybody pay the tax from all his income and still there could be a stipulation for a maximum old age income as there is a minimum income. It would be much more social justice and some more relief of the small income man would be justified and economically wise the same as the income tax relief voted on.

Medicare.—The cost of the contributions of the senior citizen went up every year—of course we know of the tremendous increase of medical expense. Mr. Ford, refusing a general health program talks under the title of "catastrophic sickness benefits," first of increasing some more the costs for the senior citizen, by charging him a percentage of all benefits and then promises to limit the expenses, to $500 or $250, respectively and only for hospital and nursing* homes. What about the catastrophic expenses for necessary nurses, ambulance expenses, etc.? Can people with a salary of $40,000 or more and high expense accounts ever try to understand the plight of people living on $250 or $300 a month if an average heating bill is about $50 a month or more?

ITEM 3. STATEMENT OF BEATRICE DOYLE, SENIOR CITIZEN OUTREACH AIDE

I am Mrs. Beatrice Doyle, presently Senior Citizen Outreach aide with the Warwick Community Action Program in the Westerly area of Rhode Island. I am here, however, as a concerned private citizen to point out the inequality of Federal supplemental security income payments upon which so many of our senior citizens depend.

*And doctor bills.

Currently a glaring inequity exists between Federal supplemental security income payments received by those (1) who are primary or secondary social security beneficiaries and the payments received by those (2) who have never earned sufficient social security credits as primary beneficiaries or are ineligible as secondary beneficiaries by reason of lack of marriage to a primary beneficiary, and who have no pensions, annuities, or other income.

Individual beneficiaries in category No. 2 receive under the Federal supplemental security income law $20 less than category No. 1, even though the need is the same. How does this come about? The aim of the Federal supplementary security income program is to provide supplemental payments when needed, so that anyone 65 or older, anyone blind or disabled can have a basic cash income of $157.70 for an individual or $236.60 for a couple.

People can have money coming in (Social security, veterans payments, pensions, etc.) and still receive supplemental security income payments. In arriving at the amount to be paid, the first $20 a month income will not affect the Federal payment. Any other income (apart from earnings), above the first $20 a month will reduce the Federal payment. There is a different formula for earnings.

Therefore, if you have no money coming in, in the form of social security (perhaps because you were not engaged in covered employment or were not married to a primary beneficiary) have no pension, annuity, etc., your monthly income will be $20 less. When you live at the lowest end of the economic scale, $20 looms as a sizable amount.

A correction of this situation should be handled on the national level as it affects many, many persons. In Rhode Island with a population of under 1 million, there are 7,000 senior citizens so discriminated against.

Feeling that national action could not be waited for, a bill will be introduced in the Rhode Island House of Representatives this week to remove this inequity.

ITEM 4. STATEMENT OF ELIZABETH DOLAN, WARWICK COMMUNITY ACTION, INC.

My name is Elizabeth Dolan. I live in Warwick, R.I.

I would like for a few minutes to explain to you some things about the Warwick community action program to explain what they have meant to me personally and plead not only for their continuance but also for their expansion.

My primary contact has been with the foster grandparent program. Under this program, I work 4 hours a day, 5 days a week with mentally handicapped children in a special education class.

In this class, we work on a one-to-one basis with the children helping them with their needs in reading, writing, spelling and arithmetic. It would do your heart good to see a child master a problem that has been bothering him for hours with some help from a foster grandparent.

My experience with the foster grandparent program started after four operations in which artificial bearings were put into my hip sockets. After the operations I went from a wheelchair, to a walker, to crutches, and then to a cane. Then a friend of mine recommended that I join the foster grandparent program.

Since I joined the program I have never been so happy as I have been—to be able to go to work each day to help these children. This is now the joy of my life because I am a widow 71 years old and live alone. My work is my whole day.

Another way that Warwick community action has been a blessing to me and hundreds like myself is their housing assistance program through which I had some repairs done to my house. These were financed by an interest-free loan—which I have since paid back in full. What a thrill to restore my house to a sound home again.

You can appreciate that it would be almost impossible for a 71-year-old widow to obtain a conventional loan.

For myself and the many others who benefit so greatly from these elderly programs, please try to contemplate the heartbreak any reductions or cessation would cause and please support these programs that are so necessary in our senior days.

[Enclosure]

Home Maintenance Program for Elderly

FACT SHEET

The purpose of the program is to provide the opportunity for elderly with limited resources and fixed incomes to have available a program to make home repairs affordable without asking for charity.

Emphasis will be placed on providing the elderly with the opportunity to remain living in their homes.

Eligible activities:

Structural repair.—Roof, walls, windows, gutters, downspouts, weatherstripping.
Plumbing system repairs.—Minor nature.
Electrical system repairs.—Minor repairs.
Entrance repairs.—Doors, steps, and porches.
Basic amenities.—Exterior painting and other improvements of psychological importance.

Eligibility:

Homeowners aged 60 and over.
Limited income and resources.
No relatives physically capable of doing work.
House structurally sound.
Resident of Warwick.
Can be improved with relatively minor repairs.
Homes with minimum housing citations have priority.

How to apply:

Contact: Warwick Community Action, Inc., Housing/Community Resources, 2117 West Shore Road, Warwick, Rhode Island 02886.

Coordinator: Fran Pinto, 737-3743.

A worker will make a home visit. Initial intake will include personal data, financial data, and a brief description of the nature of the repair problem.

In the first program year one of the most significant statistics is the amount paid back. The agency projected that $2,000 of the amount loaned out would be paid back. The actual amount was little less than twice the projected amount.

Elderly homeowners are proud and shrewd people. Out of very meager fixed incomes a majority of clients send payments on a monthly basis. At times perhaps only a $2 payment is received, however, the payment is faithfully made.

In talking with clients, we find that their attitude is such that they are so appreciative of the program and realizing it is based on a revolving fund basis, they want to help perpetuate the services. We find they are satisfied with the quality of work and are appreciative of a program that enables them to financially maintain their homes with dignity.

Each application is reviewed on an individual basis. Home visits are made to obtain financial data as well as personal circumstances and maintenance needs. A visit is made by the maintenance director and the needs are discussed. Loans are granted for the purchase of materials. Labor is provided free of charge to the client. When repairs are completed, a financial repayment plan is made to fit in with the client's budget without adding financial strain. Also evaluations are completed at this time to be sure the work was completed satisfactorily and to discuss any additional needs.

My referrals are obtained through the Minimum Housing Department. These are handled on a priority basis. No one is refused because they have no way to repay for materials. In cases of this nature either the agency absorbs the cost or donations of materials is sought.

SERVICES PROVIDED BY HOUSING ASSISTANCE/COMMUNITY RESOURCES

Home maintenance program for elderly in Warwick

The purpose of this program is to help homeowners aged 60 and over with limited income and resources to do necessary repairs to homes that are structurally sound but have minimum housing violations or needed repairs that would qualify as violations.

Housing assistance—relocation

Keep a listing of possible rental units. Take names of people who are looking for housing and also make referrals to any programs of subsidized housing that might be available.

Housing assistance—landlord/tenant relations

Have a working knowledge of landlord/tenant rules and regulations to provide counseling and referral where problems occur.

Housing assistance—legislation

Knowledge of any new housing legislation, Federal, State, and local: and advising community people of such when applicable.

Emergency housing

Provide emergency shelter to families left homeless as a result of natural disaster such as fire, storm, etc. Referrals taken from anyone in need in the State of Rhode Island. Supportive services and followup provided. Occupancy is on a 5-day renewable lease contract.

Consumer education

Provide workshops in any area of consumer concern. Workshops and mini classes are held in any subjects relative to the high cost of living and consumer problems.

Winterization and fuel crisis

Aid and counsel clients in energy conservation and with heating and utility problems.

Community resources

Provide technical assistance to groups and organizations in the city organizing around a community concern. These may be established groups, or informal community groups formed to meet specific needs or problems. Emphasis is placed on working with and through area board representatives to keep them informed about Warwick community action programs and receive input as to community concerns.

ITEM 5. LETTER FROM LILLIAN N. OLIVER, CRANSTON R.I.; TO WARWICK COMMUNITY ACTION, INC.; DATED JANUARY 14, 1976

GENTLEMEN: I am a close friend of Mrs. Inez Shoren, and as she is totally blind, she requested my assistance in writing this letter. Her address is 108 Brinton Avenue, Warwick.

Last summer two of your men completed the following work for her—

1. Painted outside of her home.
2. Installed stairwells on porch.
3. Repaired screens on porch.
4. Repaired brick on front part of home.
5. Nailed some shingles down on home.

All of this work was done within a short period of time and the men were very good workers. Mrs. Shoren was thoroughly pleased and considers the job quite satisfactory. I personally thought the paint job was very nice and a wonderful improvement.

Mrs. Shoren extends her thanks for the help she received in this work which was very well done.

Very truly yours,

(Miss) LILLIAN N. OLIVER.

P.S. She regrets she is unable to attend the meeting.

ITEM 6. LETTER FROM S. EVERETT WILKINS, ATTORNEY, PROVIDENCE, R.I.; TO SENATOR FRANK CHURCH, DATED JANUARY 28, 1976

DEAR SIR: I attended your public hearing in Providence on January 26, 1976, and extend my compliments on a well managed affair. I am writing to express my concern over a subject which I did not present at the hearing because of time limitations.

I believe that unless escalating hospital costs are brought under stringent controls, any National Health Insurance program will bankrupt the country. Since medicare became effective, hospital costs have increased by about 300 percent, most of which can not be blamed on the national rate of inflation, which is much less than that. In Rhode Island the Blue Cross premium for Plan 65 (which reimburses for medicare deductibles) was $4.45 per month in 1966 and is now $12.03 per month. Furthermore the 1966 rate carried a factor designed to build a 2-month reserve, which by litigation

has been reduced to a half month. Of our elderly population of 105,000, almost 77,000 pay for this coverage.

What has happened is that the availability of open-ended medicare funds, disbursed with no effective controls, has caused hospital managements to became careless and irresponsible in the area of fiscal prudence. A prominent Providence doctor commenting on recent increases in Rhode Island hospital rates, said to me, "What can you expect? They have far more employees than they need. They are stumbling all over themselves over there, and 50 percent of them don't put in an honest day's work."

A lady of my acquaintance, a thrifty "Yankee Gal", related to me the following. While a patient in a hospital she remonstrated with a nurse who had thrown away an apparently usable piece of linen and received the following reply, "Say, if you knew the waste that goes on around here—why should I be careful?"

Incidents such as these do not in and of themselves make a hard case against hospitals, but they do give rise to well warranted suspicions; and the most appalling fact is that there is no end in sight.

Congress did not intend that medicare funds should be carelessly guarded. When medicare was enacted, Blue Cross Association sold the Government a phoney bill of goods to the effect that Blue Cross organizations could be trusted as fiscal mediators to monitor hospital operations. This was not true because they are too closely allied with hospitals and doctors, and also because no person examining a hospital to police its costs should live in the community where the hospital is located. The approbrium certain to result from a job well done will deter him from effective performance.

If you feel that this subject merits your attention, I suggest that it should be frankly acknowledged that Blue Cross cannot control hospital costs and that another means must be devised. As to the other means, I suggest that the existing system of examining national banks could well be emulated. What keeps a banker on his toes is the knowledge that any day he may find one of Uncle Sam's bloodhounds sniffing around his bank for something on which to chew. Hospitals need the same type of treatment.

Very truly yours,

S. EVERETT WILKINS.

ITEM 7. LETTER AND ENCLOSURE FROM CHARLES GERARD, PROVIDENCE, R.I.; TO SENATOR FRANK CHURCH, DATED JANUARY 28, 1976

DEAR SENATOR CHURCH: I should like to say at the beginning that I very much enjoyed the hearing held by your U.S. Senate Special Committee on Aging, at the Providence Public Library Auditorium, on January 26, 1976.

I wanted to insert at that time what I have said in my letter below, written to the *Providence Journal*. However, I considered it inappropriate to use the time needed for discussion, so I refrained. However, I did not intend to forgo expressing myself.

The letter was written on January 17th, but printing was delayed until I signed the form allowing the *Journal* to edit for space, libelous content, if any, etc. It finally appeared in the *Providence Journal* for today, January 28th. Meanwhile, I derived much pleasure from the *Providence Sunday Journal* of January 25th, where the subject was editorialized. I enclose a copy of the editorial, of which I have only one copy. This I am sending to you but am unable to supply a copy for Senators Kennedy and Pell.

[From the *Providence Journal*, Jan. 28, 1976.]

LETTERS TO THE EDITOR—SOCIAL SECURITY TRUST FUND

The Jan. 17, 1976 *Journal-Bulletin* stated that President Ford was planning on asking for 1977, a Social Security tax rate of 6.15 percent, to be applied to a base of $16,500; up from 5.85 percent on $15,300 for 1976.

Why don't Congress and President Ford face the inevitable, I.E. application of the rate—any rate—to entire earnings? This should be applied universally.

They should then extrapolate and compare with actual returns for 1977. They just might find that the percentage for everyone might be reduced from Jan. 1, 1978 on.

I read recently that 100,000 persons in the U.S. receive earnings of $100,000. Now $16,500 times 6.15 percent times 100,000 persons comes to $101,475,000. Also, $100,000 times 6.15 percent times 100,000 persons equals $615,000,000—a difference of $513,525,000 which would be added to the Social Security Trust Fund. Think what could happen with per- [sic]

Oh, the "hue and cry." But why not?

Most people earn below the taxable base. Why should they pay Social Security tax on their entire wages while others pocket the taxes they should pay on everything above $16,500?

I am not unmindful of the employers' matching contribution. I hear many say: Why worry about federal deficits? The country is too rich to go broke. Perhaps everyone should be reminded that after World War I, one could buy one trillion German marks for a $1 bill.

CHARLES GERARD.

Providence.

The unfinished remark in the fourth paragraph was—probably inadvertently cut off by the linotypist—that the social security fund could benefit far more from the persons earning from $16,500 to $100,000 and from $100,000 to wherever it takes us. Imagine if you will, what the president of General Motors would pay at 6.15 percent, on $750,000, the amount he was once paid during one year, as a salary and bonus. At $16,500 he would pay $1,014.75 as social security tax; taxed on $750,000 he would pay $46,125. social security tax. How about the tax on President Ford's $200,000. A mere $12,300 to add to the social security fund. Everyone is aware that labor cost is the most expensive part of any business. Just imagine the contribution to the social security fund, if the most expensive part (labor) of the trillion dollar G.N.P. were taxed at 6.15 percent.

I still contend that it wouldn't take too long to drop down the social security tax percentage for everyone, if everyone's salary or wages were taxed for their entire amounts. Start with 1976 or 1977, at 6.15 percent of everything, not $16,500. There should never again be established a base for social security tax purposes, a base such as $16,500, or anything else. When anyone and everyone pays his fair share the percentage should drop. A man earning $100,000 would pay $6,150.00 at 6.15 percent; but after the fund is built up and taxes are reported, the social security tax percentage could conceivably drop to 3 percent, taxing him $3,000; or perhaps 4 percent, taxing him $4,000. Now, to what other country can a man go to, to earn $100,000 and take home as much as he does or even will, at the rates we apply for income tax and social security tax? Reasonable question, right.

I should like some "knucklehead" to explain to me the logic of a base of $16,500 for social security taxes, but no such thing for income tax. If this is logical, then it is logical that a man and wife be allowed to combine their income for social security tax purposes, so that they will pay social security tax on only $16,500. The $25,000 man earning the $25,000 by himself is allowed this privilege of stopping at $16,500. The argument makes sense.

A person with a gross of $100,000 could end up with a net of at least 17 times the social security payments made to a single person drawing the maximum, that is $350.00 X 12 months, or $4200.00. Why should the $100,000 man be allowed to raise his standard of living to the point of using his entire net. He certainly should be able to put away more than the person, who, for any number of reasons never reaches beyond the minimum of $2.40 an hour. He is getting his while he is working and will get the maximum social security when he retires. Not most, but at least a very great number of people don't earn enough now to qualify for maximum social security payments, which are based on payments made against established taxable bases. I remember so well the brouhaha that resulted when the late John E. Fogarty introduced, or threatened to introduce, a bill for a base of $15,600. Now we're up to $16,500. How do you like that?

It doesn't matter to him that today we have many aged persons starving, not quantitatively, but qualitatively and nutritionally.

NO ENERGY TO RESIST

President Ford, if he holds to his present logic, won't have to have ships, nuclear weapons, bombers, etc. to hold the Russians at bay. Pretty soon they will easily be able to take over, because the over 200 million of us will be chronically ill of some very debilitating disease. We will not have the energy to resist pygmies let alone Russians. Make a total of all disease totals and you will exceed 200 million, by virtue of the fact that many, not a few, have several chronic diseases. Between the FDA, AMA, HEW, etc., we've hit the jackpots on moronic regulations. Ask Senator Proxmire, he knows the battles he has had with the FDA, relative to asinine regulations for a simple thing like vitamins. We should thank God for fighters like him.

My personal feeling is that unemployment compensation percentages should be applied to a person's total earnings. Rhode Island and Massachusetts have each borrowed over $100 million to date, for the payment of unemployment compensation. It is supposed to be repaid to the Federal Government within 3 years. Now, how do you

suppose they are going to accomplish that miracle. They have borrowed while collecting normal taxes. How much does the economy have to improve for them to get taxes that will allow them to pay off this indebtedness and build up a good black figure. Well, I don't think either one is going to make it within the next 3 years, nor the next 5 years, nor the next 10 years. These borrowings will be forgiven. Want to bet?

What is illogical about making business pay on all earnings, instead of $4,200? Rhode Island has a piggyback income tax, based on one's Federal income tax, which in turn is based on one's entire income. So social security establishes a base and Rhode Island unemployment establishes a base. Crazy, huh.

Rhode Island put in a merit rating system for unemployment compensation, several years ago. To stop firms from moving to other States. If we didn't put it in would they go to Illinois and Michigan where percentages go up to 4.5 percent or a couple of others that go higher? No of course not. Those firms stayed, some at 1.2 percent, stabilized their work forces and robbed the fund of badly needed money. Those that have fluctuating manpower needs are not large enough or numerous enough to keep up the fund. Result, the fund is always in the red. Why not return all of them to 1 percentage and see whether they move out of State. They may move out of State and suddenly see the percentage rise in that State.

For unemployment compensation there is only one answer and that is the same as social security. One percentage for all, and applicable to one's entire earnings.

CHARLES GERARD.

ITEM 8. LETTER FROM ROBERT WALSH, PUBLIC AFFAIRS OFFICER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; TO GARY GOOD, SOCIAL SECURITY EMPLOYEE ON DETAIL WITH SENATE COMMITTEE ON AGING, DATED JANUARY 21, 1976

DEAR MR. GOOD: The supplementary security income [SSI] rolls in Rhode Island have increased from 9,438 in December of 1973, just before the State relinquished administration of the program of aid to the aged, blind, and disabled to the Social Security Administration, to 16,141 in November of 1975. This increase of almost 60 percent represents the highest percentage increase of SSI beneficiaries during that period of any of the six New England States.

All District Offices of Social Security across the country, including those in Rhode Island, used leads from the social security master beneficiary records [MBR] in a program of outreach to elicit SSI applications. In Rhode Island, 16,000 people were contacted by mail in this endeavor. Of the 5,500 who replied only 10 percent were found to be eligible.

The names of the remaining 10,500 people culled from the MBR leads were provided to the Rhode Island State Division of Aging whose employees have been attempting to reach these potential eligibles through door-to-door contact since July of 1975. This outreach endeavor is being conducted in conjunction with the State Agency's attempt to reach aged people who can benefit from the State's programs of hot meals, transportation to hospitals and doctors, home health care, etc.

Since the inception of this latest outreach program the State Division of Aging has provided social security with the names of 955 possibles, only 77 of whom have been determined to be potentially eligible for SSI. SSA does not expect to get more than 5 percent of eligibles from the 10,500.

The Providence District Office estimates that only some 500 eligible SSI recipients, at the most, have not been reached.

As to media outreach efforts, all 10 radio stations in the State are still airing SSI spot announcements several times a day and have been since the inception of the SSI program in January of 1974.

All three television stations [the two in Providence plus the station in New Bedford, Mass., whose signal also covers northern Rhode Island] have been using the SSI spots two or three times a week. Some nine live broadcasts on SSI were aired on the Providence ETV station during the first quarter of 1974.

Releases have been appearing in daily and weekly newspapers at the rate of about two a week until lately when the dailies have cut back.

Field representatives and other officers of District Offices have been averaging about 35 to 40 speeches on SSI a quarter.

During the first SSI outreach program in 1974, District Offices conducted extensive training for the Red Cross volunteers who were the principal contact persons in that effort. Most recently, Rhode Island District Offices have conducted SSI training for employees of the State Division of Aging who have been working on the MBR leads.

Incidentally, over the past 6 months 70 to 80 percent of the SSI applications taken across the country have been for persons in the disabled and blind categories rather than in the aged category. In Rhode Island more than 80 percent of the SSI applications have been in the nonaged category.

Hope this report fulfills your needs and that the committee hearing in Rhode Island on Monday, January 26, 1976 is a successful one.

Sincerely,

ROBERT WALSH.

ITEM 9. LETTER FROM VINCENT VESCERA,* PROVIDENCE, R.I.; TO SENATOR FRANK CHURCH, DATED JANUARY 26, 1976

DEAR SENATOR CHURCH: Today I had the pleasure of seeing you in person for the first time. I was very much impressed by you. I am a little bashful when I speak in public as you may remember that I spoke at the hearing on only one subject. I said that we needed the W.P.A. back again. You told me to use the microphone and speak into it. I had never used one before. But what I had to say I said. I wish that you would run for President as you have been in the forefront for the betterment of social security which applies to all senior citizens. We need someone like you in the White House.

I would like to elaborate a little more on the fact that we need W.P.A. We do not need it to build roads, sewers, or sidewalks, or to cut down on the free time of so many idle people. We need it to build houses for the lower class of people. There is a great deficiency in finding housing for the poor people. The government should bear the cost of the labor of building these houses and let the poor families pay for the material that is used. What is needed is a three bedroom house, with a kitchen and a pantry on a lot 50 by 60. This would provide the elderly with some responsibility.

The government could put millions to work at prevailing wages. The family man could be put to work for 30 hours a week while the younger people from 16 to 20 years old could work 20 hours a week if they are single. Clerical jobs like bookkeeping should be done by girls who qualify for that type of work, not the kinds of jobs that they are doing today. We will never get rid of the depression the way that we are doing it today. They call it another name today—recession.

You know and I know that there are more people out of work today than during the depression of 1930 to 1941. It is not 8 percent but I believe that it is more like 18 percent if you count all the girls and boys who need work when they get out of school.

That is all I have to say.

Sincerely yours,

VINCENT VESCERA.

ITEM 10. LETTER FROM SUSIE TOMASSO;** TO SENATOR CLAIBORNE PELL, DATED JANUARY 20, 1976

DEAR SENATOR PELL: Six years ago, my husband passed away. Since he was an invalid, I devoted the last 20 years of my life to his almost constant care. When he passed away, I spent one of the most frustrating, depressing years of my life. My life no longer had a purpose, and I dreaded my very existence.

Then a miracle happened. One day a friend, Clarice Gottberg, suggested that I get out more and become involved with a Senior Citizens Group—RSVP. At first, I wasn't very excited about the prospect, but as I became involved, suddenly a whole new world opened for me. When I first joined, there were only a handful of us, but in the last 5 years our chapter has grown to over 300.

Through my association with RSVP, I became involved in many other volunteer groups—Save the Bay, eye testing of youngsters in schools, and volunteer work at the IMH—to name just a few. A singing group, The Gingham Girls, was formed, and we go out several times a week bringing happiness and meaning into the lives of people confined to nursing homes and mental health facilities.

RSVP and similar organizations mentioned above are mostly funded by local and Federal Government, and at this time we are desperately in need of funds. These, and similar Senior Citizens Organizations, have rescued a great many of us by giving our lives a useful and needed purpose and meaning. We have become dependent on them, more than they have become dependent on us. I, for one, wouldn't know what to do without them. I hope that you will do everything in your power to insure continued funding for such programs, in order for us Senior Citizens who have given so much to this great country, can continue to do so.

Thank you.

Yours truly,

SUSIE TOMASSO.

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*See statement, p. 2089.

**See statement, p. 2114.

Appendix 2

RELATED MATERIAL SUBMITTED FOR THE RECORD

ITEM 1. EDITORIAL FROM THE *PROVIDENCE SUNDAY JOURNAL*, JAN. 25, 1976; SUBMITTED BY SENATOR JOHN PASTORE, FROM RHODE ISLAND

Social Security Needs Total Review

President Ford is quite correct in recognizing that the Social Security trust fund "is headed for trouble." But his proposed increase in the Social Security tax is a mere stopgap remedy that would be inadequate and unfair to millions of workers. Instead, Congress needs to undertake a broad review of the entire system and develop a new revenue base that will produce equitable benefits while remaining fiscally sound.

Last year, for only the third year in its history, the Social Security system operated in the red: it rang up a $3-billion deficit by year's end. Unless the system's finances can be brought into balance, the deficit is expected to reach $20-billion a year by 1990. Ultimately, this trend would endanger the system's ability to pay benefits.

The system is sound enough for now: present beneficiaries have no cause for alarm. Even though benefit payments now are exceeding revenue, the system still has a cushion of more than $40-billion, which is ample to insure benefits for at least the next several years. The real concern is over the system's long-range health, and it is on this point that Congress needs to concentrate.

What has happened to weaken the long-term integrity of this program that Mr. Ford called "a vital part of our economic system"?

One cause has been the changing ratio between the numbers of workers, whose payroll taxes support the system, and retirees, who receive the benefits. In 1950, there were 12 contributing workers for every recipient. Now, as the over-65 segment of the population has grown, that ratio has fallen to 2.5 to 1. There are fewer working taxpayers paying for benefits to more retirees, and this trend will be magnified as the population growth rate falls off.

Another part of the problem, dramatically visible because of the recession, is that unemployment reduces Social Security revenues. People out of work contribute no payroll taxes. At the same time, however, inflation has worked to increase benefits: under a cost-of-living escalator clause enacted in 1972, benefit levels rise in relation to the Consumer Price Index. Yet inflation has sped ahead of 1972 estimates: benefits are now rising faster than income, and in time some recipients may receive more in Social Security than they did while working.

Somehow, income and outgo have to brought into line. President Ford's remedy of increasing the Social Security tax is unsatisfactory, principally because it hits hardest at low-income workers. Unlike the graduated income tax, the Social Security tax rate is the same for workers at all income levels. Indeed, an estimated 15 million workers with incomes too low to be subject to the income tax still must pay Social Security taxes. For these workers, especially, the present 5.85 percent rate is already too high.

INCREASE WAGE BASE

A preferable approach would be for Congress to increase the wage base subject to the Social Security tax. This base is $15,300 this year and under a formula already in the law will expand to $16,500 next year. But a further broadening, say to $24,000, would raise more revenue while spreading out the burden among workers better able to pay.

Other proposed changes also would raise revenue as well as bring about greater fairness. Low-income workers could receive exemptions from Social Security taxes for part or all of their income, as is now done with the income tax. Social Security taxes could be extended to apply to all income, including that from interest and capital gains, instead of merely that from wages and salaries. There clearly is need, too, for revising the benefit formula to keep future payments from soaring out of control.

A Social Security tax increase, such as President Ford has proposed, would ease the short-term deficit at the cost of postponing the major structural overhaul that the system needs. Social Security cannot be evaluated in a vacuum: it must be analyzed in connection with other income transfer programs, existing and proposed, such as national health insurance and a negative income tax to supplant welfare programs.

It may be too much to expect Congress, in an election year, to grapple successfully with such a complex issue. Perhaps new budget data will show that the President's proposed tax increase is unavoidable. But Congress must avoid the temptation to let

the long-term problem slide: another few years without major reform of Social Security and its fiscal solidity will be dangerously weakened.

ITEM 2. ARTICLE FROM THE *PROVIDENCE JOURNAL*, JAN. 26, 1976; SUBMITTED BY SENATOR CLAIBORNE PELL, FROM RHODE ISLAND

SIDONIE BROWN'S FULL LIFE IS TANGLED WITH THE THREADS OF HISTORY

[By Carol Stocker]

PROVIDENCE,—Sidonie (pronounced see-doe-ny) Brown is 92 years old, and yet it's true when she says, "People don't think of me as just an old lady."

Her vitality is amazing. She gets around town on the bus and watches television religious services in Hebrew, one of the eight languages she speaks. Her thick silky hair, once titian red, is now piled in white and butteryellow swirls. Her eyes are clear, her teeth her own and her mind is definitely her own. Her character is sturdy as a well-seasoned cast iron pot, the kind they don't make anymore.

One of the city's brighter secrets, she is tucked behind the anonymous facade of public housing units at Manton Heights. But inside the private world of her apartment, color explodes from mounds of braided rugs, crochet and petit point projects in electric blue, acid green and pinks hot enough to be combustible.

Although she once had servants and purchased her gowns at exclusive Fifth Avenue shops, Mrs. Brown now lives on Social Security which doesn't allow for non-necessities like knitting yarn. But that doesn't seem to bother her. Her basic needs are slight and she has either transcended the rest of life's baggage or lets it take care of itself.

The yarn and fabric, for instance, does take care of itself. It is contributed by local manufacturers, the State division on aging or people who want her to make things for them, for which she never requests payment. No visitor can leave her house with empty hands.

"I go down to the shopping center and give pot holders to the elderly people who shop there. Whatever my hand grabs, I give 'em," she says, proffering a fist full of pot holders. "I give 'em, I give 'em, I give 'em. It gives me pleasure."

Mothers from the project send their children over to Mrs. Brown's when skirts and pants need free-of-charge hemming. Neighbors lacking the necessary patience even ask her to sprout their avocado seeds for them. She may comment to herself about the fecklessness of the modern personality, but she complies.

"She's always a giving person," said William Speck of the Division on Aging. Director Eleanor Slater and Mrs. Brown have a first-name relationship. "You know Eleanor—I gave her one of these afghans."

Flowers and a new television set are from friends who want to return the good will, but it's doubtful that any reciprocate the regular hours each day that Mrs. Brown spends praying for "all the world." Hers is a very busy life then, lived in the present.

Longevity runs in the family. Her mother lived to be 99 and her grandfathers lived to be 103 and 107. But Mrs. Brown is more than a survivor. She had also lived richly enough that, like a character in a novel, her life story is tangled with the threads of history.

Her ancestors were prosperous landowners in Mrs. Brown's native Belgium, and one grandfather, Alphonse Delano, invented the graphite and sulfur match about 1840. But Mrs. Brown's father "liked to travel, so he flipped a coin for either Australia or America, and it fell to America." The family ended up in Johnston, where the father, Frank Bruyneel founded and ran a shop under his name which produced fine handmade cigars and employed about 25 persons.

But Sidonie didn't care for her new country at first. She found it puritanical. "They wore their skirts all the way to the floor and people called me a loose woman because my ankles showed." So, after a few months she returned to Belgium, where she entered the Order of the Holy Trinity.

It was at the convent that she was tutored in needlework and languages, but the order refused to assign her to its work with leper colonies "because I was too young and had a long time to live." Unenthusiastic about being cloistered instead, she left before taking her final vows.

PEOPLE DON'T THINK OF ME AS JUST AND OLD LADY

Her only marriage, to an American, ended after 4 years when he was killed in World War I. The young widow worked at Shepard's for awhile during the war. It was an era of immigration when downtown Providence was a babble of tongues and her facility with French, German, Italian—her family owned a villa in Italy—Spanish

and Flemmish, in addition to Latin, Hebrew and English, made her a valuable employee. The same linguistic ability led to an important position in sales with Western Electric in New York City.

She was sent to Cuba when the oceanic telephone cables were being laid there, and the second dial phone call between Cuba and the United States was to her astonished family in Johnston, via a Providence operator. "They said, 'You're crazy! Where are you really calling from, Sidonie?'"

One of her mother's relatives was Belgium's consul general in Havana and got her work at both the Belgian and American consulates, all while she continued on salary for Western Electric. She was the model of the successful, feisty "working girl," in the new post-war 1920s world of the roaring Havana, and was a good place to be.

That vanished world suited her patrician orientation. "I liked it because there was no middle class, only the very rich and the very poor. And since I worked at the consulate, I was with the rich." There were nights at the casinos, dances and a trail of despairing Don Juans. There were also trips to a leper colony far from Havana, where she fulfilled a long-time ambition to serve.

It came to an end when she became ill. Her doctor didn't tell her that she had cancer, which was a word to be whispered if used at all then. "He just said I was going to be 'a very sick little girl' and that I should go home and be with my own people." The Cuban physician, also of the very rich, incidentally, was Fidel Castro's paternal grandfather.

It took more than 40 operations, large and small, before Mrs. Brown licked cancer, and went on to outlive all her doctors.

That triumph wasn't the end of the story. She went on to work, first as a volunteer, then paid, at the State Institute for Mental Health and the old State Infirmary, where she taught such crafts as chair caning and mattress making, sharing her belief that useful work sustains and enriches life. She also traveled abroad extensively. But her biggest duty was caring for her elderly parents in the big family house in Johnston.

ILLNESSES WIPE OUT FAMILY'S FINANCES

The protracted illnesses usual to old age wiped out the family's finances, and now that there is nothing left, Mrs. Brown speaks with unbitter enthusiasm about Medicaid.

But the eventual loss of her parents was a great shock. And in the following numb confusion, most of Mrs. Brown's personal letters and mementoes from her long life were callously thrown out by the woman who took over her home when she was moved into the Manton Heights apartment.

Mrs. Brown still seethes with incredulity about the treasures lost, including correspondences with her distant cousin, Sara Delano Roosevelt, which might have had historic value. The former President's mother's letters to Mrs. Brown, who is also a Delano, were fueled by curiosity about her adventurous father's origins in Belgium, and Mrs. Brown still honors the confidentiality of those family tales.

The two women corresponded largely in French, the mark of the socially educated, and "she invited me to Hyde Park, but I never got there." Franklin was a New York State official and married, during the period of the correspondence which continued until after he was stricken with polio.

"She was a strong woman. She wrote me, 'I am the head of this family and I will always be the head of it.' But no mother ever idolized her child the way she idolized Franklin. She didn't write much about Eleanor. She wrote mostly about Franklin."

Mrs. Brown added that she didn't think much of the recent dramatization of Franklin and Eleanor's life on TV. "There wasn't much to it. It took a little bit here and a little bit over there. It jumped around too much."

Of the treasures of a full life, there remain these things: An acorn plucked and saved at her birth on Sept. 3, 1883. Two ancient wooden matches in a plastic vial, handled reverently like splinters of the cross, the only relics left from a long board of matches which was given away piece by piece, from the old family match factory.

There were also old fine cigars, made by her father's hands, but she's given away even the last of them. "Not to be smoked! To be smelled!" There is a formal dress in her favorite color, blue, left from the many bought and given away in her younger days. This one, however, has been saved for a final function.

There also remains life. The years ahead will be measured in yards of yarn, and maybe other gifts.

Appendix 3

INFORMATION ON WARWICK, R.I., "GERIATRIC DAY-CARE" CENTER*

"GERIATRIC DAY-CARE" is the name of the inovative program for mature adults at the Warwick Central Baptist Church on 3270 Post Road. The goal of the program is to provide daytime physical and emotional care for the partially disabled elderly.

Designed to help keep families together when this would not be possible without daytime care, it fills the gap between self sufficiency and being institutionalized.

Mrs. Elaine Aldrich is director, and working with her full time is Mr. Craig Szwed, who has his Bachelor of Science in Human Development. There are, as well, volunteers from URI who work 24 hours per week as a part of their university curriculum. Pictured at right is one such volunteer, Miss Kathy Gibson, demonstrating an oxygen breathing device available at the center. There are some 40 volunteers who are on call as special needs arise.

The center accepts people on a weekly basis (Monday through Friday), or on specific days each week, or on an occasional basis as the need arises. The cost of this service is but a fraction of full time care in a nursing home, and this can be further reduced by financial assistance from the State Division on ageing.

The center accepts clients begining at 7:30 a.m. each weekday and cares for them up until 5:30 p.m. A low salt lunch is served them, and snacks are available throughout the day. Beds are provided, and baths are given two days each week.

Pictured left is Mrs. Eva McGlauflin, who is able to find enjoyment at the center despite the fact she is 90% blind, confined to a wheelchair, and crippled in one arm. Limited therapy is provided, and the center is concerned with rehabilitation of the total person...which includes mental, physical, social, and emotional needs.

Pictured at right is Craig Szwed, (far right) receiving advice from Kathy Gibson as he plays cribbage with a client who has more experience at the game. The center shows weekly films from the Warwick Film Library, arts and crafts instruction is a regular part of the program, and field trips take clients to various places in the state.

The center just began operations with an initial grant from "Warwick Community Action," and new clients will be accepted. For additional information call 739-2828.

*See comments by Senator Pell, p. 2097

Appendix 4

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CHURCH: If there had been time for everyone to speak at the hearing in Providence, R.I., on January 26, 1976, re: "Future Directions in Social Security: Impact of High Cost of Living," I would have said:

The following replies were received:

DAWN ANN ADOIAN, PROVIDENCE, R.I.

I only work part time and my income is small. I will not be 62 years old until July of this year. I got stuck twice with apartments which did not include heat and they were so filthy I don't see how the inspectors let it pass. I had to move. In this place, the young people do not want the older people living in the same house. Many are using the hall and celler lights for their own use.

I do not have TV or other extras and my bill still goes up. I came home from work one day and found the outside back door wide open and latched to the wall. My gas bill for these 2 months were very high and I said I would not pay it. That door had evidently been left open everyday that I was at work. I complained to the owner and he called it petty. I have to pay the bills, not him. I called the electric company about the lights left on and he said that they [the owner] wanted a light on day and night. There was a big fight over this and names were called and I was then asked to move, which I wanted to do anyway. I complained to the gas company about the smell from the clothes dryer and the furnace. It was all too much for the chimney which needed cleaning. Nothing was done. This man upstairs is evil and he caused a lot of trouble for an older woman who lived here and finally caused her to be put out. You should hear the racket.

I came to the hearing while I was very sick with a high temperature just to be present. I ended up having to stay home from work since I was very sick with a bad cough.

I pray that I'll find a place by next week so that I can move. I leave people like this in the hands of God. You'd think they were coming through the ceiling. I had been in a State sanitarium for 4 years and 9 months. I could not walk and I was treated like an animal.

Please have the inspectors go and see some of these places and the kind of people that live in them and who try to run your life the way they want to.

THEODORE BELISLE, SLATERSVILLE, R.I.

I am an elderly 71 years old. The increasing cost of living is hurting to the point that in order to maintain our regular daily routine, I have to go out and get part time work. I do not want charity but the money that was taken from my pay years ago should insure my living without any worry. But that check that I receive every month is shrinking in buying power.

In 1937 when money was taken from my pay for my old age, I felt at that time that when I got old I would have some security. With the inflation, although we did get some increases, I find it harder to make ends meet. I do appreciate the fact that we have medical programs, but medication today is more costly than ever, even with all the help of medicare.

We, my wife and I, have to pay Blue Cross about $240 a year and medicare costs us about $135 a year. This total amount of about $375 equals about $7 per week which we could certainly use for a few extras once in a while.

Although I am complaining bitterly, my wife and I feel very fortunate to have good health. What will happen when our health fails? God knows.

Fortunately my wife and I do some RSVP volunteer work. It fulfills our need to be useful and needed. Also it provides the opportunity to meet other people and be of service to them. Thank God for RSVP.

ALYCE M. CROWDER, PROVIDENCE, R.I.

Let us remain in our homes. Find those that are taking our homes away from us because we cannot pay our bills with our welfare checks.

Get the young people back to work. They can and will help us.

I will pray for Senator Pell's bill. God bless all of you.

The attorney general's office took care of my bill but I still must pay my electric bill and I will receive it every month. I still owe $42 on the previous bill. We have too many junk shops that do not pay any electricity.

Also, the withholding tax from our pay does not help us senior citizens.

BARBARA DENNETT, PORTSMOUTH, R.I.

So many of us who "live" on social security find it increasingly difficult to keep up with the high costs of food and taxes. We cannot buy food items that we need for good nutrition or clothing necessities. We must cut corners to pay the town taxes.

We worked so hard for so many years to own our small retirement home and it will break our hearts to have to sell it and leave the community we love so much. Please allow us to have these golden years without worry and care.

ADA FLETCHER, PAWTUCKET, R.I.

Why is something not done about the enormous rent increases. Never is anything said at any meeting which refers to rent controls. For instance, I am a senior citizen over 80 years of age and live in an apartment consisting of 1-3/4 rooms and a small pantry. All the furniture and the refrigerator belong to me. The refrigerator has to be placed in the parlor because there is no room in the pantry. In a matter of 6 months the rent was raised 56 percent. It was $80 only 6 months ago when a real estate man bought this apartment house. Now my rent has been increased to $125 per month which is more than I can afford as I only get social security. I have no other income. The high cost of food these days takes most of my pension. I pay my own gas, electric and telephone bill. I must have the telephone. Washing has to go out. I must also pay for insurance. I am not alone in this situation so it would be helping a lot for the aged if the gougers of rent was stopped.

ALINE GIGUERE

I am 68 years old and living on a limited income of $209 a month.

The stamp office keeps calling me in for a re-evaluation and they raise my stamps $2 more each time. I am now paying $40 and I was paying $36 and my income stays the same.

One time I had to go down and they raised me from $36 to $38 and did not give me more stamps. They took away the cost of living bonus we were given because I had to pay $38 without more stamps.

We were given a raise in social security, they gave me raise in social security but they took it off my SSI check, so my income remains the same and they still keep charging me more for the stamps.

I am finding it very hard to live.

HOPE HUGHES, PROVIDENCE, R.I.

I find the price of oil to heat my home is outrageous. I live alone and pay over 40 cents per gallon. Electricity and food prices are all so high and are getting out of hand.

The above complaints are also from many of my senior citizen friends.

MRS. ORVIN LARLOX, WESTERLY, R.I.

None from Westerly feel that they can attend the meeting in Providence on the 26th because of the cost of getting there.

We would have liked to say that we could have used the money for transportation. We have no minibuses in Westerly although we have asked many times about them. We have always been told that there is no money for Westerly. We have none of the nutrition programs nearer than Peacedale which is at least 25 miles from here. You either have to pay for bus transportation or if anyone is able to drive his own car then that means money for gas.

Also reaching senior citizens who do not belong to an active group could or should

be reached and the money used to help them. With us being at the other end of the State, it would be nice if someone would come down and talk to us. We have two groups here.

ADELARD A. MENARD, WARWICK, R.I.

With the rising cost of living and the constant increase of property taxes, some relief be given to the senior citizens in this property tax area, to enable them to retain their homes and not be forced to fall on low-income housing and in many cases welfare. This they do not want, they wish to retain the home that they have raised their families and to spend their remaining years in peace and dignity.

In the transportation area we in Rhode Island are fortunate to ride free on all buslines in the State. I am speaking now of the senior citizens who live off and away from the regular buslines and must depend on the minibus transportation to take them to their doctors, shopping, etc., but the minibus is underfinanced to a point where they must stop operations to maintain their buses as they are doing right now. More buses are needed so that they may be taken out of line regularly to make the repairs needed without shutting down the service.

WILLIAM A. PELLETIER, MAPLEVILLE, R.I.

The White House Conference on Aging held in Washington, D.C., attended by 3,500 delegates from every State in the United States, I being one of the Rhode Island delegates in 1971, took up the very question of where do we go in regard to social security?

The consensus of those attending were that the social security trust fund would some day be in trouble as it now seems to be.

It was voted unanimously at this conference that part of the social security benefits be paid out of general revenues instead of continuing increases in social security taxes and I have reasons to believe that these facts were to be reported to Congress.

We as a great Nation can afford to spend billions of dollars in foreign aid out of general revenues, for which I have no argument, but it seems to me that this great Nation which we all support can well pick up part of social security benefits out of general revenues.

TINA ROWE, WARWICK, R.I.

When you raise social security benefits for the elderly, you should raise the standards of the other programs, because I work with the elderly and have been doing so for the past 3 years. But because of the recent raises a lot of these people have been taken off the food stamps and medical assistance. In the end they suffer more because they have to buy their own medication which sometimes costs more than the raise they got. Some of these poor people at the end of the month have to go and beg for food. In addition, the months that have 5 weeks are unreal to them. I thank you for looking into and taking an interest in the elderly.

CHARLES B. RYAN, WOONSOCKET, R.I.

While social security strives to provide an adequate income for people in retirement, the retired senior volunteer program (RSVP) strives to make that retirement more meaningful by encouraging participation in unpaid volunteer community service. For those 1,400 retirees in Rhode Island who volunteer through RSVP, volunteer service gives purpose to their lives not possible through any other service to the aging. RSVP promotes physical, mental, and emotional well being. Further, RSVP restores to the community resources lost through retirement: The experience, the skill, and the energy of our retired citizens.

RSVP volunteers receive no stipend or other hourly payment for their volunteer work. RSVP programs provide their volunteers with accident insurance, reimbursement for out of pocket expenses, transportation, and coordination.

Through RSVP, retired citizens help other retired citizens: Delivering meals-on-wheels, waiting on tables at mealsites, assisting at special clinics, visiting with the homebound, and performing community outreach. People other than retirees also benefit from the help RSVP volunteers: School children are tutored, hospital patients are served, the retarded are encouraged. The retired senior volunteer program in Rhode Island works in cooperation with over 200 local community agencies. Last year in Rhode Island RSVP volunteers performed 180,000 hours of service, benefiting over 45,000 people.

We urge your committee to recommend renewal of RSVP enabling legislation which

is to be considered in June. We urge you to encourage a higher more adequate funding level for the program so that it may be made available to more retired citizens. We also urge that local match requirements for Federal funds for RSVP be reduced from the present 50 percent to 25 percent.

There are six retired senior volunteer programs in Rhode Island. They are listed below along with the names of their sponsors and the communities they serve.

RSVP	Sponsored by	Communities served
Blackstone Valley RSVP, 490 Broadway, Pawtucket, R.I., Maria Bankosky, director, telephone No. 732-5514.	Blackstone Valley Community Action Program.	Pawtucket, Central Falls, Lincoln, Cumberland.
Cranston RSVP, 52 Rolfe St., Cranston, R. I., Nancy Johnston, director, telephone No. 781-1275.	City of Cranston	Cranston.
East Shore RSVP, 100 Bullocks Point Ave., East Providence, R.I., George Foster, director, telephone No. 437-1005.	Self-Help, Inc	East Providence, Warren, Bristol, Barrington, Newport.
Providence RSVP, 1 Cathedral Sq., Providence, R.I., Helen Graves, director, telephone No. 861-9800.	Catholic Charities	Providence.
Warwick RSVP, 2117 West Shore Rd., Warwick, R.I., Clarice Gothberg, director, telephone No. 738-4727.	Warwick Community Action.	Warwick, West Warwick, Coventry.
Woonsocket RSVP, 45 Arnold St., Woonsocket, R.I., Charles B. Ryan, director, telephone No. 766-2300.	City of Woonsocket.	Woonsocket, North Smithfield, North Cumberland, North Lincoln.

CHARLOTTE SCOTT, PROVIDENCE, R.I.

I am an elderly woman with no savings, and only a social security check for income. My check is for $249.10. After I pay my rent, gas, and electric bills, pay for food stamps, and life insurance for my burial, I am left with $50 for the whole month, to pay for clothes, and other necessary items. This is not enough for me to get by on, and there are many with incomes less than mine.

With such a tight budget, I am rather upset to see the price of utilities go up and up. One year ago, in January of 1975, my gas bill was $34.05. In January of 1976 I had to pay $43.62. I am living in the same house, and this has been a mild December, so I do not see why I have to pay more.

One other complaint I have, is that the utility companies have little concern for the elderly. Last week my pilot went out, they said because of low pressure in the pipes. They would not turn it back on unless I paid them $8 to have a man come out and light it. I won't have the money until the beginning of February. I have no choice but to wait until then until I can have my heat again.

Also, the last two times my social security checks have increased, my landlord has raised my rent. One time I got a $10 social security increase, and my rent went up by $10. The other time my check went up by $18 or $16, and my rent went up by $13.

MARTHA W. SULLIVAN, PAWTUCKET, R.I.

The Blackstone Valley Community Action Program, Inc., supports senior citizens activities through a comprehensive senior center program and an extremely active RSVP program. Approximately 250 low-income elderly are reached each week through these programs. The availability of programs that offer meaningful activity to seniors; a place to go other than their one room, staff to counsel and assist them, and programs to help them maintain an active involvement in the community are imperative. Unfortu-

nately, funding for these types of programs is either completely lacking or require considerable matching funds; the RSVP program sponsored by this agency currently requires 40 percent matching funds.

The high cost of living makes it impossible for many senior citizens to participate in community groups without the support of local senior centers and related programs. Legislators should be aware that funds are mandatory if local programs are to continue to aid ever expanding numbers of elderly.

CHARLES SWARTZ, EAST PROVIDENCE, R.I.

I would have reiterated the attached statement which I sent to you in 1973. I received a courteous but unsatisfactory reply.

I am happy to see that you and Senator Fong are now cosponsoring S. 871 which would correct a long standing injustice.

I want to bring up for discussion something that has brought hardship and injustice to many people upon their reaching retirement age and that is the limitation on earned income that is written into our social security law.

The present limit is $2,100 per year and will go to $2,400 in 1974.

Upon reaching retirement age a person has only two choices:

1. Continue a full schedule of work beyond his strength and impaired capacities, or

2. Plunge into instant poverty.

There is no possibility for a third choice which would maintain health, dignity, and a decent standard of living by being able to taper off: Work on a reduced schedule at a reduced pay but still be able to earn much more than $2,400.

Why should a person who has earned $8,000, $10,000 or $12,000 per year suddenly be limited to $2,400 in order to receive what he has paid for during a lifetime of work?

I know that there were historical reasons for this provision but I submit that they do not apply in today's inflation blated world. It is an anachronism and should be completely eliminated so as not to inflict unnecessary hardships on people willing and able to continue to be self-supporting, tax-paying, contributing members of society. Moreover, the limitation on earned income is unjust because there is no limit on unearned income. Income from investments and property; interest, dividends, rents, etc., do not limit a person by 1 cent in receiving his full social security payment.

Also, at age 72 there are no limits. Why is there this penalty at age 65? Why must these precious 7 years be years of overwork or years of poverty instead of years of gradual adjustment to a new situation?

The fact that Congress has been slowly and painfully raising the limit on earned income over the years is proof that our Senators and Representatives have recognized the basic injustice of this provision in the social security law and have sought to correct it. However by adding a pittance every few years they make it appear as though it were a privilege to allow a person to continue to be self-supporting after a lifetime of work.

Congress must be made to see the light:

1. That earned income at age 65 would have the same rights and privileges as unearned income.

2. That what is good at age 72 is even better at age 65 or even 62.

JOSEPH L. TURCOTTE, SMITHFIELD, R.I.

There should be a way to anticipate inflation to give the elderly a fair start on the cost of living increase. If he is on a soup diet when he gets his increase, he will be promoted to hamburgers, but by the time he gets his increase 18 months later he certainly will be back on soup again.

I am presently involved with RSVP and I think it is a well worthwhile program and should be expanded and financed by our government. It provides our elderly a chance to get back in the main stream of life.

VIRGINIA R. WHITE, PROVIDENCE, R.I.

I spent the month of May 1975, as a guest in the home of a family in Budapest, Hungary. The little I learned of the government health care available to the people was very impressive. I realize that the program may never be available in the United States but it might be worthy of consideration in the creation of a program for the elderly. Rhode Island Group Health Association comes closest of anything I know of.

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MEDICARE AND MEDICAID FRAUDS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 7—WASHINGTON, D.C.

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HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD W. BROOKE, Massachusetts
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DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

Medicare and Medicaid Frauds:

Part 1. Washington, D.C., September 26, 1975.
Part 2. Washington, D.C., November 13, 1975.
Part 3. Washington, D.C., December 5, 1975.
Part 4. Washington, D.C., February 16, 1976.
Part 5. Washington, D.C., August 30, 1976.
Part 6. Washington, D.C., August 31, 1976.
Part 7. Washington, D.C., November 17, 1976.
Part 8. Washington, D.C., March 8, 1977.
Part 9. Washington, D.C., March 9, 1977.

(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

MEDICARE AND MEDICAID FRAUDS

WEDNESDAY, NOVEMBER 17, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10:10 a.m., in room 318, Russell Senate Office Building, Hon. Frank Church, chairman, presiding.

Present: Senators Church, Moss, and Percy.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; Donna Gluck, resource assistant; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. The hearing will come to order.

We would like to welcome our witnesses this morning. The purpose of today's hearing is to learn what can be done to improve the management and the fiscal integrity of the medicare and medicaid programs.

I am sure that members of this committee and the American public generally have been shocked and dismayed by the recent disclosures of fraud and abuse in Government health care programs.

I want to say that all the members of this committee appreciate what Senator Moss has done in the last 2 years in bringing this situation to light, and I want to express on behalf of the committee, Senator Moss, our gratitude for your leadership in opening up a field of fraud that seems to be pervading the entire medicare and medicaid system. I do not know of a more urgent problem of this kind that faces the Government and, on behalf of the committee, I simply want to express our deep appreciation for your work.

By now it should be clear to everyone that reform cannot wait. It is the cruelest paradox that I can think of that thousands of our elderly are going without the health care they need, and yet we lose millions of dollars to fraud and mismanagement.

Our two witnesses today will further demonstrate the severity of existing problems and they will give us some guidance concerning legislation which is needed.

Mr. Charles J. Hynes, the New York special prosecutor for nursing homes, brings with him the statewide perspective of his special work. Mr. Sam Skinner, U.S. attorney, northern district of Illinois, will tell us what we can do to strengthen the hand of Federal prosecutors.

Cost Effectiveness Praised

I am particularly interested in the cost effectiveness of the New York special prosecutor's office. I am told Mr. Hynes has recovered many times the amount of money spent on his investigation. In fact, he recently announced that his auditors find $2,500 in medicaid overcharges for every man-day of effort.

If all prosecutors could claim such a return we could pay off the various State, municipal, perhaps even national debts.

In the coming months or years we will consider national health insurance plans. I want to make it clear this morning that we want to make sure that the elderly are not short-changed in our efforts to make health care more generally available to all Americans. At the same time we will make every effort to make sure we do not repeat the mistakes that have been made in medicare and medicaid and that we take such corrective action as may be available to us.

Senator Percy, you have played an active role in the investigations to date. If you have a statement you would like to make at this time, we will be happy to receive it.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator Percy. Thank you, Mr. Chairman.

I would first and foremost like to say how very pleased I am that Senator Moss could be here this morning. I have worked intimately with him for 6 or 7 years as the ranking Republican on this Subcommittee on Long-Term Care. I have known his devotion to this field. He has conducted his subcommittee in a totally nonpartisan fashion, and we have worked intimately and well with the staff appointed by the Democratic members.

It has always been a nonpartisan relationship, and I have drawn upon them for advice, counsel, and support, and I commend them and commend the leadership we have had.

It is a great tragedy to have his continuing guidance and leadership taken from our committee, but I know he shall have a lifetime interest in the field. We cordially invite him to participate in every way possible. We are gratified by his presence this morning.

I would like to express my deep appreciation to Senator Church and the staff of the Aging Committee for these investigations. I would also like to welcome Mr. Charles Hynes and Mr. Sam Skinner this morning to testify before the committee.

I look forward to their suggestions as to how we can enact legislation which will curtail fraudulent practices in medicare and medicaid programs and, furthermore, how we can alleviate obstacles which presently impede Federal prosecutions.

First Convictions Received

Last Thursday, November 11, Samuel Skinner, the most active U.S. attorney in terms of medicaid fraud prosecutions, received the first convictions under the 1972 Federal law prohibiting kickbacks in the medicaid program.

Since 1969, Senator Moss and I have been concerned with nursing home scandals and medicare-medicaid frauds. It pleases me that after 7 years of hearings, repeated investigations, and numerous reports, our efforts are finally bearing fruit.

The purpose of a public hearing such as this is to disseminate information as to what our policy is going to be and how the law is going to be implemented. I feel we should serve notice today—publicly—that with the Skinner convictions we can now effectively serve notice to all who would defraud and abuse the medicaid program. They simply cannot and will not escape prosecution.

We passed the law. The law is going to be carried out and has now been put into effect. Congress and the judicial system mean to put an end once and for all to one of the worst scandals of our time: medicaid fraud and abuse.

Persons who would defraud the elderly poor, I think, are the most reprehensible—certainly those in the medical profession themselves who have taken a vow to serve their fellow man. I think it is an unconscionable action on their part to engage in these practices—those under the cloak of engaging and caring for the poor who profit from the poor.

The same goes on Wall Street. There is money to be made on the poor, providing they are elderly—particularly if they are elderly. I think we intend to move, and move strongly.

We have had witnesses before us who are now serving time in jail. We intend to carry this forward and, Senator Moss, I pledge to you that the committee will carry on in the spirit in which you have chartered our course.

Prior to the efforts of Sam Skinner and Charles Hynes, little had been accomplished with the slap on the hand we have been giving the doctors convicted of medicaid fraud. We need to strengthen the medicaid laws at both the Federal and State levels. Some steps have been taken in that direction, but more are needed if we are going to clean up our medicare and medicaid programs and move on to national health insurance.

Abuses Threaten Proposed Program

I, for one, will do everything possible to assure the enactment of the medicare-medicaid antifraud bill during the 95th Congress. Both political parties have pledged to carry forward a national health insurance program. Until we can find a way in these much smaller programs to carry them out without the millions of dollars of fraud that we have, there is no possibility of having a sensible, sound, rational national health insurance program where the potential of fraud would not run into the billions. This is really what we are

aiming at—to find out how to administer these programs in such a way that we can even broaden the health care that is needed for all Americans rather than just the elderly.

I welcome these hearings and certainly appreciate the testimony we are about to have from our distinguished witnesses.

Senator CHURCH. Thank you very much, Senator Percy. I surely agree if we are to move ahead with a national health program, we are going to have to demonstrate we can competently manage those programs that now exist for the elderly and that we can eliminate this problem of kickbacks, payoffs and bribes that have been disclosed through the investigations of this committee and the special work of Senator Moss.

I want to ask Senator Moss for whatever statement he would like to make at this time. Before doing that, I think it might be appropriate to include in the record three articles that appeared in the New York papers yesterday. One appeared in the New York Times which discusses the 26 indictments that have been issued by the special prosecutor and our witness this morning, Charles J. Hynes, and also has to do with kickbacks that he will be discussing this morning, and a similar article appearing in yesterday's Daily News giving further details.

And finally, a New York Times article published yesterday entitled "Medicaid's Lab Fees Being Cut Up To Half," which indicates how bloated the costs have become due to these fraudulent practices and the immense savings that can be realized through the efficient enforcement of the law.

[The articles referred to follow:]

[From the New York Times, Nov. 16, 1976]

HEALTH CARE PAYOFFS CALLED RIFE BY HYNES AS 26 ARE INDICTED

NURSING-HOME PROSECUTOR CHARGES KICKBACKS BY SUPPLIERS—FEELS ALL MEDICAID IS INVOLVED

(By Richard J. Meislin)

The State's special nursing home prosecutor charged yesterday that illegal kickbacks from commercial supplier's were widespread in the health-care system in New York State, and he announced the indictments of 26 nursing home owners, operators, employees, and suppliers.

The prosecutor, Charles J. Hynes, said that up to half the 125 nursing homes in the metropolitan New York area could be involved in the alleged kickback schemes.

"Our indication is that the same kinds of abuses are found in all provider services in medicaid," Mr. Hynes said, adding that he included hospitals and pharmacies.

Mr. Hynes, whose jurisdiction is limited to nursing homes, said his 18-month inquiry had uncovered evidence of kickbacks ranging from 5 percent to 33 percent of business volume from suppliers of a variety of goods and services to health care facilities.

He indicated that additional indictments were expected soon from grand juries hearing evidence about other aspects of the alleged kickback schemes.

SOME INDICTMENT DETAILS

Thirteen nursing home officials—in most cases, operators or administrators—were charged in yesterday's indictments with conspiracy and with violating the anti-kickback provisions of the State health laws. Eleven suppliers were

charged with perjury, and two meat company owners were accused of bribing a witness, criminal solicitation and conspiracy.

The indictments were returned by five grand juries in Brooklyn, the Bronx, Queens, and Nassau and Suffolk Counties.

Mr. Hynes said that his investigation, which focused on 30 of the metropolitan area's major nursing home suppliers, had uncovered three major kickback schemes:

(1) "Inflated billing," in which the supplier would bill the nursing home for more than the amount actually owed.

(2) "Phony billing," in which a false invoice would be issued for deliveries that were never made.

(3) "Phony items," in which bogus items were included and charged for in an otherwise legitimate bill.

In each of these cases, Mr. Hynes said, the nursing home official would pay the amount requested by the supplier. The supplier would then return to the official, in cash, the difference between the actual amount owed and the inflated bill.

The nursing home would then file the inflated bill with the State health department for medicaid reimbursement, the prosecutor said.

Yesterday's indictments open a new area of inquiry by Mr. Hynes, whose investigation to date has concentrated on nursing home operators who allegedly filed false medicaid claims to cover personal expenses.

OWNER WHO WORE MICROPHONE

Instrumental in the inquiry, Mr. Hynes said, was a New Jersey nursing home owner who, while opening a new facility in Emerson, N.J., agreed to wear hidden electronic equipment while negotiating contracts for his nursing home with 30 major suppliers in the New York area.

The bugging was conducted with the approval of Joseph Woodcock, the Bergen County Prosecutor, Mr. Hynes said.

In more than half the 50 conversations recorded in this manner, the vendors on their own initiative proposed kickbacks to the nursing home operator, Mr. Hynes asserted. He would not name the nursing home informant, but he is identified in several indictments as Ira Feinberg, who is facing an 18-month sentence on a Federal stock fraud conviction relating to another nursing home.

Confronted with the tape recordings, several suppliers agreed to wear electronic listening devices themselves, and in subsequent visits to nursing home owners they recorded discussions of the kickbacks and the transfer of money, the State prosecutor said.

Mr. Hynes said that the average monthly kickback discussed in the conversations recorded by his informants was $500 per supplier.

These conversations resulted in the indictments against the 13 nursing home officials.

In 11 other cases, suppliers who allegedly had discussed kickbacks with Mr. Feinberg denied any knowledge of illegal propositions, and they were indicted on perjury charges that carry a maximum 7-year prison sentence.

Twenty of those indicted surrendered yesterday morning to the special prosecutor. Six others, not yet named, are expected to surrender "within the next day or two," Mr. Hynes said.

[From the New York Daily News, Nov. 16, 1976]

26 ARE INDICTED IN KICKBACK PLAN AT NURSING HOMES

(By Marcia Kramer)

Twenty-six persons were indicted yesterday in a nursing home swindle that prosecutors said involved up to $4 million in kickbacks from vendors and in medicaid fraud. The charges were based on an 18-month investigation by grand juries in three boroughs and in Nassau and Suffolk counties.

Charles J. Hynes, the State nursing home special prosecutor, said that while 13 nursing home officials at seven homes had been indicted, the investigation by his office had revealed that as many as 50 percent of metropolitan area nursing homes were involved in the kickback arrangement. There are 125 homes and related facilities in the New York region and 753 in the State.

The prosecutor said that the suppliers viewed kickbacks as part of their normal course of doing business. They contracted with the operators to supply cleaning services, paper products, meats, groceries, and clothing for the residents. He estimated that each home operator dealt with 10 vendors, each of whom shelled out an average monthly kickback of $500.

11 SUPPLIERS NAMED

Besides the nursing home officials, the indictment named 11 suppliers and two meat company owners. The home operators were charged with the receipt of specific cash kickbacks from the vendors; suppliers were charged with committing perjury in connection with grand-jury testimony and the two meat-company owners were charged with offering a $1,000 criminal solicitation bribe to a government witness.

The indictments climaxed an investigation that began in May 1975 when a New Jersey nursing home operator, who had been convicted on Federal fraud charges, agreed to cooperate with the special prosecutor's office.

The operator, Ira Feinberg of Paramus, posed as a man who planned to open a nursing home in Emerson, N.J. Working from a list of 200 suppliers, all of whom did business in excess of $25,000 a year with nursing homes, Feinberg invited the top 30 suppliers to his office to discuss business proposals. The conversations were secretly tape recorded for presentation to the grand juries.

The prosecutor said that in most of the taped conversations the suppliers offered kickbacks of up to 33 percent a month.

The alleged schemes fell into four categories:

(1) Inflated billing, which raised the actual costs of goods received.

(2) Phony billing—invoices for goods never delivered.

(3) Phony item invoices, in which nonexistent items were listed on otherwise legitimate bills.

(4) Front money—in which the nursing home operator received substantial loans from suppliers in return for long-term contracts.

In each instance, the prosecutor said, the operators submitted the bogus bills to medicaid for reimbursement.

Although none of yesterday's charges alleged medicaid fraud based on the inflated supply costs, sources said that fraud indictments linked to the kickbacks are expected within two months.

Special Assistant Attorney General Philip Stern, who headed the investigation, said that the kickback scheme was a three-step process.

First, the operator wrote a check to the supplier for the inflated bill. Then the supplier would give the operator a cash payment reflecting the difference between the real costs and the inflated invoice. The third step involved the nursing homes submitting the inflated bills to the State health department for reimbursement.

In one case, the operators of the Franklin Park Nursing Home in Franklin Square, L.I., were charged with receiving approximately $42,000 in cash payments from an unnamed meat vendor. The operators, Louis Hodes and Herman Surkis, were charged with conspiracy and 21 violations of the health laws.

The nursing home officials named in the indictments include:

Aaron Feuereisen, owner of the Far Rockaway Nursing Home, 13-11 Virginia St., Far Rockaway, Queens, charged with receiving $17,700 in kickbacks; Herman Greenbaum and Josef Levi, of the Queens-Nassau Nursing Home, 520 Beach 19th St., Far Rockaway, $11,700 in kickbacks; John Marksamer, operator of the Woodbury Nursing Home, 8533 Jericho Turnpike, Woodbury, L.I., $15,966 in kickbacks; Jeffrey White of the Woodbury Health Related Facility, 8565 Jericho Turnpike, Woodbury, L.I., $3,965; and Samuel Leifer, director of the River Manor Health Related Facility, 630 E. 104th St., Brooklyn, $12,523.

Charged with bribing a witness was Sidney Lieberman, 62, owner of a Brooklyn meat company.

The suppliers were identified as Donald Berkowitz, 45, general manager of Donnell Box Meat Distributors, 547 Monida St., Bronx; David Lev, 48, owner of Lev Bros. Produce Co., 1110 54th St., Brooklyn; Lewis Gross, 45, manager of Kleen Linen Service, Inc., 5610 Second Ave., Brooklyn, and Joshua Pomerantz, 30, president of Pomerantz Paper Co., 239 26th St., Brooklyn.

Other suppliers named were Joseph Segal, 27, vice president of Full Line Distributors, 1313 39th St., Brooklyn; Chaim and Joseph Weinstock, owner and

president of the Boro Park Aquamat Corp., 2109 Summit Ave., Union City, N.J.; James T. Heelan, 45, president of Olympic Maintenance Inc., Robbins Lane, Jericho, L.I.; Anthony Fanza, 40, a salesman for the Jamaica Food Co., Inc., 187–40 Hollis, Jamaica, Queens; Donald Luneberg, 33, owner of Jet Laundry, 245–17 Jamaica Ave., Bellrose, Queens, and Raymond Servidio, 30, a salesman with DiMirando & Sons Produce Co., 191 Second Street, Huntington Station, L.I.

The names of six other defendents were not released by the prosecutor because they are not yet in custody.

[From the New York Times, Nov. 16, 1976]

MEDICAID'S LAB FEES BEING CUT UP TO HALF

MOVE BY NEW YORK CITY AGENCY SLATED TO TRIM REIMBURSEMENT COSTS BY $3 MILLION A YEAR

(By Pranay Gupte)

Medicaid reimbursement fees for the most frequently ordered laboratory tests will be reduced by up to one-half, thereby saving the program an estimated total of $3 million a year, New York City's medicaid administration announced yesterday.

The city's action is a part of an economy move designed to trim at least $10 million from New York's annual $1.9 billion in medicaid expenditures, according to Dr. Martin Paris, the city's associate commissioner of health.

But the announcement yesterday, made jointly by Dr. Paris and by Forest Williams, director of medical assistance in the city's department of social services, drew bitter criticism from representatives of the 250 laboratories in the city that participate in medicaid.

"We are initiating a lawsuit against the city concerning these new rates," said Irvin R. Karasik, a lawyer who represents several small and medium-sized laboratories. "This is a most serious matter because our survival is at stake."

SCHEDULE HELD DISCRIMINATORY

Mr. Karasik said that the new fee schedule would be, in effect, discriminatory toward the smaller laboratories because they would be much less able to absorb the cutbacks than some of the bigger laboratories, such as Metpath Inc. of Hackensack, N.J.

His view was endorsed yesterday by Metpath's president, Robert Burns, who acknowledged in an interview that the new fees could indeed be absorbed better by larger concerns such as his.

But the position of the laboratory representatives did not appear to surprise Dr. Paris.

"We fully expect to be sued a lot on this," he said. "But the labs' cost of producing services has decreased immensely because of new and better techniques, and lately they were getting an unreasonable built-in profit margin."

$10 MILLION PAID IN YEAR

Dr. Paris said that the city's medicaid program had paid $10 million last year to the laboratories in fees, of which about 75 percent went to 16 large laboratories.

"So you see that smaller labs are frozen out of medicaid anyway," he said, adding that it was the administration's contention that a substantial part of the lab fees was funneled into kickbacks by the labs themselves.

Responding to Mr. Karasik's charge that the new rate reductions—which would affect such services as blood tests—would be discriminatory to the small labs, Dr. Paris replied: "Do we have an obligation to subsidize the smaller labs? We are not going to subsidize inefficient labs."

But Dr. Paris also sought to stress in a telephone interview from his office at 330 West 34th Street that the new rate reductions would also affect the larger laboratores because the cutbacks concerned the most commonly ordered tests—such as blood and urine analyses—that were done by the labs through automation.

Dr. Paris noted that in a telephone survey conducted by medicaid officials, the administration had found a discrepancy of 500 to 800 percent in the rates of tests available to individuals in labs and the rates charged to medicaid.

"There unquestionably were kickbacks here," Dr. Paris said, stressing that the city's observations concerning alleged illegalities by laboratories paralleled those contained in a report earlier this year by a special U.S. Senate subcommittee. That report, prepared by the staff of Senator Frank E. Moss, Democrat of Utah, alleged that it was a widespread practice among laboratories to share their "extraordinary" profits with medicaid physicians in the form of kickbacks.

Senator CHURCH. It is my pleasure to turn to Senator Moss for such remarks he would like to make at this time.

STATEMENT BY SENATOR FRANK E. MOSS

Senator Moss. Thank you, Mr. Chairman, my dear friend. I am pleased to be here and be with my great friend, Senator Percy of Illinois, who has served as ranking Republican member of the subcommittee on Long-Term Care so effectively and diligently over the years.

It is both heartening and disheartening to be here. I am delighted to see that you, Mr. Chairman, and Senator Percy are going to press ahead on the investigation and also the legislation that will grow out of this. My only disappointment is that after the first of the year I will not be able to continue as a member of the subcommittee or the full Committee on Aging.

It is my belief that this committee, created as a special committee some 15 years ago, has become really one of the most effective and hard-hitting of committees in the Congress. We are not what is called a legislative committee in that we cannot lay legislation before the Senate; but we do have the investigative powers that have been used so effectively and also the power of recommendation so that legislative committees benefit from our work. Much good has been accomplished, but much remains to be done.

I am delighted you are continuing this work on medicare and medicaid because, although we have been able to accomplish a good bit, as you pointed out, very much remains to be done and must be done to protect our elderly, the sick, and the poor. And I think you two Senators who are here must and will be in the forefront of pushing this investigation.

"NOTHING IS GOING TO FALL BEHIND"

I am very pleased; in fact, I feel assured that nothing is going to fall behind by reason of the fact that I cannot be with you, because I am sure both of you will carry on very effectively. I did want to be here at least part time this morning to welcome the two prosecutors who have come this morning to tell this committee what they are doing in their two great jurisdictions.

I have come to be friends with both of them, and I admire them very greatly. Mr. Charles Hynes took over where our committee left off in New York last year because he received the books and the records which we had under subpena. I am happy to see he has already succeeded in sending several of these unscrupulous operators

to jail—one of the things that had to be done in this field. He was of great help to me.

As you may remember, when I walked into the medicaid mills, it was with the help of Mr. Hynes. He had me all wired for sound, in fact, so that I could do that and we would know exactly what went on from what I said and what others said to me while I was there. This turned out to be a very great break in finding those who were abusing and defrauding the system.

A few weeks ago Mr. Skinner of Illinois announced the indictment of eight medicaid mills and six of the clinical labs that we had investigated there in Illinois. And he, too, has been doing a great job.

So I am pleased that these two great public servants have followed through on the work which our subcommittee and this committee was able to get started and for which this committee must now push for further remedial legislation to give them the full tools they need to make sure the medicaid and medicare programs work.

Like you, Mr. Chairman, I do not want to see the system damaged in the sense the poor and the elderly do not get medical services. There have been those who have stood up and said: "Well, why don't you just lop $1 billion out of the fund? Then there won't be so much money to go around."

Well, the problem is, the cuts would come out of the services. It would come down hard on the poor and elderly who need that care and service. What we have to do is find ways to stop this hemorrhage of funds where the money is siphoned off illegally and redistribute it toward improved care.

This is a happy occasion, and I think a good omen, that right now, with Congress in adjournment, still your committee is pressing on. I do commend you, Mr. Chairman, and my friend, Senator Percy, as well as those who have come here this morning. I am sure we are on the right track.

Thank you.

Senator CHURCH. Thank you very much, Senator Moss.

Mr. Hynes, would you like to proceed with your testimony?

STATEMENT OF CHARLES J. HYNES, DEPUTY ATTORNEY GENERAL, OFFICE OF THE SPECIAL STATE PROSECUTOR FOR NURSING HOMES AND SOCIAL SERVICES, NEW YORK CITY; ACCOMPANIED BY HARRY BLAIR, ADMINISTRATIVE ASSISTANT, AND ALBERT APPLETON, EXECUTIVE ASSISTANT

Mr. HYNES. First, Mr. Chairman, and members of the committee, I would like to introduce the gentlemen at the table. To my right is Harry Blair, administrative assistant; to my left is Executive Assistant Albert Appleton.

Mr. Chairman and members of the committee, I would like to begin by telling you how much I appreciate this opportunity to appear before you this morning. What I would like to do, with your permission, is to read some of the remarks from the text and then offer the text to the stenographer for the record.[1]

[1] See p. 772.

Senator CHURCH. That will be fine.

Mr. HYNES. Your committee, Mr. Chairman, has been most helpful and cooperative to my office in the past, and we are much indebted to your assistance and the encouragement in the execution of the difficult task that faces us both.

When last we met, this committee had just finished holding hearings in New York City and had turned over to my office various books and records of local nursing homes that were of great value to us.

I would like nothing more than to tell you today that since that time the forces of evil in the health care industry in my State and elsewhere had been vanquished; that order and justice had returned to the benefit of our old people and that we can all go home and live happily ever after.

OUTCOME UNCERTAIN

Unfortunately, the sad truth is that the outcome of the battle remains very much in question, both in New York State and nationwide. I fear that there still exists a climate in this country where the exploitation of old people is a respectable and risk-free profession, and that our Nation is in danger of losing far more than Federal and State tax dollars—it is in danger of losing a cornerstone of the American way of life itself.

I am afraid that fraud in New York State exists on a massive and pervasive scale. We are now in the process of completing an audit of literally the entire proprietary nursing home industry in the State. We expect that audit to identify about $70 million in fraudulent nursing home costs.

We have concluded that the false submission of direct costs is but one aspect of provider fraud. We have uncovered phony construction costs and concealed ownership of related companies in webs so entangled that even the principal owners cannot set them straight.

But the all-time favorite kind of fraud is for health care figures to write off personal expenditures as costs of doing business, thereby obtaining reimbursement with taxpayers' dollars.

The following is a laundry list of some of the more egregious examples of the free-wheeling personal expenditures we have discovered so far and which has been underwritten by health care funds:

Personal maids and servants; private residential landscaping; travel expenses; food items at levels you would not believe; luggage; works of art, including paintings by Matisse and Renoir in one instance; vast quantities of liquor; interior decorating; dental and medical care; pharmaceuticals; heating fuel for private residences; charitable contributions; political contributions; profits to investors; private automobile expenses; private pension plans; vacation expenses; real estate taxes; mink coats; personal investment stock; renovations to private homes; entertainment; legal fees; theater tickets; tickets for sporting events; high fidelity stereo equipment, and so on.

Only 2 days ago grand juries in five New York counties, empaneled by my office, returned indictments against 26 nursing home owners, operators, employees, and suppliers. This is by no means the end of the situation. The investigation is actively continuing. As a result of the investigations conducted so far in this field, there is reason to suspect that as many as half of the 125 nursing homes in the New York area could be involved in one form or another of the various kickback schemes.

We have uncovered evidence of kickbacks of between 5 percent and 33 percent of the volume of business from suppliers of various goods and services to health care facilities.

26 Indicted

On Monday we indicted 13 nursing home officials for willful violation of health laws and conspiracy; 11 suppliers for perjury; and 2 meat company owners for bribing a witness, criminal solicitation, and conspiracy.

These indictments climaxed an investigation which began in May of 1975 when a New Jersey nursing home operator who was then engaged in opening a new nursing home in Emerson, N.J., agreed to cooperate with our office.

Working from a list of major nursing home suppliers, those who dealt with four or more nursing homes or did business with nursing homes in New York in excess of $25,000 or more annually, the nursing home operator invited the top 30 suppliers to this office to discuss business proposals. All of the conversations were covertly recorded on tape.

The kickback schemes fell roughly into three categories:

One: Inflated billing—in which the supplier would give the nursing home official a bill for an amount exceeding the amount actually owed. The nursing home operator would then submit the bill to medicaid and be reimbursed for the inflated amount.

Two: Phony billing—in which the supplier would give the nursing home official a receipt for deliveries never made. The nursing home official would then submit the bogus receipt for medicaid reimbursement. We are investigating medicaid reimbursements.

Three: Another item would be the "phony item," in which the supplier would give the nursing home official a receipt for a bill where there were legitimate items as well as phony added into the bill.

A final scheme that we uncovered during the course of the investigation was one used by a certain linen company where front money would be given to a nursing home which was starting up and a contract for services would be given in return. And each year the linen company supplier would inflate the cost of the linen supplies by a percentage to include the kickback. Again, we are investigating whether or not, as a result, medicaid was tricked into giving illegal reimbursements.

Several of the suppliers, when confronted with the tape recordings, agreed to cooperate in the investigation. Wearing body microphones, they then visited nursing home officials with whom they had pre-

viously established kickback arrangements. These tape recordings picked up conversations in which kickbacks were explicitly discussed and money handed over. The average kickback discussed was $500 per month per supplier per home.

To put it plainly, Mr. Chairman, we have found ourselves steeped in the investigation of a massive, institutionalized, ongoing white-collar criminal conspiracy throughout the length and breadth of New York State. For a prosecutor, this is a murky area; an area with few established statistics detailing its exact nature and extent; an area that has, until very recently, been swept under the corporate, governmental, and political rugs of this Nation.

It seems to me from the nature of the beast that no State agency, no matter how well equipped, trained, and motivated, can "go it alone."

Federal Superstructure Needed

What is really required is a Federal superstructure in which the States can operate in those instances where they demonstrate the resources, ability, and willingness to do so. Failing such circumstances, there needs to be a comprehensive and dedicated Federal effort.

Mr. Chairman and members of the committee, I have met with representatives of more than a dozen States over the last 24 months while my investigation has been ongoing. In almost every instance, when followup calls were made to the various representatives, the same complaint was made. There is no financial commitment to this kind of investigation. They have no resources.

Currently, Mr. Chairman, we have a situation that does not really make sense. The Federal Government each year gives out literally billions of dollars in taxpayers' money to fuel the engines of medicaid and medicare. This is done within a framework of laws, rules, and regulations which, for the most part, are reasonable and workable. But from an enforcement point of view, Mr. Chairman, there is very little now being done either by the Federal or State Government in proportion to the magnitude of the problem.

At this point, Mr. Chairman, I want to make it clear that my purpose here is not to blame anyone for this state of affairs or charge negligence or anything else. The reasons for this state of affairs are many and varied, and I am confident that it is not through willful neglect that we find ourselves in our current predicament.

Nevertheless, we are where we are, and the situation, from the law enforcement point of view, is desperate. Still, rather than weeping and wailing, I would rather treat it as an opportunity to start from scratch and fashion an effective nationwide enforcement structure that can turn the currently crowded profession of stealing Federal and State health care moneys from one that is respectable and risk-free to a perilous and despicable pursuit.

By way of analogy, Mr. Chairman, I would point to the Internal Revenue Service which, by dedication, a high standard of professionalism and great vigilance has made the evasion of income taxes in this country into a most hazardous occupation. It seems to me that with the growing amounts of moneys being expended in pursuit of health care schemes in this country each year we can do no less.

Established State prosecutors such as district attorneys are currently so overworked, understaffed, and underfinanced that it would be wildly unrealistic to expect that they can cope with health care fraud. As I have explained, the schemes in operation are so complex, wide-ranging, and sophisticated that they require a special staff of highly trained professionals working full time to even provide a ghost of a chance of coping with them.

"Attorneys . . . Stretched Very Thin"

The U.S. attorneys currently are in much the same position. Most, if not all of them, are currently stretched to the limit of their resources to deal with ongoing criminal and civil problems and lack the resources to take on pervasive and complex fraud schemes such as those extant in the health care field.

Normally a U.S. attorney relies on the various Federal law enforcement agencies to develop criminal cases to be referred to him for consideration. If he believes a prosecution is warranted on the basis of evidence handed to him, then he acts if no action is taken. The agencies that provide him with these cases are rather highly specialized in areas other than health care and, as a result, this problem has had a tendency in the past to fall through the cracks of law enforcement jurisdiction.

If one considers the nature of health care fraud as I have discussed here today, I think it is fair to say that this reflects no discredit on these agencies. Clearly, to combat health care fraud on an ongoing and effective basis, a special and separate investigative and prosecutorial framework is necessary; and I see no alternative but that it be Federal.

This is not to say that I don't believe the States have a role to play and an important one. I think the Federal Government could develop a framework, perhaps along the lines of one that I will suggest to you in a moment, and then integrate those States into it that are willing and able to do so.

The Federal authorities could create a set of standards against which to measure a State application to participate. States meeting those standards could become eligible for Federal funds. I would suggest that, initially, a qualified State agency who had the commitment to this kind of investigation receive 100 percent funding from the Federal Government for a period of 3 years, then following that, phasing down to 50 percent.

This, Mr. Chairman and members of the committee, would be a powerful incentive to the States to establish an ongoing and effective agency to police the expenditure of health care dollars and would, in the long run, lessen the Federal burden by the establishment of Federal-State partnerships.

Even so, the number of States that would participate in such a scheme would, of course, likely be limited. For the rest I see no alternative to Federal intervention to keep the health care entrepreneurs honest and prevent a recurrence of the present chaotic situation, if indeed we can succeed in cleaning it up to some degree.

To do this, I would suggest the establishment of a special bureau or office within the Department of Justice dedicated entirely to health care fraud. This bureau would have to be staffed with the same types of professionals—auditors, investigators, and attorneys—all schooled in the mysteries of the delivery of health care services, that we have developed in New York State, operating under the same strike-force type of philosophy without which indictments and convictions in this field would, in my opinion, be next to impossible to obtain.

Additional Assistants Suggested

In addition, I would suggest that each of the 90 U.S. district attorneys be provided with an assistant, in addition to the complement he is now allowed, who would work full time in the health care fraud area with the cooperation of the bureau I mentioned in operating out of Washington.

The personnel of this Washington bureau could be loaned on an as-needed basis to the various U.S. attorneys. In those States with agencies of their own that received Federal certification, the State agencies and the U.S. attorneys could work in tandem both with each other and with the Washington bureau.

In my view this, or something like it, is clearly what is needed. Many of the targets of our investigations operate across State lines and, of course, as a State prosecutor, I am unable to follow.

In addition, I have found that the trail of fraud and thievery leads to medicaid mills and hospitals—indeed, with the whole provider service—in New York City. However, I am powerless to follow that trail because of lack of money, personnel, and jurisdiction. I have my hands full right now just trying to cope with the problems we have.

Mr. Chairman, the conspiracies to defraud the public in the health care field are enormous in scope and complexity and pervasive through every area of our Nation. To cope with them effectively will require a massive effort on the part of the Federal Government. I see no other way.

Mr. Chairman, New York responded to a scandal in 1974 with the appointment of my office and, more important, the funding necessary so we could do a job. But how many times in the past have we seen a great hue and cry in the media about some pressing social evil uncovered in our midst? Each time, press exposés are followed by pious pronouncements from those in positions of leadership. Promises are made, commissions and special prosecutors appointed, lengthy and erudite reports are issued, a few indictments handed down, and occasionally a prison sentence is imposed and served.

Then what happens? Usually, after a brief period of quiet, it becomes business again as usual for the bad guys, and another 20 years go by before another newspaper explosion—and the process is repeated again.

Those who stand up and announce earnestly in some public forum that this time it has to be different—that this time we have to take steps to make sure it doesn't happen again—those people are con-

signed by a jaded and scandal-weary press and public to the categories of amiable crackpot, office seeker, or worse.

Well, Mr. Chairman, this time it does have to be different. This time we do have to clean it up. And if we can't prevent it from happening again we must prevent it, at the very least, from becoming respectable and risk-free to deal with old people like a commodity in the futures market in Chicago.

It is simply too important and too central to our existence as a Nation to permit this matter to be treated like just another scandal.

To prevent the merchandising of our elderly from becoming risk-free will take more than the creation of special State prosecutors and the writing of some inspired editorials in our leading newspapers.

It will require a comprehensive, well financed, and organized Federal preserve dedicated to eradication of health care theivery. It will require a pronounced change of attitude on the part of the public in general—and the judiciary, in particular.

The crimes against our old people, despite their frequently tragic overtones where human life is concerned, primarily fall under the heading of white-collar crime as far as the law is concerned.

Sentencing: A Difficult Issue

The moment you attempt to deal with white-collar crime you must also deal with an issue few lawyers and almost no prosecutors want to touch—sentencing, which is the single most difficult thing a judge has to do.

The bitter truth is that there is simply little precedent and less enthusiasm in America about sending white-collar criminals to jail. The reasons are many and complex and I will not dwell on them here.

But if we are to prevent the criminal exploitation of old people from becoming a respectable profession, then our Federal Government has got to start taking an interest and playing an actual role, and judges have got to start sending people convicted of these crimes to jail. It is as simple as that.

This time the men and women who have stolen our tax dollars and preyed upon our parents must be apprehended and prosecuted, and those found guilty must be sent to prison. A weary and cynical public must be shown beyond doubt that such artful crimes are neither respectable nor risk-free.

I believe the people of this Nation are hungering mightily for justice in these matters and to see the white-collar criminals—who loot their treasuries and mock their laws and institutions—put in jail where they belong.

The price for failure can be high, Mr. Chairman—a precious segment of our democracy itself. For, as one of the great parliamentarians and champions of democracy, Edmund Burke, once observed: "All that is necessary for the forces of evil to triumph in the world is for good men to do nothing."

Thank you.

[The prepared statement of Mr. Hynes follows:]

PREPARED STATEMENT OF CHARLES J. HYNES

Mr. Chairman, members of the committee, my name is Charles J. Hynes. I am a deputy attorney general of the State of New York in charge of the office of the special State prosecutor for nursing homes, health and social services. I would like to begin by telling you how much I appreciate this opportunity to appear before you this morning. Your committee has been most helpful and cooperative to my office in the past and we are much indebted to you for your assistance and encouragement in the execution of the difficult task that faces us both.

When last we met this committee had just finished holding hearings in New York City and had turned over to my office various books and records of local nursing homes that were of great value to us.

I would like nothing more than to tell you today that since that time the forces of evil in the health care industry in my State and elsewhere had been vanquished, that order and justice had returned to the benefit of our old people and that we can all go home and live happily ever after.

Unfortunately the sad truth is that the outcome of the battle remains very much in question, both in New York State and nationwide. I fear that there still exists a climate in this country where the exploitation of old people is a respectable and risk-free profession, and that our Nation is in danger of losing far more than Federal and State tax dollars—it is in danger of losing a cornerstone of the American way of life itself.

I am proud to say that the State of New York has made a major commitment to reverse this tide, not only with the establishment of an office specially mandated to investigate fraud and abuse in the nursing home industry, but in providing the necessary funding to do the job. From the outset, Governor Carey has insisted that the resources made available to me mirror the broad scope of the problem. As a result, we are now the largest statewide office in the country dedicated to the investigation of white-collar crime.

As of today, I have a staff of more than 400 people, including some 300 professionals—attorneys, auditors, and investigators—working closely together out of regional offices in New York City, Long Island, Syracuse, Rochester, Westchester, Buffalo, and Albany. Our investigation to date has resulted in the indictment of 76 persons, and the conviction, thus far, of 20 of them.

Our efforts to date, while far from complete, have brought about a number of accomplishments. Together with the substantial assistance of the New York State Department of Health:

—We have brought about improvements in overall care for those in nursing homes.

—We have achieved the identification and return of many thousands of dollars stolen from the State over a 5-year period—and not always through criminal proceedings, but frequently by civil action, as well.

—We have addressed ourselves to the task of putting in place an ongoing mechanism that, once our task is completed, will effectively serve to identify, retard, and eliminate fraud in the medicaid-sponsored industry and to eliminate the potential for fraud in the future.

Before expanding on medicaid fraud, the persistent problem which brings me here today, I thought it would be helpful to give you a brief description of some of the investigative areas my office has undertaken thus far.

The first is patient abuse. This extremely sensitive area poses enormous problems for a prosecutor. Quite obviously we are obliged to prove crime beyond reasonable doubt. Although an incident of abuse may appear on the surface to be outrageous, the strict burden of proof required in a court of law necessarily imposes severe limitations on the ability to secure convictions. Secondly, witnesses—for a variety of reasons—are reluctant, and often unable, to testify, or to do so effectively. Nevertheless, we have succeeded in achieving a number of significant convictions arising out of the abuse of helpless patients in nursing homes.

UNANNOUNCED VISITS INSTITUTED

In an attempt to improve the quality of care in nursing homes, we have instituted with the cooperation of the State department of health an ongoing series of unannounced, surprise visits to facilities throughout all seven regions of the State. Although these inspections have been successful in significantly upgrad-

ing standards of care, there continues to be a great deal of room for improvement.

A third area under investigation by our office is that of adult homes. We have only recently undertaken this new assignment, which involves the licensing and operation of some 530 such facilities in New York State. Eighty percent of these are proprietary facilities sheltering some 18,000 residents. Twenty-five percent of these residents have been discharged from mental hygiene institutions. Currently we are evaluating the scope of whatever fraud and other crime may exist in the adult home industry. If it appears that a full-scale investigation is needed, we will begin that work in the spring of 1977.

And then, there is the widespread and pervasive problem of medicaid fraud itself.

I am afraid that fraud in New York State exists on a massive and pervasive scale. We are now in the process of completing an audit of literally the entire proprietary nursing home industry in the State. We expect that audit to identify about $70 million in fraudulent nursing home costs.

We have concluded that the false submission of direct costs is but one aspect of provider fraud. We have uncovered phony construction costs and concealed ownership of related companies in webs so entangled that even the principal owners can't set them straight.

But the all-time favorite kind of fraud is for health care figures to write off personal expenditures as costs of doing business, thereby obtaining reimbursement with taxpayers' dollars.

The following is a laundry list of some of the more egregious examples of the free-wheeling personal expenditures we have discovered so far and which has been underwritten by health care funds: Personal maids and servants, private residential landscaping, travel expenses, food items at levels you would not believe, luggage, works of art including paintings by Matisse and Renoir in one instance, vast quantities of liquor, interior decorating, dental and medical care, pharmaceuticals, heating fuel for private residences, charitable contributions, political contributions, profits to investors, private automobile expenses, private pension plans, vacation expenses, real estate taxes, mink coats, personal investment stock, renovations to private homes, entertainment, legal fees, theatre tickets, tickets for sporting events, high fidelity stereo equipment, and secret personal profit.

Only two days ago grand juries in five New York counties, empaneled by my office, returned indictments against 26 nursing home owners, operators, employees, and suppliers. This is by no means the end of the situation. The investigation is actively continuing. As a result of the investigations conducted so far in this field there is reason to suspect that as many as half of the 125 nursing homes in the New York area could be involved in one form or another of the various kickback schemes.

We have uncovered evidence of kickbacks of between 5 percent and 33 percent of the volume of business from suppliers of various goods and services to health care facilities.

On Monday we indicted 13 nursing home officials for willful violation of health laws and conspiracy, 11 suppliers for perjury, and 2 meat company owners for bribing a witness, criminal solicitation, and conspiracy.

These indictments climaxed an investigation which began in May of 1975 when a New Jersey nursing home operator who was then engaged in opening a new nursing home in Emerson, N.J., agreed to cooperate with our office.

Working from a list of major nursing home suppliers (those who dealt with four or more nursing homes or did business with nursing homes in New York in excess of $25,000 or more annually), the nursing home operator invited the top 30 suppliers to his office to discuss business proposals. All of the conversations were covertly recorded on a tape.

The kickback schemes fell roughly into three categories:

(1) "Inflated billing," in which the supplier would give the nursing home official a bill for an amount exceeding the amount actually owed. The nursing home operator would then submit the bill to medicaid and be reimbursed for the inflated amount.

(2) "Phony billing," in which the supplier would give the nursing home official a receipt for deliveries never made. The nursing home official would then submit the bogus receipt for medicaid reimbursement.

(3) "Phony item," in which the supplier would give the nursing home official a receipt for deliveries which were made. However, the receipt would also include fictitious items not included in the delivery. The nursing home operator would then submit the bill for medicaid reimbursement.

Under each of these proposals, the nursing home official would write a check to the supplier. The supplier would then return, in cash, the phony or inflated amount which constituted the kickback.

In addition, a number of the indicted suppliers proposed a fourth technique: "Front money," in which the nursing home operator would receive substantial loans from suppliers in return for a long-term business contract. The loans would then be repaid by means of inflated bills and subsequent medicaid reimbursement throughout the time of the contract.

Eleven Indicted for Perjury

When the same suppliers were summoned before grand juries months later, 11 denied under oath that they discussed or offered any of the illegal propositions mentioned above. They were subsequently indicted for perjury.

Several of the suppliers, when confronted with the tape recordings, agreed to cooperate in the investigation. Wearing body microphones, they then visited nursing home officials with whom they had previously established kickback arrangements. These tape recordings picked up conversations in which kickbacks were explicitly discussed and money handed over. The average kickback discussed was $500 per month per supplier.

To put it plainly Mr. Chairman, we have found ourselves steeped in the investigation of a massive, institutionalized, ongoing white-collar criminal conspiracy throughout the length and breadth of New York State. For a prosecutor this is a murky area—an area with few established statistics detailing its exact nature and extent; an area that has, until very recently, been swept under the corporate, governmental, and political rugs of this Nation.

My office is considered to be a new concept in the battle against such flourishing white-collar crime. Not only are we funded on a scale that enables us to address the scope of the problem—our budget this year is $6 million—but we are armed with broad and unique powers to carry out our investigations. For example, we are empowered by statute to issue nonjudicial, factfinding subpenas which are returnable at my office in proceedings which form the basis for civil actions and recommendations to the Governor.

The investigation of complex and sophisticated white-collar crime is a long and tedious operation. Generally, we begin by sending a team of auditors into a facility or by bringing the books of the nursing home into our office. Our auditors, using a variety of sophisticated techniques developed, tested, and refined from the inception of our office, make preliminary judgments as to the validity of the expense claims submitted by the facility to the State. This initial audit work generates leads which are handed over to the investigators who operate under the direction of an experienced prosecuting attorney assigned to the case. Underscoring this investigative effort throughout are the following considerations:

—Was there a false submission of patient-related expenditures?

—Was there a material misrepresentation of fact?

—Was it intentional?

Once we are reasonably certain that criminal activity was involved in the operations of a particular nursing home, the evidence is presented to a grand jury which must determine whether or not there is reasonable cause to believe that a crime has been committed, and who has committed it.

These crimes are "paper crimes," and the only "smoking gun" we are likely to find is a set of phony books and records.

Since the extent of white-collar crime is limited only by the ingenuity of the white-collar criminal, we have launched our investigative assault on several different fronts:

—My office and the State health department—the State agency responsible for monitoring and setting nursing home rates and standards—have entered into a memorandum of agreement designed to insure that our work dovetails with and complements the program and monitoring work of the department of health.

—We provide the State health department with technical assistance and up-to-date training.
—We have extended ourselves to providing information and expertise beyond New York State. I have encouraged—and continue to encourage—law enforcement agencies throughout the country to avail themselves of our knowledge, experience, and intelligence information—and they have done so. Florida, Michigan, Ohio, Colorado, and New Jersey are only some of the States we have worked with.
—We have developed standard procedures for referrals of criminal information leads, both from our office to other governmental agencies and to our office from those offices. For no arm of government has a right to think that it can achieve success in an arena of these dimensions without such regular candid exchanges.
—We have developed sophisticated computer programs to assist in investigations, and have assisted the New York State Bureau of the Budget in a cost analysis of both nursing homes and adult homes.
—In addition to these efforts, it is imperative that we initiate and support legislative recommendations which will help to eliminate the problems which infect the Medicaid program. We reach out to citizens in the communities to aid us in enacting remedial changes in the law. In fact, I plan to submit within the month my first package of such proposals.

"Best Lawyers White-Collar Criminals Can Buy"

We have selected and trained a staff of capable lawyers who are, for the most part, former prosecutors. This cadre works closely with our special investigators—former police detectives, ex-FBI agents—and auditors. We conduct frequent in-house seminars. We have invited prominent members of the legal profession in and out of law enforcement who have lectured to the staff and kept them current on the latest developments in the law, strategy, and techniques—all this in the pursuit of a standard of excellence which is necessary to cross swords with the best lawyers that white-collar criminals can buy. The building blocks in this project are patience, aggressiveness, innovation, and raw talent.

Our office has recently put together a manual which lays out in detail a tested and proven design for the successful investigation of health care fraud and which we will make available on request. We stand ready to cooperate with any agency which seeks to tackle this problem for, Mr. Chairman, New York State has no monopoly on medicaid crimes. And we cannot go it alone.

In fact, it seems to me from the nature of the beast that no State agency, no matter how well equipped, trained, and motivated, can "go it alone."

What is really required is a Federal superstructure in which the States can operate in those instances where they demonstrate the resources, ability, and willingness to do so. Failing such circumstances, there needs to be a comprehensive and dedicated Federal effort.

Currently, Mr. Chairman, we have a situation that doesn't really make sense. The Federal Government each year gives out literally billions of dollars in taxpayers money to fuel the engines of medicaid and medicare. This is done within a framework of laws, rules, and regulations which, for the most part, are reasonable and workable. But from an enforcement point of view, Mr. Chairman, there is very little now being done either by the Federal or State Governments in proportion to the magnitude of the problem.

At this point, Mr. Chairman, I want to make it clear that my purpose here is not to blame anyone for this state of affairs or charge negligence or anything else. The reasons for this state of affairs are many and varied and I am confident that it is not through willful neglect that we find ourselves in our current predicament.

Nevertheless we are where we are and the situation, from the law enforcement point of view, is desperate. Still, rather than weeping and wailing I would rather treat it as an opportunity to start from scratch and fashion an effective nationwide enforcement structure that can turn the currently crowded profession of stealing Federal and State health care moneys from one that is respectable and risk-free to a perilous and despicable pursuit.

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Established State prosecutors such as district attorneys are currently so overworked, understaffed, and underfinanced that it would be wildly unrealistic to expect that they can cope with health care fraud. As I have explained the schemes in operation are so complex, wide ranging, and sophisticated that they require a special staff of highly trained professionals working full time to even provide the ghost of a chance of coping with them.

The U.S. attorneys currently are in much the same position. Most, if not all, of them are currently stretched to the limit of their resources to deal with ongoing criminal and civil problems and lack the resources to take on pervasive and complex fraud schemes such as those extant in the health care field.

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Separate Framework Needed

If one considers the nature of health care fraud as I have discussed here today, I think it is fair to say that this reflects no discredit on these agencies. Clearly to combat health care fraud on an ongoing and effective basis, a special and separate investigative and prosecutorial framework is necessary; and I see no alternative but that it be Federal.

This is not to say that I don't believe the States have a role to play and an important one. I think the Federal Government could develop a framework, perhaps along the lines of one that I will suggest to you in a moment, and then integrate those States into it that are willing and able.

The Federal authorities could create a set of standards against which to measure a State application to participate. States meeting those standards could become eligible for Federal funds. I would suggest that, initially, a qualified State agency receive 100 percent funding from the Federal Government for a period of 3 years following which the Federal share would be phased down to 50 percent.

This would be a powerful incentive to the States to establish an ongoing and effective agency to police the expenditure of health care dollars and would, in the long run, lessen the Federal burden by the establishment of Federal-State partnerships.

Even so, the number of States that would participate in such a scheme would, of course, likely be limited. For the rest I see no alternative to Federal intervention to keep the health care entrepreneurs honest and prevent a recurrence of the present chaotic situation, if indeed we can succeed in cleaning it up to some degree.

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In addition, I would suggest that each of the 90 U.S. district attorneys be provided with an assistant, in addition to the complement he is now allowed, who would work full time in the health care fraud area with the cooperation of the bureau I mentioned operating out of Washington, D.C.

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"This Time We Must Succeed"

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The moment you attempt to deal with white-collar crime you must also deal with an issue few lawyers and almost no prosecutors want to touch—sentencing.

The bitter truth is that there is simply little precedent and less enthusiasm in America about sending white-collar criminals to jail. The reasons are many and complex and I will not dwell on them here.

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The price for failure can be high—a precious segment of our Democracy itself. For, as one of the great parliamentarians and champions of democracy, Edmund Burke, once warned: "All that is necessary for the forces of evil to triumph in the world is for enough good men to do nothing."

Thank you.

Senator CHURCH. Thank you for your statement, Mr. Hynes. I remember reading not too long ago about the first doctor—or dentist, I do not recall—who had been actually sent to jail on a fraud charge connected with medicaid. It was so exceptional and so unique that it made the newspapers all acress the country.

How do you get judges to begin to understand that doctors and dentists and white-collar people should be as equally accountable as ordinary street criminals?

Mr. HYNES. Judicial attitudes.

Senator CHURCH. How do you affect the judicial attitudes so these people are given sentences comparable to the kind that are now pretty much reserved for the street criminal?

Mr. HYNES. Mr. Chairman, I think they have to understand the pervasiveness of the problem. I can only give you, by way of analogy, my previous experience. I was in charge of the rackets bureau of the district attorney's office in Brooklyn between 1970 and 1974. And as you well know, Mr. Chairman and members, police corruption was heralded as a pervasive situation during that period.

We had a special commission which investigated problems of police corruption. At that time, the prevailing judicial attitude—and a well-meaning one I might add—was that what other punishment could be given to a police officer than for him to lose his respectability, his badge, his pension, and all those things which go with becoming a police officer—all the pride and respect he gets in his community?

PUNISHMENT: A KEY DETERRENT

It was our position and our direction to try to make it clear to the judges that we cannot have this kind of repetition of activity; that police corruption had become pervasive in New York City and the only deterrent was assurance of a speedy trial, conviction, and punishment. The punishment was the key.

In 1973, 24 police officers who were assigned to control gambling and corruption in New York City—more specifically, in Brooklyn—were indicted. Twenty-two of those were convicted after a 4-month trial, and each and every one of them received jail sentences of between 1½ and 3 years.

I am told from friends of mine in the police department today that one of the reasons that we have one of the highest levels of integrity in the history of that department today is the fear of punishment.

It seems to me the more it becomes clear to judges in New York, and maybe across this country—that the deterrent factor is every bit as important as rehabilitation.

Senator CHURCH. You mentioned in your testimony, Mr. Hynes, that you thought medical profiteering, kickbacks, and things of that kind might be as prevalent in the hospitals as they are in the nursing homes.

Mr. HYNES. That is a result of the 18-month investigation which we just concluded. Many of the people who have cooperated with us, offenders who had been previously involved in kickbacks, indicated—I state this very carefully, this is a continuing investigation—indi-

cated that the nursing home kickback scheme had no monopoly over the system; that it extended to other provider services, including hospitals.

Senator PERCY. Could I ask for clarification, Mr. Chairman?

You have pointed out that 80 percent of adult homes or nursing homes are proprietary?

Mr. HYNES. Yes.

Senator PERCY. Most of our hospitals are nonproprietary, nonprofit. Do you find any difference there at all? Is there an equal amount of fraud and kickback in the nonprofit hospitals?

Mr. HYNES. It depends on whether there is opportunity for this kind of fraud. In May of 1975 when this New Jersey operator agreed to cooperate with us—you are, of course, aware New Jersey was a flat-rate State as opposed to a cost-plus State like New York. We were not optimistic we could get this kind of activity rolling with the difference of payment.

But it was clear from the conversation we had from the various vendors that it mattered not whether it was cost-plus or flat rate, voluntary or proprietary. The same amount of moneys were available. The only difference, of course, was the initial one step further; in addition to the cash kickback was the opportunity to seek the repayment from medicaid of the inflated voucher.

Senator CHURCH. The amounts are staggering to me.

You testified in connection with the kickbacks in New York alone, that you would estimate the overpayment would run in the range of $70 million. Is that $70 million in a single year?

$70 MILLION OVER 5-YEAR PERIOD

Mr. HYNES. No, that is over a 5-year period. That is the statute of limitations we investigated.

Senator CHURCH. And that is in more than half of the New York nursing homes; I take it that would be in the New York City area?

Mr. HYNES. Yes.

Senator CHURCH. You have found evidence of the kickback practice ranging anywhere from 5- to 33⅓-percent overpayment?

Mr. HYNES. That is correct.

Senator CHURCH. In those cases, you said you were investigating to determine whether these overpayments which were billed in various fraudulent ways had, in fact, been reimbursed by medicaid or medicare. Do you mean by that, that your investigation is not yet sufficiently complete so you can testify that the reimbursements have been, in fact, taking place?

Mr. HYNES. There is just one step remaining, Senator. Of course, New York State reimbursement forms are backed up by vouchers for the various services. We are not aware of any situation where there were duplicate vouchers issued by a vendor which contained the amount of the kickback in one of the legitimate vouchers. So there is reasonable suspicion when the nursing home operator puts in his request for reimbursement that he submitted the phony voucher. The books and records of the various homes have been subpened.

We are now in another round of litigation, but we are confident these vouchers were used.

Senator CHURCH. It would be very surprising, indeed, if they had not filed for the full amount of the reimbursement.

Your testimony with regard to remedy—that is a key matter of interest to this committee. You say you think there must be a Federal remedy; that the States alone are unable to solve the problem because of its magnitude.

How did your agency get started?

Mr. HYNES. As a result of the massive scandal uncovered by the media, Governor Carey, who took office in January 1975, asked the attorney general to appoint a special prosecutor.

Myself and two other assistants began on the third floor of an old State building in New York. We received some additional funding from the State to set up. We were charged by the mandate of setting up a statewide investigation. We then received a budget of approximately $3.6 million. We spent $3.4 million of that in the first year.

We have offices in Albany, Syracuse, Rochester, Buffalo, New York City, Long Island, and the Westchester area. We have a current operating budget of $6 million. That would include the additional investigation which would be charged to adult homes—DCF's—domicile care facilities.

We received enormous commitments from New York State in terms of funding. One of the problems we have been confronted with—we have now spoken to nearly a dozen States and there is a common threat of the following:

FUNDING UNAVAILABLE

What we generally do is give a 1- or 2-day introductory explanation of what we are doing. When there is a followup by people on my staff, the consistent answer is that we do not have the funding and we cannot get the funding.

How is it that you excited enough interest in the legislature to get the funding? How is it? Scandal. The adult home part of our investigation is a step forward and it was because of the work of this committee.

We did not react this time. We initiated on the basis of information we received about problems in the adult-home industry. But apparently there is very little enthusiasm in most of the States I have dealt with to launch this kind of statewide effort.

Now it seems further that you can provide an incentive which would underwrite the cost of this kind of investigation, at least in the initial States. I picked 3 years because it will probably take that kind of time to have an investigation run smoothly and effectively.

Senator CHURCH. Well, in your case where you have been able to recoup $2,500 a day for each man-day of labor spent——

Mr. HYNES. I do not want to mislead you, Senator. That is identified. The recovery process is undeterminable. But for the figures, we have recouped in cash half a million dollars. We have tied up

the assets of two other nursing home operators to the extent of $3.6 million. I am very confident we will get that in the next couple of months.

But, in addition, we are in the process of identifying the overpayments. But the due process procedure, as it should be, is strictly along constitutional lines.

Senator CHURCH. But knowing what you do now and estimating what your recovery is likely to be, you are more than paying for yourself, are you not?

Mr. HYNES. Yes, no question about that. It requires the initial amount of money, whether it comes from the State or Federal Government, to launch this kind of investigation.

Senator CHURCH. At least 50 percent of the funds for medicaid comes from the State in New York, as is true for the State of Illinois, and a substantial part of the money from medicaid is contributed by each State.

In my own case—a less developed State like Idaho, I think, contributes a third of the amount but, nevertheless, a substantial part. You would think the State legislatures would have a reason to protect such large outlays of State money to make certain that it is not being siphoned away and that would demonstrate the success of your particular group—the contagion might spread.

WOULD STATES ENFORCE ADEQUATELY?

But if we were to provide for Federal funding, say, for the first 3 years and point to success stories of the kind your own effort represents, do you think then with that kind of inducement the States themselves would set up appropriate enforcement facilities so that it would not be necessary to establish a new and permanent Federal agency or some agency for this purpose?

Mr. HYNES. I do not know, sir. That is why I suggest the alternative remedy.

Senator CHURCH. Do you think it would be worth experimenting to see if the States would respond sufficiently well so that we do not just add another layer to an already huge Federal bureaucracy, or do you think the issue is of such a magnitude and the experience you have had is such to suggest we ought to go ahead with legislation that would set up a permanent division within the Department of Justice devoted exclusively to this purpose and a separate U.S. deputy district attorney in each State to prosecute these cases?

Mr. HYNES. I honestly do not know. That is why I suggest the alternative. It seems to be not mutually exclusive.

I can tell you the representatives I have met with in more than a dozen States would be very happy with the form—that they get the kind of funding that is necessary to start an investigation.

Senator CHURCH. You stated in a speech you made last week—I think you delivered it in Dallas—that one of the chief accomplishments of your office to date has been to bring about an improvement in the overall quality of medical care afforded to those currently in nursing homes.

Mr. HYNES. Yes.

Senator CHURCH. In what ways has this care improved as a result of your work?

Mr. HYNES. We have had responses to allegations that there was a relatively poor level of care in the homes, practically on a statewide basis. We have, with the full cooperation of the New York State Department of Health, engaged in surprise, on-site, unannounced visits to nursing homes in every region of the State.

Since we are prosecutors, we are not permitted to go on the premises of a nursing home, nor should we, without the permission of the nursing home operator. The department of health has inspection capability. What they had to do was to enter the homes in those cases where we are not given consent to enter and make observations. They are trained by us to look for those things which would be necessary to prosecute.

I think the program has been successful because of the surprise nature of the operation. No one can be certain who will be coming from either our office or the State department of health in any period of time.

PROSECUTED ON NINE COUNTS

Out of one of those inspections, we prosecuted the owner of a home in Westchester. He was indicted for nine counts of violations of the public health law. They were all misdemeanors. He was convicted after a fairly extensive trial. He was fined as a result of that prosecution.

But more importantly, his home is closed up. I think the spotlight of publicity, the ongoing kind of investigation that we are conducting, has accrued to the benefit of the people in the home. We get this not only from health department inspections but community people who visit the homes regularly.

Senator CHURCH. Your unit, I take it, is the only one of its kind in the country today—is that correct?

Mr. HYNES. Yes.

Senator CHURCH. Is it authorized for any time period?

Mr. HYNES. No, its authorization depends very much on the commitment of Governor Carey. Based on my prior experience with the Governor, he has an enormous commitment to this investigation.

Senator CHURCH. Is there any particular reason why your jurisdiction should continue to be limited to nursing homes? What happens when your investigators uncover municipal fraud, let's say, in hospitals, in medicaid mills, or the like?

Mr. HYNES. We make a practice of turning over the information to prosecutors with jurisdiction. As to whether or not we should expand our jurisdiction, we intend shortly to bring the data that we have compiled over the last 23 months to the attention of the Governor and to the legislature for them to make a judgment as to how we should broaden the jurisdiction.

I might say in at least two instances where we had investigations, owners of nursing homes own hospitals, and we intend to go to the Governor and ask for at least broadened jurisdiction for that limited purpose. I do not anticipate any problem.

Senator CHURCH. What kind of opposition, if any, have you run into? Do you readily obtain the support of the local district attorneys in connection with your work?

Mr. HYNES. Yes, without question.

Senator CHURCH. Active support from the State agencies?

Mr. HYNES. Yes, sir, we are very happy with the cooperation we have received on all levels.

Senator CHURCH. How about the cooperation you have received from the Federal agencies—the Department of Health, Education, and Welfare?

Mr. HYNES. We have been working with people from the New York region of HEW. They have been very responsive to our needs and, in addition, we have had at least two joint prosecutions with two of the four U.S. attorneys in New York State: U.S. Attorney Fiske for the southern district of New York, and U.S. Attorney O'Carroll from the western district of New York.

Senator CHURCH. I was interested, when listening to your testimony, in your explanation of the ways that you are able to uncover these practices. I suppose this is a lawyer's question but, nevertheless, it concerns me because of other investigations I have dealt with: with the CIA and the FBI, the unlawful use of wiretaps and of bugging devices.

"ENTRAPMENT" CHARGE PRECAUTIONS

As you have proceeded, have you encountered charges of entrapment—of unlawful use of electronic devices—anything of that kind? What can you tell me about how you proceeded in such a way as to make the evidence admissible in court and avoid countersuits?

Mr. HYNES. During this investigation, the one we just concluded, no court-ordered electronic surveillance was required. A well established Supreme Court case, the *White* case, covered this situation.

In terms of entrapment, we will proceed in any trial we have in this case and will establish that issue. We are very confident there was no entrapment. In each instance, the proposal was made by the person who ultimately was indicted or ultimately cooperated, because of a decision that the goods were on him. So we have had no problems. I do not anticipate a problem.

I guess the precise answer to your question is "Not yet," because this is really the first investigation that we have had—a prosecution we had in which the use of electronic surveillance was used.

Senator CHURCH. You are persuaded as a lawyer that your use of electronic devices was wholly within the law?

Mr. HYNES. There is no question about it. And it is necessary, too, Senator, because without that kind of corroboration, which is a prerequisite for any prosecution in New York State law, there would not be a prosecution.

Senator CHURCH. Senator Percy.

Senator PERCY. I will try to be very brief. I have a board meeting at 12 noon.

I would like for you to step out of your role of the law enforcement official and see whether you can philosophize for us for a moment on

why we have this situation, as you described on page 2, as the climate in the country where you say the exploitation of old people is a respectable and risk-free profession. It almost gets down to the point about the crime we have against old people in this country by youth.

"Sixty Minutes" had a marvelous program on the aged in the Soviet Union; the reverence the people have for the aging. They certainly have in Communist China. The Chinese have always had reverence for the aged.

Why is it in this society we have a condition where aged, particularly old poor, are often specific victims of exploiters as well as youth criminals?

Mr. HYNES. Senator, I have not met a defendant who has been convicted—20 have been convicted so far in our investigation—who really focused in on that precise problem. None of them believed they were doing evil to the old people. It was a question of dollars and cents.

The Federal and State Governments had thrown these massive amounts of money into the State. There was no enforcement. So it is difficult for me to step out of the enforcement area.

The fact of the matter is there was no enforcement. In New York State we had 60 auditors prior to 1975 to regulate the books and records of 2,400 facilities, including nursing homes, adult homes, health-related facilities, hospitals, and the like. And though there is substantial evidence that year after year they cried out for more auditors, year after year they were rejected and turned down.

THE "INVISIBLE" CRIME

That is one of the peculiarities of white-collar crime. That is why I suppose what I am asking for is a public change in attitude. Everyone can relate to the fear of mugging or the rapist or the murderer. That is something you see. That is something that is vivid and frightens you.

What people do not see, it has been my experience in organized crime investigations, is the lost-tax drain. The tax-money drain affects people every day in equally terrible ways, but people do not focus in on that. Nor do the defendants in white-collar cases focus in on that. They do not believe it is a question of personalities with human beings. It is dollars and cents. It is that simple.

Senator PERCY. Health care is one of the biggest businesses in this country, and it is essentially conducted, so far as hospitals are concerned, on a nonprofit basis. But when you cite, as you did yesterday, that half of the 125 nursing homes are engaged in kickbacks and fraud, payoffs, and so forth, how does that compare to other businesses in the private sector?

You have white-collar crime there, but would you not say it is a very small percentage of the total business that is done, as against the 50-percent here?

Mr. HYNES. I do not know, Senator. The practice of rebates is not an uncommon one. It could be anyplace in this country. Of course, the crime is committed if there is no report of it on State or Federal income tax. And in here the difference between this kind of rebate is

that the State of New York—we believe the investigation will show—underwrote the rebates.

Senator PERCY. But in this case, what is good for General Motors is good for the country. Can you imagine what would happen to half of the transactions carried on by General Motors if those who are somehow engaged in their purchases received kickbacks? You know there is a very, very small percentage of this going on because they have very tight controls. They have procedures that have been worked out through a period of years.

My own business experience reveals occasionally you do have a problem, but it is a rare instance when you get a case like that. Generally, your internal auditing procedures are such that no one would dare do it. The chances of doing it and getting caught are simply too great.

Here you imply the crooks are rushing into this business. Why is it then that HEW—why is it that our health organizations and our governments cannot set up procedures ahead of time?

You are proposing, and rightfully so, that you receive an increase in your budget, but that would promote enforcement after the crime has already been committed. Can we put equal emphasis at the beginning of this process? In student loans alone, HEW revealed we have $1 billion worth of unpaid, overdue accounts in the student loans out of $8 billion. That is a pretty high proportion.

TIGHT STANDARDS NEEDED INITIALLY

Any business would go broke if they had that percentage. They generally run around losses of 1, 2, or 3 percent. Wouldn't you say we really have to start at the beginning? When you set a program up, set it up in such a way that inducement for fraud, kickbacks, payoffs, and so forth, is miniscule because you set a very tight standard to begin with. Doesn't that lighten the load on law enforcement?

Mr. HYNES. I could not agree with you more.

Senator PERCY. You mentioned that in your undercover investigation in New Jersey, suppliers and vendors immediately contacted new nursing homes as soon as they opened for business to set up kickback arrangements. Is this a common practice then, in your judgment, in New Jersey and New York?

Mr. HYNES. At least in New York. We did not pursue it in New Jersey beyond the investigation.

Senator PERCY. You have indicated legislation would be desirable. What is the most urgent piece of legislation, in your judgment, that Congress should enact as early as we can in the 95th Congress?

Mr. HYNES. I was referring in that statement, Senator, to New York State legislation. One of the pieces of legislation I have asked the Governor's staff to work on to introduce in our next session is a very simple piece of legislation requiring vendor certification. You require a vendor to sign, under penalties of perjury, a confirmation that each item has been delivered to a nursing home.

In addition, in response to the other part of your question, we are looking at the possibility, which we do not believe is too compli-

cated, of setting up some kind of procedure within the State department of health in conjunction with our office to look into the standards of price lists throughout the State.

We believe it is a rather simple matter and subject to computerization to look at price lists over the State for the various goods and services given to nursing homes, and then have the computer capability of kicking back a voucher which is clearly beyond the scope of regular pricing.

Another part of legislation we are interested in getting is simply one directed to penalties. A nursing home operator, in one instance I think of, could be involved in kickbacks of more than $100,000 over a 2-year period, and the crime is a misdemeanor. The punishment for that misdemeanor is a year in prison.

Where a public official can take $5 for some activity in the State of New York, that is a felony. There does not seem to be equal justice in those kinds of situations despite the fact public officials—we demand from public officials higher ethics.

Senator CHURCH. Isn't that also true under Federal law that it is merely a misdemeanor?

Mr. HYNES. Yes.

Senator CHURCH. So far our efforts to convert it to a felony have not been consummated. We hope to do that next year.

Mr. HYNES. We are trying to draft legislation which would make it very much along the line of a private statute which we have for officials in New York.

Senator PERCY. I think that ought to be one of our high priorities.

Mr. Chairman, I have questions to put into the record and give Mr. Hynes a few remaining questions [1] so we can bring on Mr. Skinner.

I want to express my appreciation to you and our colleagues for being with us.

Senator CHURCH. I have just one final question. It is something that still puzzles me.

When a banker embezzles $300 from a bank and he is indicted for it, it is not uncommon for him to be sent to jail. Or if it is $1,000 or $5,000, jail sentences for embezzlers are not infrequent.

EMBEZZLEMENT VERSUS MEDICAID FRAUD

Is the reason that judges are reluctant to impose jail sentences for medicaid fraud—in these cases much larger sums of money—the fact the money is stolen from the Government rather than from private banks or private businesses? Do judges feel stealing from private institutions is punishable by jail sentences, but stealing from the Government is such common practice one should be content to impose a fine and let it go at that?

Mr. HYNES. Senator, I have practiced in New York State, New York City, the better part of 14 years on both sides of the fence, as a defense lawyer and prosecutor. I cannot believe that for a moment. It is simply a matter of judicial attitudes. I firmly believe we have decent people on the New York bench to change this attitude.

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[1] See p. 787.

In Erie County—Buffalo—we convicted a nursing home operator of extortion, whose common practice was to take the parents of the victims into a disgusting part of his complex which was literally a sewer, and indicate, because medicaid had such God-awful regulations, he could not afford to keep mom and dad in the decent part of the facility, but for $150 or $200 a month under the table, he would be glad to accommodate him. No one came to us until after the mother and father died.

Then he was prosecuted and convicted. He was given a sentence of 3 years on each of the counts to run consecutively. The judge in that case said, "I find no distinguishable difference from someone who mugs in the street and someone who would mug in a nursing home."

By the way, last week the appellate division unanimously affirmed that conviction and the day before yesterday a court of appeals judge, which is the highest court, declined a review in that case, and the defendant will begin serving that 10-year prison term on Friday.

I think the attitudes can change.

Senator CHURCH. Do you think more frequent prosecution in this field will have the effect of changing judicial attitudes? Is it that so few cases have been brought or so few prosecutions have been brought that accounts for the light sentences?

Mr. HYNES. The key is exposure, what your committee is doing, has been doing, it will have an impact; what the media has done will have an impact. It is a combination of things, Senator.

Senator CHURCH. Thank you very much.

Mr. HYNES. Thank you very much.

[Mr. Hynes' letter in response to Senator Percy's questions follows:]

STATE OF NEW YORK,
SPECIAL PROSECUTOR FOR NURSING HOMES,
HEALTH AND SOCIAL SERVICES,
New York, N.Y., December 9, 1976.

Hon. CHARLES H. PERCY,
U.S. Senator,
Dirksen Senate Office Building,
Washington, D.C.

DEAR SENATOR PERCY: Enclosed below is the additional information you requested following my testimony before the Special Committee on Aging of the U.S. Senate. I am pleased and gratified by your interest and I hope this information will assist you and the committee.

You addressed to me four specific questions:

(1) *How does your office coordinate its efforts with those of the New York Department of Health?*

To avoid duplication of effort, a memorandum of agreement was executed between our office and the State health department. The memorandum provides for mutual consultation before targeting audit work. Pursuant to that agreement our initial responsibility is to concentrate on investigation of all proprietary nursing homes in New York State. The State health department is responsible for the auditing of voluntary nursing homes and referring any cases of fraud to us. Our work dovetails with and complements the program of the State Health Department.

Also, pursuant to that agreement, we have spent considerable time in joint training sessions with the State health department. Our training was conducted by an auditor, investigator, and attorney, each emphasizing the experience of their particular discipline and how it was helpful to the health department auditors. The State health department sessions for our office's auditors were conducted by a rate setting supervisor and a field audit supervisor, again each giving the benefit of their expertise.

We have conducted a series of unannounced ongoing inspections with the State health department throughout all seven regions (New York City, Long Island, Syracuse, Rochester, Westchester, Albany, and Buffalo), of the State. We believe these joint inspections have contributed to the upgrading of standards of care in nursing homes and health related facilities.

Finally, we refer to the State health department for civil recovery of all our audit findings. We often work with the State health department in the recovery process. We also work with the department on legislative matters of joint interest.

(2) *To what extent have you worked with appropriate agencies in other states?*

We have worked with many agencies in other states. The Attorney General's office in Ohio, the State Attorney's Office in Dade County, Florida, the State Commission on Investigation in New Jersey and the Criminal Division of the United States Attorney's Office in Boston, Massachusetts are some prominent examples. Representatives from various law enforcement and monitoring agencies from the States of Michigan, Colorado, New Hampshire and Maryland have been to our office to learn about our investigation. My office is committed to providing law enforcement agencies outside New York State with the experience and expertise we have developed over the past two years in investigating this massive, on-going white collar criminal conspiracy.

As I mentioned in my recent testimony before the Senate Special Committee on Aging, many of the targets of our investigations have operated across State lines. As a State prosecutor, I am unable to follow them once they leave New York. Despite the aid and goodwill I have received from other jurisdictions, their cooperation is necessarily limited by their lack of available staff, particularly in State agencies.

(3) *How does the existence of kickbacks among some vendors affect competition (i.e., between independent suppliers who could provide the service but will not offer kickbacks)?*

There is no doubt that these schemes completely undermine normal business competition. No honest supplier, however efficient, can sell in a market where fraud against the government gives his competitor 25 percent to 35 percent cost advantage. We have numerous claims (admittedly self-serving) that these practices had to be engaged in to meet the competition. It is a Gresham's Law situation of dishonest practices driving out honest ones.

(4) *Could you estimate how much money we could save the Government and patients if we could eliminate the numerous kickback schemes?*

A full estimate is impossible. We are still actively investigating, so the extent of these schemes is uncertain. They impact on the reimbursement of each home differently, but in New York State, approximately $250 million of the annual cost of nursing home care are for vendor supplied services. Even if these schemes turn out to be largely limited to the New York City metropolitan area, (where some vendors were in 50 percent of the homes), the dollar volume they could be inflating is enormous. The normal kickback, as I described, is 25 percent to 35 percent.

However difficult it is to state a figure, there is no doubt of the harm they cause. The elderly suffer in the Medicaid kickback schemes among vendors and nursing homes because they receive something less than the full dollar amount of goods and services to which they are entitled. The taxpayers also suffer—as it is from their pockets that the kickbacks are reimbursed. And finally, though no less importantly—the honest vendors also suffer.

The problem is pervasive as it not only diminishes the income of those wishing to conduct their businesses with integrity, but the financial gains of those engaging in illegal schemes discourage the honest vendor and ultimately lead to a weakening of his resolve.

Thank you again for your interest and for making available to me the opportunity to assist you and the other committee members by sharing with you my experiences in dealing with medicaid fraud.

Very truly yours,

CHARLES J. HYNES.

Senator CHURCH. Our next witness is Mr. Samuel Skinner, U.S. attorney, Northern District of Illinois.

STATEMENT OF SAMUEL K. SKINNER, U.S. ATTORNEY, NORTHERN DISTRICT OF ILLINOIS

Mr. SKINNER. Mr. Chairman, Senator Percy, although I am here alone and I have submitted my prepared remarks [1] to the committee I would like to just mention a couple people who should be here with me because they have been putting forth the efforts, including helping me with that report as late as last night. They are busy taking pleas today in nursing home cases. I think it is best we get more convictions and sentences. Bill Elybury, Glynna Freeman, Tom Johnson, and a number of other people in my office have been working very hard.

I am going to depart a bit from my prepared remarks because of the time and because I think what I said in there would be repetitious of what has already been said.

I have been a prosecutor for 8 years; almost 9. Before that, I had been in business working for the IBM Corp. in computers and systems. So in my remarks today, I think I have tried to add a little bit of my experience in both these fields as I go forward.

I have been a U.S. attorney since June 30, 1975. When I first became a U.S. attorney, having served in the office 7 years, it became quite apparent to me that fraud in Federal social programs was increasing at a very alarming rate.

I was interested to hear Senator Percy comment about the student-loan program. Medicaid and medicare are a major problem in my district, but VA-loan programs, SBA programs, FHA housing programs, food stamp programs are of equal importance and have equal problems.

FIRST FRAUD UNIT IN NATION

I set up and have still in existence the first governmental fraud unit in the Nation to address these problems. It started with four lawyers. It now has 10. These are not new resources, Senator Church. They are resources I have allocated for my existing staff.

The Congress has not seen fit to increase the budget too much for U.S. attorneys, and they are in dire need of additional resources. But we felt that it was a problem which had to be dealt with, so we reallocated and just did not prosecute some cases of a minor nature so we can address this problem.

We empaneled a special grand jury under the act of 1968 and 1970 that Congress gave us. It is for 18 months and meets three times a week, all day, addressing these problems. About 50 percent of their time is spent on medicaid problems.

We use immunity and plea bargaining very extensively. I would like to at least make this comment for the record because, as you are well aware, there are efforts in the Senate and House to cut back substantially on the Federal grand jury bill and the rights and effectiveness of Federal grand juries. If they do that, it will have a direct effect on our ability to perform in areas such as this.

We would not have been able to receive the convictions, the fines, the jail sentences across the board. We would not have been able to make the cases through use of the grand jury, through use of immu-

[1] See p. 792.

nity, through use whenever necessary, of court-ordered wire taps, consensual monitoring, pursuant to the law. Our overreaction to Watergate, I hope, will not become a major problem for prosecutors who have a very difficult job to do.

We have used statutes that exist on the books. We have very few laws that directly deal with this problem. We have used existing criminal statutes. We have 1396(h), the kickback statute, and did receive our first convictions.

We have also used a statute that was designed primarily for corrupt organization and organization activity called RICO, which allows us to not only file criminal charges of a felony nature where there are repeated activities of illegal kickbacks in nursing homes, it also allows us to criminally forfeit to the Federal Government the interest in the nursing homes, the clinics, the proprietary interests, subject, of course, to liens.

We find this to be a most effective deterrent against others. Last week we received evidence of $50,000 in kickbacks between nursing homes and druggists that we were able to prove. We were able to obtain jail sentences of anywhere from 60 to 90 days on a plea of guilty, plus fines of $900,000 from these nursing homes—without any evidence, that we were able to develop, of the Government actually being defrauded, because in Illinois the bills are submitted directly to the State by the pharmacist.

Kickbacks May Affect Quality of Care

I am not so sure, however, that in generating the kickbacks the pharmacist might not have to take steps that would decrease the inherent quality of care. We just were unable to prove it.

I think that demonstrates the importance in a strong deterrent in these crimes. These people are removed from the programs. They control about a third of the nursing home industry in northern Illinois. So we have gotten some good results. We found the same experiences in nursing homes that Special Prosecutor Hynes found in kickbacks on a regular routine basis.[1]

Senator Moss's report of the subcommittee is one of the first things I read back in 1975. The information in that report was 2 and 3 years old. It was almost like a book of how kickbacks operated in Illinois. His light and the beacon this committee set out was not seen for some time. I am glad it has been seen now, because that subcommittee was right on the money as to what was going on. You will recall that was in California and other States as well.

We have also seen activities in what are known as the medicaid mills. A number of people have been indicted. There are all kinds of allegations that are now pending before district court. The indictment we have with one of the biggest medicaid mills in Illinois, 26 organizations in one conglomerate. We found everything, from the drawing of excess blood so the samples can be sent several places for several analyses and then billed to the State.

We found people were seeing every station and every doctor within the clinic, even though they did not need to see them. We found a

[1] See "Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 2, Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," Subcommittee on Long-Term Care, Senate Special Committee on Aging, issued January 1975.

number of labs were doing tests on a number of occasions but with the same samples.

We found radiologists were examining the same X-rays four and five times and billing the State. The fraud in medicaid mills in the clinics, in the northern part of our State is, in my opinion, greater than the fraud that existed in the nursing homes. It directly relates to fraudulent billing and fraudulently obtained Federal funds.

We also have other investigations underway in optical services. We found families, entire families, received four and five pairs of glasses in a year. I might add, a low-caliber glass at that.

We found dental situations of overbilling under dental care. They are the most difficult cases to develop because you have to have a dentist actually look at the patient to see if the work was done. X-rays are taken at several different times and they are billed for the same analysis as the one X-ray.

"Lists Sold to Highest Bidder"

Overbilling; sale of Medicaid numbers. It is interesting to see, once a list of medicaid numbers is developed by a State, these lists are actually sold in the State of Illinois to the highest bidder. They use those numbers, without the medicaid patient even knowing it, to submit bills to the State.

We also found additional problems in the area of factors because of the delay in payments, the need of cashflow by the clinics and doctors, they go to factors who then inflate the bills before they forward them to the State for payment.

These are all problems that exist in the medicaid program. I believe they exist not only in New York, Chicago, but in other major cities throughout the Nation.

I am going to, for a minute, discuss why I think this happened, because I think as you discuss national health insurance in this next session of Congress it would be suicidal to go forward in a national health insurance program when we have not demonstrated to the American taxpayer we can handle the program we have already implemented.

No prior plan, no test marketing, no trying out of a program with regulations before we announce it on a nationwide scale. No corporation worth its salt in America would market a product like medicaid without testing it first. No standards which could apply on a nationwide level.

Everyone should have the same standards they can operate under. No auditing function, no oversight by Congress, no audit of any substance by the Bureau of Health Insurance or HEW and no mandating by Congress upon the States of an audit function, yet they begin paying bills.

We have in the State of Illinois one auditor, a total of five or six Midwestern region States in the Midwestern region of HEW are responsible for several billion dollars worth of HEW programs.

We had one auditor for Illinois until recently. They cannot do the job. It is just beyond imagination that you can ask anyone to do that.

The State does not have the facilities as well. They begin overnight to start spending the money with no existing program to implement or administer the program.

Finally, there is no gradual phase-in. They should gradually phase in these programs and grow with them so we can handle these programs. Overnight we started spending in my State, almost a billion dollars. Then when the program is in existence, we have virtually no audit function at all, no audit function from HEW's viewpoint.

Fortunately the Senate, in my opinion, has done more, and your committee and the subcommittee has done more to audit these programs and bring them to the public's attention than anyone else within any of the branches of government. It is unfortunate it has taken so long for the message to get across. This is imperative if these programs are going to be implemented, and they are going to be successful.

"EASY TO DEFRAUD THE GOVERNMENT"

We have no disclosure or qualification standards for providers. I have individuals who are now in the health care industry in Illinois and have been the subject of convictions recently, who, several years ago, were not only not in the health care business but had no positions of responsibility in the community at all. They saw that it was easy to defraud the Government and they got on board. Now they are making several hundred thousand dollars a year. There is no disclosure of financial interest. There is no true demonstration of who owns these various organizations.

In many cases they are sweetheart arrangements with the same ownership. We have no disclosure. I think that is imperative.

I also think we have got to address the problem at the congressional level about prosecution. And at the Federal level it is a major job. The resources are limited. There are a number of other problems that have to be dealt with. Task forces do exist in the area of FHA and HUD housing. Task forces do exist in the area of narcotics. Congress specifically appropriated funds, as you recall, for a program to deal with the drug problem. I think it is important, as Congress goes into its next session, that they give consideration to the allocation of resources or at least some demonstration of desire by Congress that a certain portion of any new resources be dedicated to this area of Federal social program fraud, especially in medicaid.

[The prepared statement of Mr. Skinner follows:]

PREPARED STATEMENT OF SAMUEL K. SKINNER

One measure of a free and democratic society is the nature and breadth of governmental services afforded its citizens. Judged by that standard, the panoply of Federal agencies which provide jobs, housing, health care, and social services in this country stands as a tribute to our Nation's commitment to an ever improving quality of life for all.

To keep pace with that commitment, financial resources of staggering proportions have been and will continue to be applied. For instance, the Department of Health, Education, and Welfare spends over $2 billion a year on over 150 programs in Cook County alone, a substantial portion of which is allocated to the medicaid program.

Regretfully, noble motivations and lofty goals do not automatically translate into meaningful and successful social programs. On the contrary, the 1970's

have witnessed the greatest ripoff in history as literally millions of dollars in hard earned and sorely needed tax dollars have been mismanaged, squandered, wasted and stolen from federally funded health care programs. As a result, Federal health care programs have become a mockery and simply do not provide the quantity and quality of medical services which the poor, the sick, the disabled, and the old, both need and deserve, and which Congress intended to provide. This national disgrace is the byproduct of two basic conditions: (1) health care programs are typically conceived, initiated and continued without regard to adequate internal and external controls, and (2) corrupt profiteers are at the ready, seeking opportunities to line their pockets at public expense.

The obvious need not be belabored—our citizens are entitled to better medical treatment and a more effective utilization of their tax dollars.

I wish to turn now to the experience of the Northern District of Illinois in the identification of, and response to, such problems on a district wide basis. In July of 1975, I stripped other units in my office of four of my most experienced Assistant U.S. attorneys to form the Nation's first Governmental Fraud Unit. This unit was established as the first phase of an effort to combat what I then believed to be a major fraud problem in the Federal and federally funded social welfare agencies, including medicare-medicaid fraud. At our request, the chief judge of the district impaneled an 18 month special grand jury to hear nothing but such cases. We began this project prepared to use the full array of traditional criminal statutes including bribery, mail fraud, wire fraud, false statements, conspiracy and interstate travel in aid of racketeering as well as civil injunctions and recoveries and (for the first time in this District) the RICO provisions of title 18. At present, the grand jury is meeting as often as three times a week, major indictments and convictions have been obtained and over 20 separate areas are under investigation. I now have 10 highly experienced assistant U.S. attorneys working full time on Governmental Fraud and the problem demands more. What appeared to be only a "major" problem 16 months ago is now more accurately seen as a mother-lode of fraud and corruption within medicaid and medicare programs.

In order to illustrate the nature and extent of this problem, allow me to turn for a moment to some individual areas of program abuse which have received a great deal of attention in my district. For obvious reasons, I shall not discuss particulars of cases currently under investigation or indictment. As to those cases, I draw no inferences or conclusions which are at odds with the presumption of innocence.

THE NURSING HOME EXPERIENCE

Since February 1975, my office has been investigating pharmaceutical kickbacks paid to nursing homes and their principal owners for the privilege of obtaining the pharmaceutical business of medicare and medicaid patients at those homes. Two indictments (76 CR 96 and 76 CR 355) charging violations of RICO (18 U.S.C. 1961 et seq.) mail fraud (18 U.S.C. 1341) and medicaid "anti-kickback" misdemeanors (42 U.S.C. 1396(h)(b)(1)) were returned by the grand jury.

Within the last week, five nursing home owners have each entered pleas of guilty to 38 counts of mail fraud and 18 misdemeanor counts as charged in these indictments. (Two nursing home owners and four pharmacists are presently awaiting trial). Two pharmacists have also entered pleas to the misdemeanor kickback statute and are awaiting sentencing. The sentences imposed on the nursing home defendants were as follows:

(1) Three were sentenced to 90 days incarceration and one was sentenced to 60 days incarceration, to be followed by 21 months probation. One was sentenced to two years probation due to his age and heart disease.

(2) In addition to incarceration, four of the defendants were individually assessed $200,000 fines and one was fined $100,000, totalling $900,000 in fines.

These jail sentences and stiff fines, being the largest ever imposed on individuals in the northern district of Illinois in any type of case, were the result of plea negotiations with the U.S. attorney's office. The severity of the sentences and fines represents our commitment to end the rather common practice between pharmacists and nursing home owners of paying kickbacks in connection with obtaining public aid pharmaceutical business.

I. The conduct discovered

The conduct alleged in the two indictments disposed of consists of a pharmacy paying monthly kickbacks to the principal nursing home owners via a management company. The amount of the kickback was, at least initially, calculated on a set amount ($3.00 to $6.00) per public aid patient per month in a home serviced by the pharmacy. In other investigations the form of the kickback payment is made under the guise of rent, consulting fees, fraudulent credit memos, loans and cash. The result of such kickback schemes is that the pharmacy must provide the same services for less money, the State and Federal government receive no financial benefit, the quality of services to medicaid patients suffers actual or potential harm, and the nursing home or its owners receive benefits over and above what they are entitled to under payment schedules established by the State. Regardless of whether the kickback is offered or required, it interjects a criteria or qualification for the pharmacist's employment that has either nothing to do with, or is counterproductive to his quality of service to the patients. In choosing a pharmacy, the nursing home owner is inclined to be motivated by which pharmacy is most willing to pay, and can best afford, the kickback, rather than by which pharmacy can best service the home's patients. Due to the financial pressure placed on the pharmacy, the kickbacks may result in the following practices:

(1) Hiring of less expensive unlicensed pharmacists to fill prescriptions;

(2) Failure to comply with regulations imposing certain duties on the pharmacist, such as checking patient medication charts to detect administration of incompatible drugs, training nursing home personnel in procedures for dispensing pharmaceuticals, and acting as a consultant to the home;

(3) Requesting and obtaining prescriptions not necessary to the patient's case such as vitamins;

(4) Billing for prescriptions not delivered; and

(5) Substituting less expensive generic drugs for prescribed brand names, but billing the State for the more expensive brand name.

In other words, the payment of the kickback causes the pharmacist to at least cut corners on the quality of the services he performs, if not engage in false billing. The patient or the Government, if not both, suffer.

II. Theories of law

To our knowledge, these cases are the first enforcement of the medicaid "anti-kickback" misdemeanor. (42 U.S.C. 1396 (h)(b)(1)). Although the offense is a misdemeanor, imposing a maximum term of 1 year incarceration, it does provide for a $10,000 fine. This heavy fine penalty enabled the court to impose the substantial fines in the instant cases. The medicaid misdemeanor also serves as a basis for the mail fraud theory.

The defendants in these nursing home indictments were also charged with using the U.S. mails to defraud the Government of its right to have its medicaid programs conducted honestly, fairly, free from deceit, corruption, bribery and kickbacks. The existence of the medicaid misdemeanor demonstrates the congressional intent to outlaw kickbacks among providers of medicaid services. The nursing homes, by entering into an agreement with the Illinois Department of Public Aid, agree to follow the regulations and statutes which guide the medicaid program and agree to accept the money allotted by the State as full payment for that provider's care of the medicaid patient. Thus, by giving and receiving a kickback, the pharmacists and nursing home owners are violating the duty to abide by the medicaid regulations, a duty which they voluntarily assumed by entering into a provider agreement with the state.

Finally, the defendants were charged with violating RICO and conspiring to do so (18 U.S.C. 1962(c) and (d)). Section 1962(c) makes it illegal to utilize an enterprise (such as a nursing home, pharmacy or management company) which affects interstate commerce to perpetrate a "pattern of racketeering activity" which includes two or more mailings in furtherance of a scheme to defraud. In addition to a possible 20 year sentence and $25,000 fine, RICO (18 U.S.C. 1963) provides for the criminal forfeiture of the enterprise which was unlawfully used. In other words, the defendants could have suffered the forfeiture of their interest in the nursing homes or pharmacies, which were used in furtherance of the scheme to defraud the Federal Government. Although these counts were dismissed by the Government, the amount of fines imposed reflect the impact of this possible liability.

The defendants in the cases pending were charged with receipt of a total of approximately $50,000 in kickbacks. They were fined $900,000. The message: no matter how enticing, the kickback isn't worth it.

THE CLINIC/LABORATORY EXPERIENCE

Since its inception, the Governmental Fraud Unit has worked closely with Federal Bureau of Investigation agents and Postal Inspectors in an intensive investigation into allegations of fraud and corruption among Chicago area providers of medical services under the medicaid program. This investigation has revealed fraud, dishonesty, and corruption within the medicaid program, similar in virtually all respects, to the activities revealed in the Staff Report prepared for this subcommittee and submitted by a Letter of Transmittal dated August 30, 1976.

In September 1976, as a result of this on-going investigation, 10 indictments were returned by a Federal grand jury charging various medical providers, that is, doctors, pharmacists, clinical laboratories, and related officers, shareholders and employees with various violations of Federal law. In a 66 count indictment, 13 individuals, including a medical doctor, three registered pharmacists, and executives and employees of 28 medical clinics and pharmacies were charged with conspiracy to defraud the United States and with mail fraud. In addition, three defendants were also charged with conspiracy to solicit and receive kickbacks from clinical laboratories to which laboratory work was referred. Seven defendants were named in RICO counts which charged a pattern of racketeering activity designed to defraud the United States and the State of Illinois out of the fair and honest administration of the medicaid program. The 28 medical clinics and pharmacies identified in the indictment and which are subject to forfeiture to the United States are located in the more economically depressed areas of the city of Chicago where the great majority of medicaid recipients reside. These clinics and pharmacies are reported to have grossed in excess of $15 million during the last 3 fiscal years. The majority of the work handled by these clinics and pharmacies is Medicaid funded.

The indictment charges diverse and imaginative procedures utilized to generate excessive work and commensurate fees. Among the activities alleged in the indictment are:

(a) Generation of a certain monetary amount of laboratory analyses and tests regardless of or in the absence of medical necessity;

(b) Administering a certain number of electrocardiograms and X-rays regardless of or in the absence of medical necessity;

(c) Issuing a certain number of prescriptions regardless of or in the absence of medical necessity;

(d) Directing patients to all doctors and medical specialists regardless of or in the absence of medical necessity;

(e) Ordering additional and unnecessary laboratory tests and analyses without regard to or in the absence of medical necessity;

(f) Forcing and requiring medicaid patients to submit to blood specimens;

(g) Mislabelling excess specimens from some patients for submission to laboratories for analyses under names of other patients from whom specimens were not obtained;

(h) Substituting and submitting their own blood specimens, urine specimens and throat cultures for laboratory analyses as the specimens and cultures of Medicaid patients from whom such specimens and cultures had not been obtained.

(i) Prescribing and dispensing no less than a minimum number of drug and nondrug items to medicaid patients;

(j) Prescribing and dispensing drug and nondrug items for which the Medicaid program provided the greatest compensation;

(k) Prescribing large sizes and quantities of certain drug and nondrug items but dispensing only small sizes and quantities of such items and thereafter billing the State of Illinois for the prescribed but not dispensed sizes and quantities;

(l) Prescribing certain specific drug and nondrug items but dispensing different, less expensive drug and nondrug items, and thereafter billing the State of Illinois for the prescribed but not dispensed items;

(m) Executing prescriptions in blank, in whole or in part, to facilitate the dispensing of drug and nondrug items without regard to medical necessity; and

(n) Prescribing and dispensing drug and nondrug items without regard to medical necessity.

This indictment resulted from a year and a half of grand jury work and lawyers' time, as well as thousands of manhours of effort by agents of the FBI and extensive cooperation by the Illinois Department of Public Aid.

OTHER INDENTIFIED AREAS OF ABUSE

The wide ranging investigations of the Governmental Fraud Unit have identified a variety of other areas of medicare-medicaid fraud. The extent to which corruption exists has not yet been accurately determined in these areas which include the following:

(1) Optical services: bills submitted to public aid a welfare family. Many optometrists who work for optical companies are paid by the hour and had not previously been advised of the dollar volume of bills submitted by their employer. This practice has only recently been corrected by the Illinois Department of Public Aid.

(2) Dental services: proving fraud and overbilling in this area is extremely difficult because aid recipients must be identified, located, and examined by a dentist and a comparison of their billings and actual dental work made.

(3) Radiological services: bills are submitted for numerous X-rays for a patient when in fact only one X-ray was taken.

(4) Overbilling by doctors, podiatrists and other health providers for services never rendered: the extent of this fraud cannot be accurately determined.

(5) The sale and distribution of medicaid numbers to health care providers: once a medicaid provider receives the medicaid numbers and names of public aid recipients, he is able to submit bills to the medicaid program without the knowledge of the medicaid recipient, without having met the recipient, and without having performed the services billed. Such information is readily available to various providers in that each time a medicaid recipient appears at a hospital, medical center, or other provider, he must provide this information. Once a provider has this information, he may exchange it with other providers or this information can be collected by various employees of hospitals, medical centers, etc. and sold to other providers. The extent of such abuse is unknown.

ADDRESSING THE PROBLEM

I do not presume to hold the panacea to all the infirmities of our nation's health care programs. The experience of the U.S. Attorney's Office for the Northern District of Illinois in the area of Governmental Fraud, however, has led to the formulation of a number of suggestions:

A. Program initiation

Health care programs which are conceived and initiated with the most miniscule attention paid to program control and provider qualification are an open invitation to thieves and quick buck artists. The lesson to be learned is that problems are created, not solved, by blindly opening the cookie jar. Well planned and coordinated programs must be staffed by competent people and tested on a limited basis before full implementation. Internal and external audit controls as demanding as those utilized by private industry, as well as uniform nationwide regulations must be in place at a program's inception and must expand as the program expands. Providers should gain entry to a program only after demonstrating professional qualifications and disclosing their economic interest in all areas of health care.

B. Program continuation

Functioning programs must be subjected to audit and review on a continuing basis. Economic interest and ownership data for each provider should be resubmitted under oath every year. This information should include all direct and indirect benefit, income and interest and should be cross-referenced by the agency. Audits of providers' billings as well as their own books and records should be periodically conducted as should reviews of patient care itself. Such reviews should be coordinated to include related providers such as doctor,

clinic, laboratory, pharmacy, and patient. Patients should be routinely advised of the goods and services billed on their behalf (as is done in the medicare program). Standardized computer programs should be designed which will catalog provider, recipient, and billing information. Questionable trends and suspect patterns can be automatically red-flagged and targeted for investigator follow-ups.

C. Other manpower needs

The Department of Health, Education, and Welfare expends $25 billion in the Fifth Region covering six States, yet there are only five investigators assigned to investigate fraud. This investigative force is so understaffed that it has no hope of obtaining or maintaining any handle on the fraud which appears to exist. No entity of private enterprise would allow the expenditure of such sums of money without providing for a far more meaningful watchdog.

Due to the past failure to supervise the medicaid program, a task force composed of experienced prosecuting attorneys, investigative agents, auditors, and members of the medical professions should immediately be formed in each major district. For assurance of long range viability of these programs, however, a permanent force of investigators, auditors and medical experts must be born and nurtured.

1. The task force

In the Northern District of Illinois, I have assigned eight assistants to supervise investigations and prosecute medicaid-medicare fraud abuses. To support this team I would suggest a task force of investigators including postal inspectors, IRS special agents, agents of the FBI, and HEW investigators assigned solely to investigate this fraud and free to exchange the information gathered. Included in this task force must be accountants experienced in reviewing and digesting complicated books and records of large business enterprises; experts in various medical fields, i.e., doctors, dentists, optometrists, podiatrists, pharmacists, etc., if only on an "of counsel" basis; experts in the procedures of each State's program with knowledge not only how the State's medicaid program works, but also how to obtain or retrieve information from the State's records or computers; experts from HEW, well versed in the Federal regulations governing these programs, and capable of explaining them to a jury of laymen. To coordinate each district's efforts, a central source of information for all districts should be established.

2. Permanent supervisory staff

Never again should Congress allow a program to grow to the present day size of medicaid and medicare without a meaningful supervisory force to prevent or minimize fraud. This does not mean that "busy work" regulations or procedural requirements should be imposed. However, a force of attorneys, accountants and investigators must be maintained if this committee's dedication and hard work is to have any long range impact.

3. GAO

The venerable and effective watchdog ought to play a major role in insuring that controls are followed and standards adhered to.

D. Statutory changes

The only statute aimed solely at medicaid fraud is 42 U.S.C. 1396(h). This statute is two pronged, prohibiting false statements or false billings and prohibiting kickbacks and rebates. The anti-kickback section has apparently not previously been enforced. Applying this section of the statute has highlighted several problems which could be eliminated by the legislative process.

Unlike any other statute, the terms "kickback" and "rebate" are used without definition. In Illinois, a pharmacist, providing services to nursing home medicaid patients, bills the state directly for those services. The payment of monies by the pharmacist to the nursing home owner cannot be a discount, since a discount must go to the entity paying the bill, i.e., the State and Federal government. Thus, it can be properly labelled a kickback. In other States, and in the medicare program, however, the pharmacist bills the nursing home, which in turn incorporates the pharmaceutical costs as a part of its bill to the State or Federal government. The payment of monies by a pharmacy to a nursing

home, if reflected in its books and passed on to the governmental sponsor, could be a legitimate payment. Thus, conduct which is a crime in one State, is not a crime in another. Only uniformity in programs and/or more specific definitions of terms can avoid this possibility of confusion.

Second, the statute is imprecise in describing who is liable. The statute prohibits anyone who "furnishes items or services to an individual for which payment is or may be made" under the medicaid program. Does this language make liable only those individuals or entities who have a provider contract with the State or does it include individuals or entities who serve the medicaid patients but submit their bills through another individual or entity rather than directly to the State or Federal government? In *United States* v. *Lipman, et al.* both the pharmacy and the nursing home had provider agreements with and independently billed the State, so this issue of interpretation did not arise. Assume, however, that the pharmacy billings had gone through the nursing home to the State for payment. If so, would the pharmacy and its owners be liable under 1396(h) (b) (1) for offering and giving a kickback to the principle owners of the home via a management company? The impact of this conduct would be equally detrimental to the medicaid program, but arguably is not in violation of the law.

Finally, there is the issue of whether the medicaid misdemeanor should be elevated to the status of a felony. The answer is yes and no. The misdemeanor, imposing minimal incarceration but substantial fines, plays an important role in the world of a prosecutor. On the other hand, some individuals are involved in numerous homes or pharmacies or clinics and merit felony convictions due to the size of their impact on the medicaid program. In the false billing arena, the prosecutor can use 42 U.S.C. 1396(h) (a), the misdemeanor proscribing false statements in the medicaid program, or 18 U.S.C. 1001, the felony proscribing false statements to any Federal agency, or both. In the kickback arena, we have used mail fraud as the felony charge, rather than 1001. If Congress desires to more directly enable Federal prosecutions of kickback payments in all Federal programs, we suggest a general "anti-kickback" felony statute applicable to all Federal programs in addition to the existing misdemeanor statute.

CONCLUSION

The spectre of flagrant corruption cannot be more disturbing than when it strikes at the heart of our Nation's system of health care. With national health insurance looming as tomorrow's probability, our track record in health care fraud must be eliminated as today's disgrace. I respectfully urge that measures be taken and resources be committed to immediately remove the pall of decay from the programs which could and should guarantee a meaningful quality of life for all our people, and a standard for civilized nations to follow.

I would like to take this opportunity to commend this committee and especially Senator Frank Moss. I have been somewhat critical of Congress in my remarks for failing to anticipate these problems and for failing to provide adequate controls and oversight. This committee and the subcommittee under Senator Moss' direction identified many of these problems at their inception. Their warnings were like a beacon from a lonely lighthouse warning of danger. It is too bad we did not see this beacon sooner. The people of our Nation owe this great American a debt of gratitude for lighting the way.

Senator CHURCH. Thank you. May I ask a question?

Mr. SKINNER. Yes, sir.

Senator CHURCH. Our last witness suggested that a special division of the Justice Department be set up for this purpose. He also alluded to the Internal Revenue Service where the enforcement agency has developed something of a formidable reputation. People, therefore, hesitate to fudge on their income taxes.

Do you think it would be more effective to set up an enforcement division within HEW connected directly with the medicare and medicaid programs as the principal enforcement agency for developing the evidence and preparing the cases that would then be turned over

to the Federal district attorneys in their respective jurisdictions? Or would you agree with our previous witness that it ought to be done as a part of the Justice Department, itself?

Mr. SKINNER. No. 1, there are several alternatives, I think, that would accomplish the same thing. I obviously am not here speaking for the administration regarding their policy. Although, as a member of the advisory committee. I know the U.S. attorneys almost unanimously feel they should be given the resources and be told, you can do the job rather than putting another structure of bureaucracy into the system.

I think one agency can play a major role. It has in Chicago. In this situation it is the Federal Bureau of Investigation. As you know, that agency has been shutting down some of its surveillance activities and it has been shifting its emphasis to the white-collar crime area. They have proved very effective.

TASK FORCE APPROACH MAY BE EFFECTIVE

I think a task force approach with people from HEW, people from the State of Illinois, with accounting talent where necessary, either internally on the payroll or externally, along with prosecutors within an office forming a task force under the auspices of the U.S. attorney who is concerned and given a mandate by both Congress and the administration to do something about the problem is probably as effective as any way that can be used. And I think it keeps the structure and allows it to permit new resources to react to the problem.

When we set up separate structures, just as you were talking a few minutes ago with Prosecutor Hynes, if he finds evidence of medicaid mills as part of his nursing home investigation, he has to give it to someone else.

With a task force approach addressing the whole problem of medicaid fraud and Federal social program fraud in a specialized area, I think you can have a flexibility under the auspices of the U.S. attorney with guidance from the department on a national policy basis to react to the problem and put whatever resources are necessary into the problem and to deal with the problem.

When you set up separate structures, you limit it. The talent is there. I am convinced, from other Federal agencies or from the outside, we can hire the talent to perform this function.

It is really two functions, Senator Church. The prosecutorial function as a deterrent for the future, but also if we did not set up enough internal audit at the beginning or during the continuation of these programs, it certainly is not too late to set that up now because it appears these programs are going to be around for a long time.

Senator CHURCH. Senator Percy, I know you are under some time constraints.

Senator PERCY. Always we say the Federal Government has to do more or the State government has to do more. What is the matter with our private associations in this country; the American Medical Association, the American Dental Association, the Association of Auditors and Accountants? Every one of these nursing homes, every one of

these businesses has to somehow have an audit; a public accountant that comes in. Why can't they catch these things? Why can't the profession itself, as being so stained by these revelations, really do something about it?

Like the American Bar Association, I think can really move on these things. There are ethical practices and standards groups. Can't they move to see that doctors and dentists who participate are taken out? What can they do, the private sector, that does not take appropriations and more bureaucracy? They keep condemning Washington and they come around here, "We have a problem." "We have to have a bigger bureaucracy, more investigators, more Government employees to stamp this out."

What can we do in the private sector?

Mr. SKINNER. I think the private sector can and does play a role in this function where only the State medical system has the ability to discipline physicians. The department of registration has a way to remove their right to practice in the State.

"BUREAUCRACY . . . ALREADY IN EXISTENCE"

But very frankly, Senator, I am going to disagree with you, as we do occasionally, because when we adopt these programs, the bureaucracy is already in existence. We decided as Americans through our elected representatives to raise the quality of care for all Americans. We have decided we are going to do that with a $1, $2, or $4 billion bureaucracy, medicare, medicaid—whatever the area is.

I think if we are going to make that kind of commitment, along with that, we have to bear the responsibility for setting up the structures, audit and administrative functions for that. If you are going to offer it to the private sector and say, run this program, some people say it should be tried. I am not so sure. There are several programs in this health care area where we should experiment with on a test-marketing basis in various areas, one part of the country with the private sector involved; another with the Federal Government totally; another with the combination of Federal/State and find out over a short period of time how they work, which works best and then choose the one that is best for the long run.

The Department of Defense has flyoffs for aircrafts before they make a decision. We certainly do not have that in the health care field. We say this is the money that is going to be spent. We are going to raise the quality of care.

But we do not do it, in my opinion, on an intelligent basis. And to ask the medical profession to bear more than their fair share of the load, I think, is unfair.

Senator PERCY. You think they are bearing a fuller share of the load today than they should be?

Mr. SKINNER. No, sir, I do not. But their ratio of the load, compared to our load ratio in the area, doing something about the problem, they are carrying the higher percentages than the Federal and State Governments are. A substantially higher percentage.

I think it is a matter of everybody working together. I would hope, and know this was a major issue in the last Presidential campaign—I

would hope the administration and the Congress would work together to set up a function that will have an ability—not another bureaucracy; it does not have to be a huge bureaucracy. It can be a coordinating council. It can work with the States in dealing with this problem. It has to be unified.

With 94 U.S. attorneys and 50 attorneys general and a number of State agencies involved, each doing it a little different, we should start sharing this information; we should start learning from each other's experiences. That is what we are doing.

Senator PERCY. I want to comment that you are the first U.S. attorney we have had before us for some time. Since I have been able to question any U.S. attorneys, we have adopted the Speedy Trial Act, we have given precedents and priority to criminal actions. The deferred civil suits and actions just cannot get on the calendar. We have got to take a look at that, no question about it.

SPEEDY TRIALS IMPORTANT

But from the standpoint of getting prosecutions, getting cases tried in this field, do you feel there is now enough, even though it has caused a problem, that you are able to bring cases to trial faster now from the commission of the crime until penalty is imposed? Is the time reasonably short?

Mr. SKINNER. It requires us to bring those cases to trial. It is very important in cases like this, because if you delay the process, there is no deterring effect. It is gone by the time you do it. So I think it has done that. It has created tremendous problems for the courts, for the Justice Department. It has caused reordering of priorities in departments and U.S. attorneys' offices.

I think it is accomplishing to some degree what was intended, but I think you are going to have to address the problem of resources, courts and other parts of the criminal justice system, if you are going to handle the rest of the problem that exists. There has not been a commitment of resources to any of these areas of any substantive, substantial nature over the last several years. And I think the time has come now to address that, if that is the priority we want to place on quick, swift justice, which, as a prosecutor, I am all in favor of.

Senator PERCY. What, in your judgment, is the main obstacle Federal prosecutors must overcome in order to convict nursing home operators and others of medicaid fraud? What is your single largest barrier right now?

Mr. SKINNER. It is a very complex area. It is not as simple as people might think it would be. You need to analyze records. Review of records can take months. Thousands of documents and records have been subpened. I have three rooms full of records subpened from nursing homes just on one particular case.

One case took 15 months with half a dozen FBI agents as well as two lawyers and a grand jury meeting once a week. There is not a whole lot that can be done to speed up that process.

You cannot add 10 lawyers to it on 1 particular case and say you are getting it done in only 10 percent of the time. But you can address with more prosecutors and more resources, more of the problems in

the same time; concurrent processing as we used to call it in the data processing field. Right now I have things waiting to be worked upon because I do not have, I cannot, in good conscience, take any more resources than I already have, although I may, and put them into this area, because we are dealing with one congressional program which is a very key program. But there are a number of programs which have problems of a similar nature which also have to be dealt with. And it is all because I think there is no preplanning; there is no management approach to these programs—not all—but before they are implemented properly, providers, people who benefit from these programs recognize quickly this is happening and they take advantage of it.

Senator PERCY. Have you had a chance to go over the Talmadge medicare-medicaid antifraud bill Senator Church and I are cosponsoring?

Mr. SKINNER. I have not yet, Senator. I am sure I will shortly, and I would be more than glad to go over that bill and send you——

Senator PERCY. Suppose we give you, before you leave, a summary of that bill and a copy.

Mr. Chairman, if we could hold open the record so Mr. Skinner's comments on that could be given to us, I think we will press forward. The language is not set in cement now. We will have a chance to revise it.

INFORMATION SHOULD BE SHARED

Mr. SKINNER. I think, Senator, the people who are in the field and who have learned from these experiences have an obligation to share that with people here in Washington whenever they can, so that we can have the benefit of the input or whatever decisions you make. It is a most difficult problem. There is not one easy answer to it. It is a problem that is growing, I know in Illinois and I am sure in other parts of the country.

I will be more than glad to offer whatever help I can.

Senator PERCY. We have a provision in the bill that attempts to clarify the prohibition against the assignments of medicare and medicaid claims to factoring firms or other third parties. However, in the past, hospitals or doctors have sought to avoid this prohibition by using a power of attorney.

The Talmadge bill would have made clear that this procedure, too, is also contrary to law. The particular provision, do you feel is worded——

Mr. SKINNER. I think the problem of factoring is directly caused by a failure of quick processing by State departments of public aid or welfare of payments. So therefore, because of the cashflow problems of hospitals and other organizations, they factor these payments, at a discount, and they will continue to do so, continue to look for legal loopholes to allow them to do so until we can find a way to quickly audit and pay these hospitals directly.

You cannot ask an organization that is not profit, such as a hospital which has serious cashflow problems, to wait several months—in some cases a year or more—for payment and then expect them to accept it.

There is just no budgeting for it; business does not budget for it, and there is a cashflow problem. The factors take advantage of the situation and recognize they have this advantage.

There is some evidence they make arrangements inside the departments of public aid for expedited service for cash payments and then they inflate the bills. It is interesting that when the HEW released the names of all the physicians and professionals who received medicaid and medicare payment in excess of $100,000, a number of them in our State said, I have only received $50,000 or $60,000. I have never seen these figures before. These are substantially greater than what I submitted to the factoring company for the forwarding to the State of Illinois.

This could be very helpful. You have to make it clear, direct payment is the only acceptable way of payment into the programs. But you have to work, by the way, Senator, with these organizations in this legislation. You cannot just say, it is going to be this way today, and accept it. You have got to take advantage of their input and listen to them.

Cooperation Necessary With Medical Profession

If we want them to involve themselves in these problems, we have got to ask for it across the board. We cannot ask the medical profession to help in one particular area and then not consult with them at least, get whatever input they want to give us on this problem before we just say this is the way it is going to be.

Senator Percy. You mentioned some ballpark figures in your testimony, as I recall it, going through the written text, $2 billion in the Federal Government in Cook County, I believe, $25 billion in the Central States Region.

Do you have any estimates in your office as to how much is being lost to fraud in these programs in, say, the State of Illinois or in your district in northern Illinois? Do you have any figures as to what percentage of fraud we can really try to eliminate, how much we can afford to spend to eliminate it?

Mr. Skinner. It appears to me—these figures, you appreciate, are very difficult to arrive at—you have to judge commonsense, based on some ratio you develop looking at a particular situation. But I would not be surprised to see a fraud figure in Illinois of close to $75 to $100 million a year or more in the medicaid program alone, which is a billion dollar program. Ten to twenty percent fraud factor in that program would not surprise me at all.

I think in some of the medicaid, as you know, it is concentrated in some of the low-income areas of our State, and the fraud we are finding in those programs and those clinics and medicaid mills, in that particular community, is large. It is staggering.

So when you consider and address the problem along those lines, I think it could reach those proportions and those percentages without any problem. It does not apply across the board to every clinic and every nursing home in the State of Illinois. There are some very fine, high-quality nursing homes who care about giving the quality of care to our senior citizens.

I had lunch yesterday with the State president of the Illinois State Medical Society to discuss one of the problems we discussed a few minutes ago. He reminded me several years ago there was no such care at all. These nursing homes are suffering from the reputation that has been developed by a few and they are offering a quality of care to senior citizens in this Nation that they never had before.

There is no, and was no alternative. So these programs are necessary, I am convinced, to afford the quality of care, and the taxpayers will justify it if they are run efficiently.

Very frankly, I give a lot of speeches in the community, as I know both of you do. This subject is a prime concern to the taxpayers in my State and my district. It is one that I get a number of questions on. It is one that I get enthusiastic response about. If we do not demonstrate we can run these programs with integrity, they are not going to send back to Washington, people who approve these programs, because they will only tolerate so much.

In essence, that is the feeling I get having given several hundred speeches in the last 8 years to community groups.

Senator PERCY. I am glad you have put in the fact there are some notable and worthy nursing homes. I have been in quite a few, and I say for the most part, the homes I have been in this year have been better than any previous business I have ever been in. I think in this whole effort, we have driven out, we have jailed a lot of people that have been in the business. and there are steady improvements being made. There are some residents, you would not hesitate to say, that do receive outstanding care.

I would like to ask, though, in the areas of fraud, you mentioned a very high figure for potential fraud. What specific types of fraud are the most flagrant, in your judgment, and what are the difficult types to detect as a Federal prosecutor goes about trying to obtain evidence once fraud or some type of cheating in this program is discovered?

PRIME AREAS FOR POTENTIAL FRAUD

Mr. SKINNER. I think the biggest area of potential is probably in the area of clinics in the medicaid program. I will address, in the area of clinics and labs that do business, what we call prime areas for medicaid care.

These organizations do millions of dollars worth of business. They have a number of patients that see them every day for one problem or another. Generally what they do is—we have seen a practice with some of the clinics—an individual comes in with a cut on his hand. He will then see every station in that clinic—go all the way around, almost like a merry-go-round. Then, of course, the State will be billed for every visit to every station, even though the patient has no problems along those lines.

This quality of care, whether the physician or the clinic should have ordered it, is most difficult to prove. Philosophy exists that these people do not have this quality of care. As long as they are in the clinic, why don't we see if they have these problems along these lines and have them visit every station? When we see them visiting every station three or four times a year, that raises questions.

As you can appreciate, these people are not well educated. They are not as helpful as far as what their problem was or who they needed to see. They do not make good witnesses for that reason. It is very hard to get inside information. In some cases we have had threats. People have been intimidated about testifying and cooperating.

In other situations, we have gotten a lot of cooperation inside from people once they are confronted with it. They accept it, but they do not like it, and they are looking for a way out. I think that is why it is very important we have this presence—this Federal presence as well as State presence—so they know there is some place they can go to bury their soul.

Some Cases Difficult to Investigate

The area of dental care is very difficult. You have to go in and actually examine individuals' dental work to see what was done before, what work was done after, and it calls for an expert opinion. Analysis of specimens—you have to find the people. If a number or specimen was submitted under the medicaid number, you have to go out and find that public aid patient and say, "Were you there?" In some of these areas of our community they move around a lot. They are not easy to find. It is not the easiest type of investigation to conduct. That is why they are so time consuming.

These are all problems we found in addressing the whole medicaid fraud problem. And they make the investigations more difficult.

Senator Percy. I want to thank you very much, indeed.

I want to thank the chairman for his courtesy in letting me go so I can get to my board meeting.

I would like to say this, though. In change of administrations, a great deal of quality in composition depends upon the quality of our Federal district court judges and circuit court of appeals judges, our Supreme Court, and our U.S. attorneys. I am very privileged to have participated in this process during 8 years of public presence, and as I look at the predecessors, in this position that you hold, one is now a circuit court of appeals judge, one is a district court judge, one is the Governor of the State; that is a pretty formidable array of outstanding men who have performed in this job.

I know of none who have performed finer than Mr. Skinner, who came out of industry—the IBM Corp.—went into public life, and has devoted himself to it.

Mr. Skinner. I may be going back, Senator.

Senator Percy. I just certainly want to express my deep appreciation for the way you and your colleagues have approached your jobs —what you have done. You are the No. 1 U.S. attorney in this country in this particular field, and in certain other fields as well.

Mr. Skinner. Thank you, very much.

Senator Percy. I speak highly of the work you have done, the dedication you have had, and I want to associate myself with whatever your future plans are whenever I can.

Thank you.

Senator Church. Thank you very much, Senator Percy.

Did I understand you to say you feel kickbacks should be a felony under the law?

Mr. SKINNER. Yes, sir, I do. I do not think the existing misdemeanor charges should be replaced with felony charges. I think we should have an additional felony charge to deal with the most aggravated situations.

We need additional tools that demonstrate to the judiciary and to the American people that we will not tolerate this type of conduct, and we want it dealt with on a particularized basis.

MINIMUM MANDATORY SENTENCE

I am also, by the way, in favor—and this will shock, I am sure, some of my colleagues in the judiciary—of a minimum mandatory sentence of at least some nature of incarceration for the most aggravated situations. We have done it in the area of firearms. We are talking about doing it in the area of narcotics.

There is no reason why we should not have what I consider to be minimum mandatory sentences—maybe not as strong as we have in other areas—to get sentences of incarceration in this area. They are deterred by going to jail. Defense counsels who discuss these cases with me tell me their clients are concerned about going to jail. If they can get away with it, there is a lot of money to be made. If they go to jail, the risks are probably not worth taking.

I have been very fortunate in my district, with rare exception, to have a judiciary who understands the importance of a deterrent sentence of incarceration in the white-collar crime area. I differ with them on a number of occasions on the length of the sentence. I think it is a matter of indication, as Prosecutor Hynes mentioned, as to the seriousness of the problem and the effect of the deterrent sentence.

The judiciary is somewhat removed in my State because of their job and what is expected of them. I do not think they have the same perspective you and I see down the trenches, so to speak. It is up to us and the media, who has done an excellent job in my State also, of exposing this problem and bringing it to their attention.

Senator CHURCH. Some of the people you have convicted in nursing home and pharmacy kickbacks, I understand, controlled about a third of the nursing homes in Illinois; is that correct?

Mr. SKINNER. That is correct, Senator. They had an ownership position in a number of homes.

Senator CHURCH. Do they also operate in Wisconsin?

Mr. SKINNER. Yes, they have some interest, although their involvement in Wisconsin is not nearly as great as it is in Illinois.

Senator CHURCH. Have any of the law enforcement authorities in Wisconsin expressed any interest in prosecuting or investigating the nursing homes that are located in Wisconsin and known by this same group you found engaged in kickbacks and other wrongful practices in Illinois?

Mr. SKINNER. I think we have had a number of discussions with Mr. Mulligen, the U.S. attorney from Milwaukee. Although I met him professionally, I think he is an excellent U.S. attorney. And I think he has recognized we are dealing with the same people. He has been,

to some degree, holding back and waiting to see our results, because there is no sense in piling on charges if you are not going to have any additional deterring effects.

A number of people that own homes in Wisconsin recently pled guilty and are going to jail with almost $1 million in fines. So I think it has not really been an action more than just waiting until they see how successful we are.

I might add, Senator, we shared the funds with the State of Illinois. We split $900,000 in fines with the State of illinois on a 50–50 basis because they are our partners in the medicaid program.

Senator CHURCH. You also mention in your testimony that you were able to secure ownership by slapping liens on these nursing homes. Can you explain that a little more fully?

FORFEITURE OF EQUITY INTERESTS

Mr. SKINNER. We decided that it was important not only to prosecute them under misdemeanor statutes but to make sure these individuals were no longer involved in the health care fields. This is sometimes difficult because of administrative regulations and legal technicalities, so we used a concept known as RICO. To a lawyer it is title 18, United States Code, section 1961. It allows for the forfeiture to the Federal Government of equity interests in organizations that are used to commit Federal crimes.

If you are an organization and you use that organization to commit two or more Federal crimes, such as mail fraud violations, you can forfeit to the Federal Government after a jury trial the equity interest in the home.

And we received permission from the department to go ahead on this approach and did so file these charges.

Obviously when we filed liens on the titles of the properties, they could not sell the homes. I think this was one of the reasons we were able to obtain the substantial fines as well as the sentences of incarceration. And we received this in cases where we were not able to prove any defrauding of State or Federal Government other than their right to have the programs run honestly.

I think this is a very effective deterrent. We have used that statute in other cases involving medicaid mills and clinics. Those cases are pending.

I think I will skip any further comment on them.

Senator CHURCH. How do you determine the amount of the lien if there has been no actual loss to the Government?

Mr. SKINNER. The statute requires if you commit the violation, you forfeit your entire interest, or any portion thereof that the jury decides should be forfeited. So the jury decides what is to be forfeited. If the home is worth $3 million net worth or equity in the home, the jury could decide anywhere from $100,000 or $3 million of that should be forfeited to the Government. If they forfeit the entire home, we would then sell it to qualified people on the highest basis. That money would go into the Federal treasury. As you can understand, it is a very strong penalty and one, I think, that causes even the most greedy nursing home operator to hesitate before he goes forward.

Prosecutions, by the way, Senator, can have a deterring effect. We think we have stopped, pretty much, the kickbacks between pharmacies and nursing homes in Illinois as a result of our prosecutions, jail sentences, and fines. At least that is the word we are getting back from the pharmacists who do business in our State.

Senator CHURCH. Our Subcommittee on Long-Term Care has investigated nursing home fraud and investigated the medicaid mills—problems that you have mentioned in connection with them.

It may well be we ought next to look into the matter of hospitals. What is your opinion, based on your experience, concerning the possibilities of medicaid and medicare fraud within the hospitals? If you do feel that is going on, who is reaping the benefits?

FEW ALLEGATIONS OF HOSPITAL FRAUD

Mr. SKINNER. I have not received allegations of fraud within hospitals on the medicare program with any degree of frequency. I do not know whether that is because there are no problems or because people have not thought about it and have not felt comfortable going forward with it.

I have a number of people tell me that when they leave the hospital they notice on their hospital bill the medication that has been given, and tests appear on their hospital bill that they do not believe they received. This, of course, is billing to private hospital programs as well as medicare, but I am not so sure that would be any great indicator.

I do think, though, because of the amount of money that is spent in these programs and because of the problems we find in the other areas, that it is an area that at least should be reviewed on kind of a pinpoint basis, in an area we think these problems may exist, to find out if they do exist.

I would be interested to see a current inventory of drugs, plus what was received during the month, plus what was disbursed and billed to the State and Federal programs as well as health insurance agencies. It might be very interesting. We might be able to do that with a computer with some degree of ease. If they have a lot more drugs being billed than they purchased, that would be a good indicator.

I do not think, in my State, that it is as great a problem as it is in other States. Hospitals are under tremendous pressures. They are generally quite professional. They are experienced. They have been in business a long time. They generally give a high quality of care. I hope it is not going to be nearly the problem we found in the new area of medicaid. But we cannot afford to assume that. We have to check it out. I think that would be a good investment of resources.

Senator CHURCH. This is my last question. You stressed again and again in your testimony that there is a lack of adequate planning, a lack of controls, proper management, and sufficient auditing. That might be understandable if we were talking about programs that had just been established, but we are talking about programs that are at least a decade old. We have been doing this for 10 years now.

We are talking about disclosures of the grossness of mismanagement, and also outlining fraud, criminal embezzlement, and all the rest of the public funds on a vast scale. Yet we still have the same deficiencies.

Evidently no action is being taken by the Health, Education, and Welfare Department to improve the administrative procedures and to tighten down on the controls, despite your efforts and despite the efforts of this committee.

Would you think that is a fair judgment?

Mr. SKINNER. To answer that—I do not duck questions—I think you are right. The programs have grown substantially over the last several years. They have been around for a long time.

I do believe there has been a failure of the HEW administration to recognize the seriousness of the problem. There is no reason I should have had but one auditor or five auditors for the whole Midwestern region of HEW. They are reacting now. I admit it is late—several branches of Government reacted late.

Your committee and Senator Moss, to hear him credit me—he is the one that started this area way back when I was first practicing law. I would have been glad to carry his briefcase then. He has done more to demonstrate these problems than almost any American in the public sector.

"THEY DID NOT APPEAR TO LISTEN"

Yet the Congress and the administration—the administrators of the program did not appear to listen. I am hopeful they will listen now. There is no question they have been inadequate in their controls.

I suppose I have been inadequate in not addressing the problem sooner. I accept responsibility for that as well. But the programs have grown substantially and the volume is growing as a number of providers enter the area.

What happened was, it grew; providers in there started passing the word that this was the way to get rich quick, and more providers started joining the agency.

I think if you will look at the number of providers that are authorized today as compared to what was authorized 5 years ago, you will see a substantial number of increased providers available, and there are more people receiving aid as the provider organizations take form.

I would just like to make one final comment, sir, if I might, in observation. I hope whoever takes Senator Moss's place—I am delighted to see he is chairman of the subcommittee and spent time here today.

I will tell you what concerns me most. What concerns me most is that the people who should be receiving these benefits and are entitled to these benefits—who we can afford to give quality care to—not only are not receiving them but they are seeing programs running away, a lack of integrity which they recognize, and it destroys their fiber. It gives them a totally false impression about the way the integrity of our Government and our private enterprise should run.

They look at these organizations. They know the bills are being submitted falsely. They know they should have this care; they know they are put in stations they should not be going to. They recognize

something is going wrong and somebody is getting rich on them. They start saying to themselves: "Well, that must be the way it is. These are professionals; these are respected people. That is the way I should conduct myself. That is the standard in my community and my Nation." That is going to destroy the fiber of our entire community if we allow that to continue.

That, in my opinion, is the real tragedy. That is the reason, more than any other, that we cannot spend enough time and care enough to do something about this problem.

Senator CHURCH. I can assure you the good work that was first initiated and carried on for so long by Senator Moss will continue to be carried on by this committee as long as it exists—as long as I am chairman—and I hope to take up where Senator Moss leaves off. I am sorry we cannot have him with us again in the next session of Congress.

Mr. SKINNER. That is good news. Your reputation precedes you, and I am sure you will do an outstanding job.

Senator CHURCH. Thank you very much. Thank you for your testimony. We appreciate it.

[Whereupon, at 12:20 p.m., the committee adjourned.]

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MEDICINE AND AGING: AN ASSESSMENT OF OPPORTUNITIES AND NEGLECT

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

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CONTENTS

MEDICINE AND AGING: AN ASSESSMENT OF OPPORTUNITIES AND NEGLECT

WEDNESDAY, OCTOBER 13, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
New York, N.Y.

The committee met, pursuant to notice, at 8:07 p.m., in the grand ballroom of the New York Hilton Hotel, Hon. Charles H. Percy presiding.

Present: Senator Percy.

Also present: William E. Oriol, staff director; Deborah K. Kilmer, professional staff member; Dianna Porter, professional staff member; Wayne Fletcher, assistant to Senator Percy; John Guy Miller, minority staff director; Patricia G. Oriol, chief clerk; and Alison Case, assistant clerk.

INTRODUCTION BY DR. ROBERT H. BINSTOCK, PRESIDENT, GERONTOLOGICAL SOCIETY

Dr. BINSTOCK. Good evening, ladies and gentlemen. Welcome to the 29th Annual Scientific Meeting of the Gerontological Society.

To begin our program this evening I would like to introduce to you the Honorable Alice Brophy, one of our society's members, who is commissioner of the New York City Department for the Aging, a position she has held since 1968. As you know, Commissioner Brophy is a former chairman of the Urban Elderly Coalition.

Commissioner.

STATEMENT OF HON. ALICE BROPHY, COMMISSIONER, NEW YORK CITY DEPARTMENT FOR THE AGING

Commissioner BROPHY. Thank you, Bob.

Welcome to New York City. It is great to have you here and to say hello to so many colleagues and friends in the audience. The program is just great. I think it is going to provide intellectual stimulation and satisfaction to everyone. Of course, the best part of every conference is greeting and making new friends.

New York City has had a severe financial crisis. There has been a ripple effect throughout the country and many communities have been facing financial crises of their own—perhaps not as great or as acute as that which we faced in New York City—and yet we have not had a cutback in human services. There has been no diminution of programs for older people.

The programs that we provide for our senior citizens in New York City are unparalleled throughout the country. Our increased exemption program which provides subsidy for all people who are living on an income of $6,500 or less, and who are paying more than one-third of their income for rent, is unique. We have, as you know, a tax abatement program that 165 senior citizens in New York City created, and in our enclaves we are feeding 30,000 older people every day. We are establishing new programs within the next few months that will give older people new options, so that the only answer to their older years will not be a nursing home.

The person to whom I give credit for both the maintenance of all the ongoing programs and the introduction of new programs is our mayor. Despite the tremendous responsibilities that his administration has had to face, he has never failed to meet his commitment to the older people of this city. They have always had the highest priority. I am both delighted and privileged to present to you tonight the mayor of the city of New York, Mayor Beame.

STATEMENT OF HON. ABE BEAME, MAYOR, NEW YORK CITY

Mayor BEAME. Thank you very much, Commissioner Brophy.

I would like, for a few seconds, to express my very deep appreciation to Commissioner Brophy for the remarkable job she has been doing for the elderly of our city.

Senator Percy, Dr. Binstock, Dr. Berliner, Dr. Cooper, Dr. Butler, Sister Schwab, Dr. Sherrod, Dr. Libow, officers and members of the society, it is a great pleasure for me to welcome you to the city of New York on the occasion of the Gerontological Society's 29th annual meeting. During your stay here I am confident that each of you who represent different disciplines will expand our knowledge and understanding of the important issues which affect America's elderly population. I am pleased that you have chosen to meet here in New York City, the home of 1½ million older Americans, many of whom will assuredly be affected by the results of your scholarship and deliberations.

Today our country must take a hard look at many problems crying out for solutions and those which affect the elderly must receive consideration and attention, not only by your, the experts, but also by the public. I am glad that you recognize this and are leading the way for change, and are pushing for action.

Times have changed, and people have changed with the times. It is imperative for all of us and for you, the leaders in the field of gerontology, to work for an end to age discrimination. It is time our society was restructured in a way which would enable our elderly to live the later years of their lives with a sense of fulfillment and a sense of dignity.

I was happy to learn that the opening session tonight will focus on health. The entire health delivery system requires new strategies and new solutions. Our distinguished chairman tonight, Senator Charles H. Percy of Illinois, has shown great leadership in the areas of health and aging through his work on the Senate Special Committee on Aging and the Senate Select Committee on Nutrition and Human Needs. I

am certain that the witnesses will contribute a great deal of valuable information at the hearings tonight.

I hope all of you will have the opportunity while in New York City to explore and enjoy its unparalleled cultural resources: its music, theaters, museums, and art galleries. In this Bicentennial year, we should remember that many older Americans, senior citizens of yesterday and today, built these world famous cultural institutions, established our educational institutions, designed our subways, constructed our highways, built our tunnels and bridges. We owe them our gratitude and we give them a respected place in our society.

So my warmest welcome and good wishes for a productive and a rewarding conference on a subject that in some way affects every New Yorker and every American. I know your work will help enlighten your fellow citizens.

Thank you.

Dr. BINSTOCK. Thank you, Mayor Beame, for welcoming us and for joining us.

Mayor BEAME. Thank you.

STATEMENT OF ROBERT H. BINSTOCK, PH. D., BRANDEIS UNIVERSITY AND PRESIDENT, GERONTOLOGICAL SOCIETY

Dr. BINSTOCK. We are honored and very fortunate to have as our opening program this evening an official hearing of the U.S. Senate Special Committee on Aging, with Senator Charles Percy of Illinois presiding. On behalf of all of our members, I would like to thank you, Senator Percy, for sharing this important public event with us.

Before yielding the floor to the distinguished senior Senator from Illinois, I would like to indicate how we came to have this program tonight. As you know, in the Gerontological Society's separation of powers, about the only program decision the president has is what to do with the opening evening session.

Now my feeling was that we have talked with each other too long, and that it was time to reach out and to have others reach in to us to discuss some of the very important issues facing the aging in this country. Therefore, I was delighted when I approached Senator Percy and the Senate Special Committee on Aging that they graciously agreed, several months ago, to hold this hearing here tonight as a proceeding of the U.S. Congress and to honor us by doing so.

By coincidence in the last few weeks, there has emerged a proposed Senate reorganization plan which, in its current version, calls for elimination of the Senate Special Committee on Aging. I am confident that the content of this evenings hearing will exemplify the important public service and leadership which is performed by the Senate Special Committee on Aging and demonstrate the need for its continued existence.

I would like to point out that on each of your seats there is a blue sheet on which any of you who wish to include a statement in the official record of this hearing can do so. Write your statement on that sheet, mail it to the Senate Committee on Aging within 30 day, and it will be included in the record.[1]

[1] See appendix 5, p. 95.

In addition, you will find a card on your seat. If there is time at the end of this hearing, we will read any specific, brief questions that some of you may wish to write on those cards addressed to a particular witness or to Senator Percy regarding the issues under discussion. Persons will be moving up and down the aisle to collect the cards if you will pass them toward the aisle. Write your questions on them and if we have time we will include some of these questions from the audience in the hearing.

Finally, I am sure you are all aware of the many important ways that Senator Percy has served the people of this Nation, as well as his own citizens in Illinois, in the field of aging. In particular, he has been very instrumental in helping to establish the National Institute on Aging, in helping to establish the program for multidisciplinary centers on aging, and he has participated in the recent committee investigation of frauds in medicare and in medicaid. In his own book, "Growing Old in the Country of the Young," he has expressed eloquently many of the major issues confronting people as they age in this country.

Without further ado, Senator Percy.

STATEMENT BY SENATOR CHARLES H. PERCY, PRESIDING

Senator PERCY. President Binstock, members of our panel this evening, members of the staff of the Senate Special Committee on Aging, and friends, I am very honored to officially convene this hearing of the U.S. Senate Special Committee on Aging. It will be recorded as such and a Senate document will be issued on this hearing.

I would like to say to President Binstock that we have never had quite this kind of setting for a Senate hearing, nor have we had as distinguished a panel. I hope we will keep our conversations as informal as possible and certainly share in it as much as we can. I have never convened a hearing where any one of the people in the audience could be an expert witness and where every word that is being uttered will be scrutinized by experts. We will have contrary points of view I am sure.

Certainly we have one thing in common, we are devoted to this field. It is a rather interesting thing that the first book I ever wrote was on the aging, but it was, to me, a natural sort of thing to do. I found at the age of 29, when I became president of Bell & Howell—in 1949—that I was also automatically the chairman of the Bell & Howell Employees' Retirement Association. Being a few years away from retirement I was not quite sure how to approach that job since it embraced everyone who had ever retired from the company and everyone who was approaching retirement age.

Through the years I was really quite shocked at how ill-prepared industry was to deal with this problem—how it looked upon its job only as a financial one—and following the life cycle of many people who did leave to find the shock that suddenly they were without a structured life. The kinds of problems they never thought they would encounter were numerous—problems of where to live, how to treat and handle their relationships with their friends, with their families, how to finance their retirement, the health problems, and nutrition problems.

We began a series very early in that period—the early fifties—of clinics and seminars beginning 10 years ahead of retirement with the members and spouses as well as the person who would be retiring from the company. I am happy to say that through the years we have had a marvelous experience and it gave me a wonderful background. I think I ought to be prepared to retire a few years from now having psychologically adapted and adjusted myself to it, and have had the privilege of working with so many other people.

For that reason I really look forward so much to being with you this evening. I think the Gerontological Society should be commended for suggesting that the issues before us deserve the attention of all of us. Through this forum I think we can share our conclusions, knowledge, findings, and research with the general public.

Medical Community "Lack of Concern"

As a member of this Senate Special Committee on Aging and the ranking minority member of the Subcommittee on Long-Term Care, I have been confronted with fairly solid evidence about the current lack of concern or knowledge by large segments of the medical community in regard to the illnesses and chronic disabilities which so often accompany aging. The Subcommittee on Long-Term Care, for instance, issued in the past year a special report which, when we issued it, I felt was a fairly shocking document about the relative absence of doctors and the difficulty of getting people who specialize in the particular problems of the aging in nursing homes. That report argues that this problem begins in medical schools where physicians of the future are trained primarily to deal with the medical problems of younger people. There is not proper attention focused on the problems of aging America and we must consider that aging America is becoming an increasingly larger part of our population through a number of factors, and it is growing very, very rapidly.

In our investigations we actually found, through testimony given to us, that doctors and physicians avoid dealing with the elderly, especially nursing home patients. The testimony varied as to why they did that. They testified before our subcommittee that they really elected and preferred to take care of younger people who can return to society. As one of them said, "We have a feeling we can return them to society as productive members." They have a concept that an elderly person was not going to be returned to society as a productive member, which is part of the psychological concerns of older people—that they are being shelved and left out, they are forgotten, and they are being dealt out of society.

That is why we have so many programs such as foster grandparents, and others, specifically designed to encourage older people who recognize there is a real role they can play in society. They are highly productive members in many other societies from whence we all originally came, and why, suddenly, when they come to the United States should they be shelved and why should they be regarded as though they are out of the mainstream of activity? Possibly that is why drug abuse is so high among older people.

We are told that unrealistically low medicare and medicaid fees and the associated red tape actually causes many physicians to decide not

to deal with the elderly. Another less obvious reason we found for the lack of physician interest in older people has been described as the Marcus Welby syndrome. The psychological reinforcement that comes from seeing the sick cured is not thought to be available in the context of the infirm elderly. One doctor—I will just quote his words—testified before us and said, "I hate nursing homes. I never go there. I get too depressed. I never feel like I am doing any good for anyone."

I wrote a book really to try to interest people in the fact that nursing homes, where a million people are in this country, can be made places of dignity and respect, of cheer and hope. Mrs. Percy and I have probably visited more nursing homes than anyone I know of—certainly in the Congress of the United States. We were in three this week. My mother has played the violin and played concerts, I think, in over 30 nursing homes in just the last year, and she has been doing it for years. She is my favorite senior citizen. Anyone that tells me they can only get depressed going to nursing homes have not been in them as recently as I have because there has been a vast change in many.

Nursing Homes Investigated

Senator Moss and I conducted hearings all over the country on nursing homes. We have driven people out of business that were in the business of making money on the elderly. We have broken up syndicates right here in New York. We have indicted and jailed people who were building up fortunes—millions of dollars—at the expense of the sick, particularly if they were old. We have changed, a great deal, the attitude of the State inspection offices and city inspection offices toward nursing homes. The Electrical Workers Union ought to thank our subcommittee, at least, because there has been a tremendous change.

There is still a long way to go, but there is improvement. For those who think that they cannot get any inspiration out of a program we started in Illinois—with all due respect to the comments made about New York having the greatest program—Mayor Daley would resent that; I don't think I have ever spoken for him before on behalf of Chicago—a program in high schools and community colleges which allows young people to go into nursing homes. I for one saw many nursing homes and looked at the guest register books and found that in 1 week two people visited the 100 people there. So we got high schools and colleges to bring young people to do just ordinary sorts of things—help with telephone calls, write letters, just sit and talk or read the newspapers, something like that.

I think what we have to do is encourage the medical profession to also look in that direction. There is so much opportunity for service. I wrote last month to 114 medical schools and put a series of questions to them and possibly, during our question-and-answer period, we can bring out some of their answers. We had a flat answer as to why there is not this interest. We must stimulate interest in the medical schools for we are still a long way from having much attention paid to geriatrics in our medical schools.

[The prepared statement of Senator Percy follows:]

Prepared Statement of Senator Charles H. Percy

Thank you, Professor Binstock, for describing the special circumstances which have led to this hearing tonight. And thank you, as well, for your own personal initiative and concern throughout all our preparations for this event.

The Gerontological Society, I think, is to be commended for suggesting that the issues before us deserve attention, not only before this distinguished audience, but before the press and public.

As a member of the Senate Special Committee on Aging and as ranking minority member of its Subcommittee on Long-Term Care, I have been confronted often with solid evidence about the apparent lack of concern or knowledge by large segments of the medical community in regard to the illnesses and chronic disabilities which so often accompany aging.

The Long-Term Care Subcommittee, for example, has issued within the past year a special report about the relative absence of doctors in nursing homes. And that report argues that this problem begins in medical schools, where physicians of the future are trained primarily to deal with the medical problems of young people.

In our investigations we learned that many physicians avoid dealing with the elderly, especially nursing home patients. Many doctors have testified before our subcommittee that given the demands on their time, they elect to take care of the younger people who can return as productive members of society. We were told that unrealistically low medicare and medicaid fees and the associated redtape greatly discourage physicians from caring for the sick and the elderly.

Another less obvious reason we found for the lack of physician interest in old people has been described as the "Marcus Welby syndrome." The phychological reinforcement that comes from seeing the sick "cured" is not thought to be available in the context of the infirm elderly. One doctor told us candidly, "I hate nursing homes. I never go there. I get too depressed. I never feel like I am doing any good for anyone." In our report we took exception to this notion, pointing out that dramatic improvement and often full recovery are possible even with the most infirm nursing home patients. Sometimes the remedy is as simple as taking the patients off of all the drugs they have been receiving.

I for one think we can expect a great deal more from our medical profession than we are now receiving.

I for one think that the medical profession should extend its blessings to all persons in all age groups, in full understanding of the needs of individuals in each group.

I for one know that today's failures to deal with the illnesses and frailties of aging will grow as the numbers of older Americans grow: 23 million today, about 31 million less than two and one-half decades from now, when the new century begins. Much of that growth will take place in the very highest age brackets, where the likelihood of long-term illness and incapacity is the greatest.

If we have problems now, we'll have superproblems later, unless we change a few attitudes and practices.

If this is already my conviction, why are we having this hearing? We have called expert witnesses to argue both sides of the medical school issue, but I have to admit right here and now that I am swayed very much by the findings of our latest survey of what is actually happening right this minute in schools of medicine around this Nation.

Last month I wrote to the 114 schools of medicine asking them three questions: Do you have geriatrics as a specialty in your curriculum? Do you have programs in which students, interns, or residents serve in nursing homes? Do you have programs which help serve nursing homes in some other way?

Medical School Survey: Results

I received 87 replies to my questionnaire. Three schools of medicine indicated they had established geriatrics as a specialty in their curricula. They were the University of Health Sciences at the Chicago Medical School, the Arkansas College of Medicine, and the University of North Dakota. Seven schools, including the University of Pittsburgh and Duke University, were viewed by the staff as very close to this goal.

In short, of the 87 schools who answered my inquiry, a total of 10 said they had a specialty in geriatrics or were in the process of doing so. Thirty-five schools said they had programs whereby students or interns worked in nursing homes. Forty-seven schools said they had other programs to serve the elderly, particularly nursing home patients. These programs reportedly ran the gamut from research in gerontology to out-patient clinics or day care centers for the elderly.

A comparison with the results of our previous questionnaires provides valuable insight. In 1970 no school had or was contemplating a department of geriatrics; only six said they had a program whereby students or interns serve nursing homes, and seven said they served the elderly in some other way.

In 1974, 13 schools said that they either had a specialty in geriatrics or were contemplating creation of such a specialty. Counting three schools who did not reply this year, the results of our 1974 and 1976 questionnaires appear to be identical on this point.

In 1974 a total of 74 schools said they had a program whereby students or interns could work in nursing homes. This year only 35 schools responded positively. As interpreted by the staff, there is an apparent decrease in interest in this area of sizable significance. Since we received 100 replies in 1974 and 87 replies this year, a look at percentages may make our comparison of the relative interest in nursing homes more meaningful. In 1974, 74 percent of the medical schools indicated having a program whereby students or interns could fulfill requirements by serving in nursing homes. This year only 43 percent of the medical schools indicated having such programs.

In 1974, 53 percent of the medical schools reported serving the elderly in nursing homes in some other way. This year 47 schools or 59 percent reported programs to serve the infirm elderly.

In summary, if our questionnaires can be taken at face value, there seems to be a slow but increasing awareness in the schools of medicine of the medical problems of the aged. There is increasing interest in the creation of departments or divisions of geriatrics; however, only

three such units have now been created. Finally, there seems to be a decreasing concern in programs which allow students or interns to fulfill requirements by working in nursing homes.

The latter finding is of particular interest to me because of my concern for nursing home problems as spelled out in my book, "Growing Old in the Country of the Young." I think the finding is all the more significant because of new research findings I am making public tonight with the permission of my good friend, Ethel Shanas, professor of sociology at the University of Illinois in Chicago. Ethel is to give a paper later this week summarizing a few points from her latest research in the United States and abroad. Several of her points bear analysis here:

—Only about 5 percent of people 65 are now in institutions, and 4 percent 11 years ago. But in 1965, the 4 percent figure totaled 650,000 persons. Now, because of the growth in our upper age population, that figure is about 1 million.

—Challenging as the institutional care situation is, there is a greater challenge facing our health care system, if we will only face up to it. In 1962, 4 years before medicare, 2 percent of the elderly were bedfast, and 6 percent were housebound.

Is Medicare Serving Housebound?

In 1975, 9 years after medicare became operational among the elderly in the community 3 percent were totally bedfast and 7 percent were housebound. In both 1963 and 1975, then, there were twice as many elderly bedfast and housebound as there were in institutions: 10 percent compared to 5 percent. Ethel says, the enactment of medicare then has not reduced the proportion of the elderly living in the community who are bedfast or totally housebound.

And so we must ask ourselves whether medicare is doing what it should do to encourage health maintenance and forms of care which will release persons from their homes or make their confinement more tolerable.

We must also remind ourselves that while the proportions of housebound and bedfast remained similar between 1963 and 1975, their numbers did not. They are on the increase as the number of elderly, particularly the very elderly, continues to increase.

A satisfactory response to these challenges cannot be fashioned without the full cooperation and understanding of the entire medical community. If, in every way possible, physicians join in the effort to keep our older citizens functioning as fully as possible for as long as possible, we have a better hope of fulfilling the full potential of our older population and our health care personnel and facilities.

I realize that one of the greatest obstacles we face is what one of our witnesses—Dr. Robert Butler—calls "age-ism, or negative attitudes toward aging and everything associated with aging.

Some measure of the magnitude of that prejudice—and the challenge we face when we try to do something about age-ism—can be found in the papers I have in my hand. They are excerpts from a scholastic aptitude test given by one school system in Pennsylvania. One of the words on which the students are tested is "senility," which I think we all agree is a specialized word indicating a clinical condi-

tion. But I think we all know that senility is a much misused word. It's been said often that when a middle-aged person forgets something, that person is called absent-minded. But let that happen to an elderly person, and that person is called senile.

To get back to the scholastic aptitude tests, there's a little poem in which the missing word is to be filled in. It reads:

"First we're little cooing babes,
And haven't much ability,
But just when we think we're getting wise,
We're suddenly in ————."

Fill in the missing word. You guessed it. (Senility.)

Later in the same test, there is a crossword puzzle calling for an 8-letter word synonymous with old age. Fill in that word. You guessed it. (Senility.)

A few days ago, the *Washington Star* newspaper published a front page survey on what children think of elderly people. The results coincided with a number of myths about elderly persons which I dispel in my book, "Growing Old in the Country of the Young."

As stated in my book one of the biggest myths is that most of the elderly suffer from serious mental deterioration and senility. This, of course, is not true. Intelligence is measured in tests of comprehension and knowledge, and shows little or no decline for the average elderly person. According to Dr. Robert E. Rothenberg, "mental deterioration rarely occurs among normal older people before the eighties." Furthermore, evidence indicates the ability to think and reason increases with age if those facilities are given sufficient use.

Several other myths that we need to dispel are that: most of the aged are disabled; older people cannot cope with change; most men and women over 65 have no sexual interest or activity; all older people are alike; old age is a disease and physical limitations imply an inability to function.

If our youth as well as many of our adults believe these myths, it is no wonder that today's medical students are not adequately trained to cope with the illnesses of the elderly. Or are they?

We have invited witnesses who may have varying views on that subject, and we will hear from them now. I am looking forward to a lively and informative discussion.

[End of prepared statement]

Senator PERCY. If our panelists would be good enough to come up to the podium.

We are very pleased to have as our first witness this evening Dr. Robert N. Butler, Director of the National Institute on Aging.

Dr. Butler.

STATEMENT OF ROBERT N. BUTLER, M.D., DIRECTOR, NATIONAL INSTITUTE ON AGING

Dr. BUTLER. Senator Percy, Dr. Binstock, gentle people, good evening.

In order to effectively meet the needs of older people for high quality medical treatment—accurate diagnosis, sensitive care, and effective treatment—it is imperative that the special perspective of the particu-

lar body of knowledge known as geriatric medicine be introduced into the curricula of our 114 medical schools, into our intern and residency training, and into our programs of continuing education. In this country today we have some 330,000 practicing physicians, many of whom are not equipped to meet the needs of today's 23 million old people—a situation which is likely to grow worse as the number of older people increases by almost 50 percent in the next three decades.

The real question is not whether geriatric medicine should be a specialty, certified or otherwise; that is essentially proprietary. Rather, the question is how can we expose every physician to the procedures of primary care which are necessary to deal with older patients just as we have exposed other primary care physicians—pediatricians, family and general practitioners, internists, and gynecologists. The body of knowledge required to care for old people is not just disease-categorical; it is broad in perspective and in keeping with the complex character of human experience—including the multiple physical, personal, and social processes that occur with age.

Geriatric Training Stimulated

There are signs of increasing interest in the teaching of geriatric medicine. The Student American Medical Association (SAMA) has called for its incorporation within the medical school curriculum; the Council of Medical Education of the American Medical Association may also now support such teaching; and the Administration on Aging has provided some funds.

Surprisingly, a recent survey of American physicians reported in the September 27, 1976, issue of Impact, an AMA news periodical, revealed that 75 percent of practicing physicians answered affirmatively the question, "Do M.D.'s need special training in geriatrics?"

At our own institution, the National Institute on Aging—part of National Institutes of Health—we are all too conscious of the negligible degree to which investigative medicine is involved in the study of the physiology of the aging human organism. We are convinced of the necessity of having more geriatric medicine taught so that it may serve as a catalyst for the research that forms the framework of a good service delivery system. By expanding our knowledge of human aging, we will ultimately enhance the quality of life of the later years and also help alleviate the great financial and emotional pressures placed upon the middle-aged and younger generations to care for the old. In addition, we would also reduce our incredible national health expenditures, many of which are associated with the disabilities and diseases of old age.

The argument on behalf of geriatric medicine is based on compelling necessities—intellectual, demographic, epidemiological, cost, and attitudinal—which can neither be avoided nor evaded. Practically speaking, the first argument in favor of the inclusion of geriatric medicine in our medical schools is that this body of special knowledge already exists, far from complete but nonetheless substantial. This fact is quite contrary to the commonly held notion that there is not even so much as a textbook on the subject.

In the disciplines known as human physiology and pathophysiology exist the data that underpin geriatric medicine. These data deal with

the differentiation of time-related changes from pathogenetic elements, from the results of socioeconomic adversities, and from the effects of personal crises. The characteristics of the changes inherent in late life can be distinguished from the concomitant crush of environmental events. Making these distinctions is the first critical step in recognizing, diagnosing, and then ameliorating what can be changed. With time comes an accumulation of long-term diseases such as arteriosclerosis and disabilities such as joint-trauma.

Symptoms of Elderly Misleading

In the later years, multiple disorders are present as the body's protective mechanisms such as immunity are compromised. Symptoms present differently in the old, and the untrained clinician often misses the diagnoses:

(1) An older person with hyperthyroidism may appear apathetic, not hyperactive.

(2) Tuberculosis may proceed in silence.

(3) Appendicitis may occur without the characteristic abdominal tenderness at McBurney's point, without fever, and without an elevated white count.

(4) An older person may even have a heart attack without chest pain and may instead appear confused, disoriented and seem like the victim of a stroke.

The second argument for the teaching of geriatric medicine is demographic. Persons 65 and above constituted 3 percent of the American population in 1900; 10 percent by the second White House Conference on Aging in 1971; will perhaps constitute 12 percent by the turn of the century; and some 17 percent between 2015 and 2020. The latter figures are predicated upon there being no improvements in the delivery of health care or any achievements in research, assumptions which are regarded as unlikely. It is far more probable that in 2020 one out of every five American citizens would be over 65 years old. With that kind of "2020 vision," we see the same Americans that constituted the post-World War II baby boom, those youngsters who were described as "greening" America, "graying" America. I, as a middle-aged father of three post-World War II children, am conscious that it is my children who will enjoy or suffer the consequences of the old age created for them here today.

The third reason for including geriatric medicine in our medical schools is epidemiological. If we are to have a good, responsible health care system, we must first accurately and realistically measure the proportions of the problem with which we are trying to deal. For example, we have to be able to take into account the high incidence and prevalence of disorders which accumulate or develop for the first time in the later years. One of these, senile dementia—so devastating to human personality, identity, and memory—is perhaps the fifth greatest killer in the United States and probably the reason at least 50 percent of the patients enter American nursing homes. Diabetes, rheumatoid arthritis, osteoporosis, cardiovascular and cerebrovascular diseases, and many more require delineation and epidemiological consideration so that our health care system will respond effectively.

The fourth imperative is cost. We in this country spent some $118.7 billion on health in 1975. Of this staggering figure, some 50 percent—$60 billion—went for chronic disease, and one-third of all acute hospital beds were used for old people. There were 1.2 million patients in 23,000 nursing homes in 1975—more patients than in our over 7,500 voluntary hospitals. Nearly one-fourth of all drugs consumed in this country were consumed by older Americans. The litany is endless.

Haphazard service delivery, resulting from incompletely trained diagnosticians and technicians, costs money. Without an "educated," sensitized corps of doctors and service delivery personnel, no new ideas germinate; new research dries up; and our health care systems stagnate. Moneysaving and timesaving, as well as lifesaving, measures cease to find their way into use.

Elderly: The American Attitude

Perhaps at the root of our failure to adequately provide for our older people is an attitudinal problem. Americans suffer from a personal and institutionalized prejudice against older people. Although this may be a primitive, universal dread of aging true in all cultures, it is reinforced and thus more striking in our own. This is a cultural sensibility that could be changed through study and education. When the medical student or the doctor shares in that negative attitude, it is all the more disturbing. The first older person that the average medical student meets in medical school, aside from some of his teachers, is the cadaver. Although many professors of anatomy thoughtfully indicate the need for respect for the body as a dissection begins, few American medical schools pay attention to the disturbing dreams, the nightmares, the nausea, the vomiting, and the confusion that the medical student faces in response to the dismemberment of the body. It is a small wonder, then, that the student, left to his or her defenses and coping mechanisms, develops a negative attitude. "Gallows" humor emerges. Youth oriented Peter Panism, or callous and cruel epithets such as "crock," "turkey," "toad," and the one I just heard—"dirtball"—becomes synonymous with the older person.

One study of University of California medical students [Spence, Feigenbaum, et al., *Journal of the American Geriatrics Society.* 6: 1976–83, 1968] showed that their attitude toward old people actually deteriorated over the course of their 4 years in medical school. Medical students are not exposed to healthy older people in the same fashion that they are exposed to healthy babies in sunny, well-baby nurseries and clinics. In fact, there isn't a medical school in the country which routinely and systematically rotates students through community senior centers. One wonders whether medical students would choose to be pediatricians if they only saw babies suffering from irreversible conditions. However, there are some signs of change. At NIA we plan to cosponsor conferences related to geriatric medicine and research with the American Geriatrics Society. The Institute also has the legislative authority to support postdoctoral training in geriatric medicine and to consider research centers in medical schools. We are actively encouraging the introduction of sections on special considerations related to aging in the classic American medical textbooks, an

idea arrived at independently by Drs. Reuben Andres and Leslie Libow.

Also, we are exploring the possible use of the mechanism of a faculty grant—an idea of Dr. James Shannon, former director of the National Institutes of Health—to help support research in geriatric medicine in American medical schools. The elements necessary for curriculum development are more or less in place. The question is, how do you create eggs without chickens? There are no homegrown geriatricians in the United States. Therefore, we need to develop faculty. Current estimates are that perhaps less than 15 of an estimated 25,000 faculty members of American medical schools have any genuine expertise in geriatric medicine. Summer and winter workshops, as well as some circuit writing by outstanding European geriatricians, might help.

We can learn much from nurses and medical social workers, who are ahead of American medicine in the area of geriatrics. We can surely learn from the "impoverished" United Kingdom, with its 10 endowed chairs of geriatric medicine, or from little Sweden with two chairs, or even Holland, which recently created its first. We, a country of some 200 million, still do not have a single endowed chair in geriatric medicine.

NIA Study of Curriculums

At the NIA we are doing a study to analyze human development courses in American medical schools to find out: How many of the 114 schools have them; for how many hours; and of those hours, how many are devoted to the middle and later years? We can also support studies that would evaluate techniques for intervening and changing the attitudes of medical students toward aging and the aged.

There has been much discussion recently of an Institute on Medicine study of medicare reimbursement which pays for the salaries of interns, residents, and attending physicians teaching in America's teaching hospitals. I cannot help but wonder if that flow of money might not be more closely examined to determine if it might not better be used as resource funds for the teaching of geriatric medicine or for the conduct of investigative studies to give additional benefit to medicare participants.

It would be most constructive to undertake sample testing of the clinical knowledge in geriatric medicine of the 330,000 graduate physicians in the United States. Questions on geriatric medicine, if incorporated into examinations by the American Board of Medical Examiners, would provide a clear incentive to American medical schools to teach care of the aged.

Fortunately, consumers in this country are becoming more vocal, and this includes matters concerning old people. Certain groups have begun to express an interest in why so few American medical schools teach geriatric medicine—32 electives among 114 medical schools. This lack of training is exacerbated by the absence of special considerations related to the aging patient in our classic textbooks of medicine and pharmacology.

Our Institute, in its efforts to create a climate for the development of quality investigative medicine in aging, is not only considering the support of biomedical research centers in medical schools, but hopes

that universities will pioneer by creating university-wide committees on aging and geriatric medicine in the expectation that this would foster innovative multidisciplinary research.

In addition, the National Institute on Aging should attract and utilize clinical and research associates in our intramural program in Baltimore—the gerontology research center—where investigative medicine could proceed without difficulty.

I am always struck, after my many years of research and clinical practice, at how colleagues who had been indifferent, if not hostile, to the idea of teaching geriatric medicine will call me when illness strikes a mother, father, wife, husband, or themselves. Then, even they recognize the need for a speciality or expertise.

I do not wish to ignore the somewhat understandable complaint of medical school deans that they already have an overcrowded curriculum, and therefore no room for geriatric medicine. I would like to reply to these complaints by pointing out that new developments in science have been incorporated before in areas such as neonatology and nuclear medicine.

Second, I would like to reiterate that we simply cannot deny geriatric medicine a place in the curriculum, because we cannot afford to do so—financially, demographically, or attitudinally.

Finally, no medical school has ever taught all that might be taught or could be taught. What we want is for students to learn how to learn. They need to learn how to approach a problem, a category, a situation. There are ways of interchanging content while still looking at the process. For example, one can learn about pharmacology by looking at older people and children as well as adults. One can learn the principles of neuropathology with careful attention to newer knowledge related to cerebrovascular disease and senile dementia.

A Task Force on Geriatric Medicine?

In closing, let me emphasize that this is a complex and important subject which requires and deserves our every consideration. It would be a most constructive step if the Institute of Medicine of the National Academy of Sciences would create a national task force on geriatric medicine to consider the best means of introducing the teaching of geriatric medicine, implementing service delivery for the aged, and encouraging research on aging in medical schools. At the same time, we at the NIA will pursue the subject of geriatric medicine through:

(1) Curriculum development;

(2) Faculty development;

(3) Study of teaching in the United Kingdom;

(4) Collaboration with American foundations;

(5) Coordination with the Veterans' Administration hospitals, especially where there are Geriatric Research Educational Clinical Centers—GRECC's;

(6) Association with the senior medical consultants—originally NIH funded—a body of emeritus professors in various medical specialities who teach in nonuniversity affiliated hospitals;

(7) Exploration of possible means of support of geriatric medicine and nursing education with the Administration on Aging, the Health

Resources Administration, the Bureau of Health Manpower, et cetera; and

(8) Discussions with the private sector—the National Retired Teachers Association and the American Association of Retired Persons, National Council of Senior Citizens, the American Health Care Association, et cetera.

Thank you very much.

Senator PERCY. Thank you very much.

Dr. Butler, as I related, is the Director of the National Institute on Aging; he has worked with the elderly for over 20 years in the fields of psychiatry and psychology and has authored many books relating to aging, including his Pulitzer Prize winner, "Why Survive? Being Old in America." I would imagine it sold more copies than mine.

Dr. Butler, our format is that the panelists will be asked to speak for 8 minutes—we will give them 1 minute notification in advance. I will ask a couple of questions of each of you as we go along, and then we will open it for discussion and questions from the audience at the end. This is a rather unusual procedure for a Senate hearing but I ask unanimous consent to do so. There is no other Senator here to dissent; therefore, it is so ruled.

I will submit all of the questions I have for our witnesses and ask them to answer. We will hold the record open for several weeks so that it is complete. I think I would really prefer to have as many questions from the audience as possible.

There are cards for which to write your questions and then you may send them up. The cards will be picked up and your president will read the question.

THE SWINE FLU VACCINATION

Now, Dr. Butler, let me give you a noncontroversial first question. Could you give us your expert opinion as to the relationship between the swine flue vaccination and the recent deaths of 11 elderly people now in 3 different States?

The city of Chicago is going ahead with the vaccinations, downstate Illinois has stopped them. We have a condition of uncertainty about this whole program. Could you tell us about that?

Dr. BUTLER. Well, it is a very serious matter and for that very reason I have to disqualify myself in terms of any expert opinion on the matter. I was deeply concerned over the summer knowing that, as part of our responsibility at the National Institute on Aging, we had to be concerned about questions that would relate to the swine flu vaccination program.

I was also interested from a research perspective because presumably the aged population might already have had immunity, having gone through the 1917–19 flu epidemic. In pursuing this question at some depth, however, I discovered that the swine flu virus was not really isolated until 1931. Therefore, we cannot be absolutely certain that that is the same virus which was so devastating to both Americans and people throughout the world.

I, of course, feel that we must investigate the problem. I am also deeply concerned that our population be properly protected should

we have a major epidemic. I don't think panic is in order but, rather, wisdom.

Senator PERCY. We will leave that question for any of the other panelists when it comes their turn to comment after their presentations if they wish, or if we have any expert advice in the room beyond the expertise of the newspaper reporters that we have had, we would certainly appreciate it.

I would like to ask, Dr. Butler, if you have had a chance to study Senate bill S. 1156, a bill to create grants to encourage medical schools in the establishment of departments of geriatrics. If you have had a chance to study it, would you care to comment on the underlying comments of that bill?

Dr. BUTLER. I think that one very important incentive to the introduction of geriatric medicine certainly could be the provision of funds. I think there are other forms of incentives, too, which are very important to us.

I would like to go back to the question of faculty development. If we do not have an adequately trained faculty which understands the basic corpus of knowledge in geriatric medicine, we are at a loss. Perhaps some of that incentive money, should it come into being, should be allocated specifically to creating a cadre of outstanding models of knowledge in the area of geriatric medicine, who could then in turn teach others in a kind of ripple effect.

PHARMACOLOGY OF AGING ESSENTIAL

Senator PERCY. The last question that I would like to put to you, I put to you simply because 30 million people saw it on "60 Minutes" and wondered about it. The "60 Minutes" television program had a psychologist who said that he had received his training in prescribing drugs for insomnia by watching the resident he followed around on his rounds. It disturbed many people because many of the responses to our survey at medical schools stated that their own training in geriatrics was the student's exposure to the older patient and the care provided by the doctor in charge.

Is this "watching of the resident on duty" type of training common in medical schools and isn't it most dangerous, especially in such instances as prescribing of drugs for older patients who often react differently to such drugs as amphetamines and stimulants?

Dr. BUTLER. It is essential that we develop the pharmacology of aging. We have the tools, the concepts, and the instrumentation to do so. It is quite surprising, as I mentioned earlier in my testimony, that our major classic textbook in pharmacology does not even have "age" in the index. In our Institute, we plan to support studies that will help change prescription guidelines as they affect the older patient. I think that without new guidelines, we continue to run the risk of overutilization of drugs, with resultant confusion that may be misdiagnosed as so-called senility. Too often, a patient is hospitalized or institutionalized unnecessarily.

Senator PERCY. Dr. Butler, thank you very much indeed.

Dr. John A. D. Cooper is president of the Association of American Medical Colleges. The AAMC is the professional association of the 117 medical schools in our country. Dr. Cooper was dean of science at

Northwestern University prior to his work with the AAMC and was associated with Northwestern in professional roles from 1943 to 1969. He received both his Ph. D. and M.D. from Northwestern University.

Dr. Cooper.

STATEMENT OF JOHN A. D. COOPER, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, D.C.

Dr. COOPER. Thank you very much. I appreciate the opportunity to present the statement of the Association of American Medical Colleges on medical education and the health problems of the elderly.

At the outset it is very important to recognize that in this country no organization, including the AAMC, has control over the curricula of medical schools. Detailed specifications of curriculum content has fortunately been avoided, since that process tends to impede innovation and to construct an inflexible program of instruction not responsive to advances in medicine, in medical science, or in new patterns of medical service.

The strength and excellence of American medical education is due in large part to the great diversity and individuality that characterizes the academic institutions that educate physicians. The medical schools vary in age, sponsorship, tradition, and goals, but in different ways each has made important contributions to better medical care through its education, research, and service programs which have generally been acknowledged to be in the forefront of all such programs in the world. Thus, it is to be expected that the schools would have responded in a variety of ways to the unique and growing challenge presented by the Nation's aging population.

MEDICAL CENTER'S ROLE

The task of the academic medical centers in preparing physicians to assume their appropriate responsibilities for services to the elderly is threefold. Medical students must be educated:

(1) To understand the normal aging process. Conceptually, this is best approached as part of the study of growth and development.

(2) To diagnose and care for the diseases most likely to impair function and threaten life in the elderly.

(3) To adjust the provision of medical services toward the effective management of chronic disease over long periods.

Within the limits of present knowledge about the aging process, it is possible to educate students about the nature of aging, either through special courses on this subject or in a sequence of courses, in which growth, development, and aging are interwoven. While the degree of emphasis differs from school to school, education about the aging process is provided effectively in all U.S. medical schools.

Additionally, elderly patients with acute illness are commonly encountered in teaching hospitals, and demonstrations and instruction on the diagnosis and treatment of these illnesses, with a special focus on the character of their manifestation in the elderly, is a commonplace occurrence in every school and every teaching hospital.

The principal problem area in educational and learning opportunity in our academic medical centers is in the long-term management of

chronic, or only slightly disabling, conditions in patients who are outside the mainstream of contemporary society. In this domain, the medical schools have selected a wide variety of approaches.

Just as there is variety in the ways that undergraduate medical education has responded to the unique challenges presented in the medical care of the elderly, so also have there been wide differences in approach at the graduate level, subsequently reflected in professional practice patterns.

Some physicians view geriatrics as a distinct specialty warranting specific residency training programs and subspecialty recognition, while others think that it is orthogonal to all specialties and that the aged will receive better care if all appropriate specialists participate in their management. Since the AAMC does not now directly participate in the process of the creation of new specialties, this organization's preference on whether geriatrics should be a separate specialty is an academic question.

Longevity Can Increase Problems

In teaching students about the problems of the elderly it is difficult to isolate the medical from the closely interrelated economic and social needs of this group. Furthermore, the interactions of these variables becomes increasingly complex as the elderly population expands. Dr. George Maddox, director of Duke University Centre for Aging and Human Development, in describing the size of the task ahead in a recent issue of *Annals of Internal Medicine*, said:

> Long average life expectancy, a distinct achievement of modern societies, has proved to be an embarrassment and a current threat to existing institutional arrangements, not only for health and welfare, but also for income maintenance, transportation, housing, and education. Medical education and health delivery systems in both countries (England and the United States) were designed for acute, not chronic, illness; they are, therefore, mismatched with the particular needs of older persons for preventive, primary, and long-term care. . . . The mismatch is troublesome in the United Kingdom and dramatic in the United States.

Thus, greater attention must be given to educating students in an understanding of the social milieu of the elderly. This requires emphasis not only on disease processes, but on the management of the patient's social adjustment problems, an objective not easily achieved unless the medical student has the opportunity to see the patient outside the hospital setting.

Debate on the technical and policy issues related to the creation of a specialty and on the appropriate approach to teaching geriatrics should not be allowed to obscure the very basic reality of how extraordinarily limited the body of knowledge about gerontology actually is. To achieve meaningful and significant solutions to this set of problems, greatly increased energy and effort must be committed to research in gerontology and a far larger fraction of the Nation's most creative aspirant scientists must be trained in this area of medical science. The association, therefore, strongly supports a rapid buildup of resources for the National Institute of Aging and feels that its broad charter, which includes research in the social and behavioral, as well as the medical aspects of aging, is most appropriate.

Medical educators are keenly aware of the dimensions of the educational challenge presented by the medical care problems of the elderly, and are generally responding effectively by developing a variety of educational approaches for undergraduate and graduate programs.

Financial Problems

That medical schools could do more is undeniable, particularly in terms of student-patient encounters in ambulatory settings, nursing homes, and extended care facilities. The major obstacle to this relates to the problems of financing, both undergraduate and graduate, medical education. Ambulatory care teaching has presented the Nation's medical schools with particularly serious financial problems. A large number of outpatients have inadequate medical care insurance or are totally uninsured. Those with coverage are often unable to pay deductibles and coinsurance. Moreover, some coverage, such as medicare, reimburses on a scale often well below what is customary and prevailing and excludes from reimbursement under "part A" the costs of the education of interns and residents in outpatient facilities. Finally, when the education of students and residents is coupled with patient care, inefficiencies are introduced that increase unit costs and prevent a high volume flow of patients. All of these factors summate in a situation in which the ambulatory care services of our teaching hospitals are incurring substantial fiscal losses and will not be able to significantly expand their ambulatory educational and service programs without adequate reimbursement for them.

Thus, development of optional pedagogic programs must await the day that medical education is on a more sound financial basis. Valuable interim assistance will be provided by the special project grants for undergraduate and graduate education in areas such as family medicine, general pediatrics, and general internal medicine, authorized in the Health Professions Educational Assistance Act of 1976 signed yesterday by President Ford, especially in making possible high-quality ambulatory care education for students and residents. But all medical care programs proposed in the future must reimburse the costs of educating the health professionals essential to provide the needed services if the advances of medical science are to be brought to the beneficiaries of the program.

In summary, the association fully supports efforts to improve education for providing the teaching of first-class medical services for the elderly in the Nation's medical schools. The efforts of the medical schools can and will improve immensely as the body of knowledge of gerontology, which is now woefully inadequate, increases through research, and the financing system is modified through legislation to place undergraduate as well as graduate medical education on a solid financial basis.

Conflicting Testimony

Senator Percy. I was particularly interested in your testimony where you said that education of the aging process is provided effectively in all U.S. medical schools. That seemed to challenge Dr. Butler's statements and at the same time were somewhat in contrast with the questionnaires I received. As I mentioned in my opening comments, I

wrote to 114 schools of medicine last month and I put to them such questions as this: Do you have geriatrics as a specialty in your curriculum? Do you have programs in which students, interns, or residents serve in nursing homes? Do you have programs which help serve nursing homes in some other way?

Only 3 schools of medicine of the 87 that replied to the questionnaire actually indicated that they have established geriatrics as a specialty in their curriculum. Seven others seemed to be indicating that they were working toward that goal and recognized that they should have them. I was particularly discouraged by the fact that several years ago 74 percent of schools said they had a working relationship with nursing homes; this last month only 43 percent had. We have almost cut it in half. So the disillusionment of nursing homes seems to have affected the medical schools' working relationship.

In light of those findings and Dr. Butler's comments, would you further expand on your statement that all U.S. medical schools are effectively providing education about aging?

Dr. COOPER. I said the statement is "the process of aging," and this has to do with the biomedical relationship of the living systems in aging. In the testimony I pointed out that we are not, in my view and, I think, in the view of most schools, providing adequate opportunity for students to understand aging patients. However, these are very specific opportunities for students to understand the process of aging, and that is woven through all of the basic science areas of medicine in which one does consider the effects of aging upon the living process in all living matter.

GERIATRIC "ELECTIVES" INCREASE

Now, with regard to the development of specific specialty tracks or specific courses in geriatrics, the AAMC publishes annually a curriculum directory, and the last directory indicates that 45 schools now offer electives in the field of geriatrics. This is up from 32, 1 year ago. In other words, we had an increase of 13 schools in 1 year. This is in spite of the fact that the medical schools, with their financial stringencies, certainly are not in the mood, nor are they able, to consider expanding programs or developing new programs. The real direction of their efforts is to stay afloat.

I think that this change has been remarkable, but we do have coming into the medical centers a large body of elderly patients. Many of them cannot afford to go any place else, and they come to the teaching hospital as the only place where they can receive care. I think we have not adequately treated them clinically.

The things that I pointed out that have prevented the development of adequate ambulatory care, not only for geriatric patients, I might add, but for patients of all ages, relate to the difficulties we have in getting reimbursement, not only for the care delivered in those settings but also for the education and training of students in those settings. I would hope that we can get that corrected so that the schools can undertake the kinds of programs which I think many of them are interested in taking and promoting if they have the financial backing to provide them.

Fortunately, this bill on the Institute of Aging will provide some short-term support for these kinds of programs. Unfortunately, we do not have the guarantee of any long-term support and schools have become very wary of taking on a program which is supported for 2 or 3 years and then is no longer supported because of lack of funds. We have had one example after another of this in legislation passed by the Congress over the past 5 years.

Senator PERCY. I would not want to assume full responsibility for that, but I can recognize the problem involved.

I would like to rephrase my question then, possibly in this way, to give you a chance to attack it from another standpoint. It has been stated that the major goal of the medical school is to provide a model of principles and practices of medical care so that the student receives a basic understanding of patients as total human beings. Now taking the elderly as an example, how are elderly persons dealt with in this model of principles and practices where you look at the elderly person as a total human being and how is this transmitted by medical schools to students today?

Dr. COOPER. I think that varies, as I tried to point out, from school to school. In some cases, as has been pointed out with the 45 schools which actually have electives in geriatrics now, they do present a concentrated program dealing only with the aged in the total scope of their problem. In other institutions it is felt that this same approach should be introduced in each specialty which deals with patients of all ages, and there is not the feeling that you need a special department or a special course. These are the two polarized views about how the care of patients of whatever age should be considered in the medical school curriculum.

VOLUNTEER TEACHERS IMPORTANT

With regard to the statement that the residents do all the teaching, I think that the residents are important in the total teaching process, but nevertheless the substantial full-time faculty and those who support the schools in their volunteer faculty appointments are also extremely important factors in the educational process. They always have been important, and they continue to be one of the major sources of the education and training of students. If we do have physicians that are oriented and sensitive to the problems of the aged, I think that this is transmitted to the students through the clinical clerkships which all the students engage in at every medical school in the country and through the residency programs in internal medicine and the variety of specialties.

Senator PERCY. Thank you very much, Dr. Cooper.

May I remind our audience that if you have questions, we would like to have your questions so we can cover as many as we possibly can. Pass them to the aisle and a member of the staff will pick them up.

Dr. COOPER. Senator, before we close, may I just give one example of a situation in your own State?

Senator PERCY. Very briefly.

Dr. COOPER. Rush Medical School, which I know very well, has just completed a $10.5 million facility which will provide a very innova-

tive approach to geriatrics, as will other schools I have listed in the written testimony. This is going to provide not only extended care facilities but actual apartments for elderly persons who wish to have the reassurance of living nearby to a medical center. This is going to be a very important facility at Rush, not only for the care of the aged, but for the educational programs both at the undergraduate and graduate level. I think this indicates the kind of innovative approaches that the medical schools have taken relative to geriatrics.

[The prepared statement of Dr. Cooper follows:]

PREPARED STATEMENT OF DR. JOHN A. D. COOPER

Mr. Chairman and members of the committee, I am Dr. John A. D. Cooper, President of the Association of American Medical Colleges, an organization established 100 years ago to represent a constituency now composed of the Nation's 117 medical schools. 400 of its major teaching hospitals, and 60 academic societies reflecting the concerns of the faculties of the medical schools. The association appreciates the opportunity to present its views as you consider the problems of the health care system in relation to the elderly. Your invitation requested that I focus my remarks on the place of geriatrics in the medical school curriculum, and on some of the problems that medical schools face in trying to accord geriatrics and gerontology appropriate emphasis.

This I shall attempt to do. It is important to recognize that no organization, including the Association of American Medical Colleges, has control over the curricula of medical schools. General guidelines on the educational programs are provided by the accrediting body, the Liaison Committee on Medical Education. Detailed specification of curriculum content has fortunately been avoided, since that process tends to impede innovation and to construct an inflexible program of instruction not responsive to advances in medicine, in medical science, and in new patterns of medical service. The Association of American Medical College's Curriculum Directory, published annually for the last 5 years, records the dynamic flux in the instructional offerings in the Nation's medical colleges that this wise policy has permitted and a perusal of its pages will attest to the wide range of variation and the lively pace of change in curricular structure within these institutions.

The strength and excellence of American medical education is due in large part to the great diversity and individuality that characterizes the academic institutions that educate physicians. The medical schools vary in age, sponsorship, tradition, and goals. Many have assumed the coloration and perspective of the region of the country in which they are located, while others have remained cosmopolitan and national in outlook. Some schools draw their student bodies from their own locale and have populated this same area heavily with their graduates; others have sought matriculants from every State in the Union and have seen their graduates scattered through the length and breadth of the land. Some have hewn strictly to traditional disciplines, fields, and specialties while others have been innovative in creating new interdisciplines, new modes of approach to the delivery of health care, new concepts of medical education and service. In different ways, each has made important contributions to better medical care through its education, research, and service programs. Thus, it is to be expected that the schools would have responded in a variety of ways to the unique and growing challenge presented by the Nation's aging population.

THE TASK OF THE MEDICAL SCHOOLS

A brief comment on the essential characteristics of this 20th century challenge and the task it presents to medical education seems in order. Aging is an inevitable, natural phenomenon. In advanced societies, however, life expectancy has almost doubled in the 20th century and the absolute numbers of individuals living beyond the age of 65 has increased very substantially. The social welfare programs initiated in Europe at the turn of the century and several decades later in the United States did not include such longevity in their planning assumptions. Thus, the realities of the aging population are inducing major perturbations in the structure of all advanced societies. One consequence is a growing concern for how to provide the medical services needed by the

ever-increasing number of citizens who are now living beyond the age of direct participation in the daily activities which engage those still considered in the mainstream.

Timely and appropriate medical service for those who have reached 65 and older is imperative; the provision of social and family services for the elderly is of equal importance. The task of the academic medical centers in preparing physicians to assume their appropriate responsibilities for these services is three-fold. Medical students must be educated:

(1) To understand the normal aging process. Conceptually, this is best approached as part of the study of growth and development.

(2) To diagnose and care for the diseases most likely to impair function and threaten life in the elderly.

(3) To adjust the provision of medical services toward the effective management of chronic disease over long periods. This means a shift away from a principal focus on acute disease and short-term care and toward greater attention to the social and economic environment of patients who must necessarily adapt to living with disabilities.

Within the limits of present knowledge about the aging process, it is possible to educate students about the nature of aging, either through special courses on this subject or in a sequence of courses in which growth, development, and aging are interwoven. While the degree of emphasis differs from school to school, education about the aging process is provided effectively in all U.S. medical schools.

Additionally, elderly patients with acute illness are commonly encountered in teaching hospitals, and demonstrations and instruction on the diagnosis and treatment of these illnesses, with a special focus on the character of their manifestation in the elderly, is a commonplace occurrence in every school and every teaching hospital.

The principal problem area in educational and learning opportunity in our academic medical centers is in the long-term management of chronic, only slightly disabling, conditions in patients who are outside the mainstream of contemporary society. In this domain, the medical schools have selected a wide variety of approaches.

Undergraduate Medical Education and the Elderly

Some schools have directed their approach toward integrating instruction about the medical problems of the elderly into conventional course work. "Integrationists" view the process of aging and the diseases of the aged as parts of a continuum; thus, both undergraduate and graduate medical students have highlighted for them the special features characteristic of the elderly in relation to the phenomena described in discipline or systems oriented courses and demonstrated in clinical exercises. At the opposite pole, other schools have undertaken to establish organizational units in gerontology and have developed instructional offerings in geriatrics. "Separatists" view the problems of the elderly either in health or disease as unique enough to warrant attention by special discipline; hence, the impetus to create departments of geriatrics, residencies in geriatrics and a certifiable specialty of geriatrics.

In a presentation such as this, it is difficult to describe in a totally coherent fashion what is happening in schools which have taken the integrationist attitude, since attention to the problems of the aged is interwoven throughout every aspect of the student's educational experience from basic science instruction in such disciplines as anatomy, biochemistry, genetics, etc., to each and every medical and surgical subspecialty. However, I would like to devote a few minutes to a brief report on some of the activities underway in several medical centers in order to give you a flavor of how the schools are responding to the problems of tonight's hearing.

(1) At the present time, 45 schools offer electives in the field of geriatrics, up from 32 1 year ago.

(2) At the Medical School of the University of California, Los Angeles, instruction in geriatrics takes place at all levels of basic and clinical science. In addition, the medical school has active teaching affiliations with the geriatric wards in each of the two of the V.A. hospitals in Los Angeles. In one, a continuing care program for the elderly employs the same personnel who cared for patients while hospitalized to continue to care for them after they have been transferred to nursing homes. The Geriatric Research, Education, and Clinical

Center at UCLA conducts research in the area of immunologic aging, and operates an education program in conjunction with the department of medicine for training students, residents, interns, and paramedical personnel.

UCLA is scheduled to open an outpatient clinic this fall, designed for patients 65 years of age and over in need of psychosocial care. This will be operated by the family practice division of the department of medicine.

In July 1977, UCLA will open a 21-bed inpatient ward for patients over 65 in the neuropsychiatric institute. This will serve as both a teaching program involving the departments of neurology, medicine, and psychiatry, and a research institute focusing on the psychiatric disorders of the elderly.

(3) At the Medical School of Case Western Reserve University, students may elect to study geriatrics in first year courses and fourth year clerkships. Examples of the first year courses in the area of the physiology and pathology of the aging are "Rehabilitation of the Aged, Disabled, and Chronically Ill," and "Inherited Defects of Nucleic Acid Repair in Cancer and Aging." Case Western Reserve Medical School is affiliated with both public and private hospitals which have combined geriatric and chronic disease units to which students are exposed as part of the physical diagnosis course. The medical school is also being funded by a grant from the Cleveland Foundation to study the British approach to geriatrics and its applicability to the United States. The basic difference between the approaches in England and the United States to the treatment of the elderly is that in the United States the tendency has been to serve the aged by admitting them to hospitals and/or nursing homes, whereas in England the basis for patient management is the day hospital. As a result of this grant by the Cleveland Foundation, the day hospital concept is under consideration at Cleveland Metropolitan General, one of the major teaching hospitals affiliated with Case Western Reserve.

(4) At Michigan State University School of Humanistic Medicine, geriatrics is a major component of a medical school curriculum which emphasizes an interdisciplinary approach to teaching with a major emphasis on the social and behavioral sciences. Geriatrics is found in this medical school's curriculum in three places: the teaching of geriatrics is one of the major objectives of the first year program which is a focal problem sequence; during the second year, students concentrate on human biology and behavior, with 3 weeks of that component devoted to the biological and developmental aspects of aging; and all students participate in a 12-week introductory experience, immediately preceding the 2 clinical years, entitled "Fundamentals of Patient Care," which includes a series of small group seminars, two or three of which are devoted to problems of the aged.

(5) The Medical School of Duke University approaches the teaching of geriatrics by integrating it into the entire curriculum. This is done by conducting a part of the teaching of students and residents in nursing homes and retirement communities. Both family practice and senior psychiatry residents spend part of their residency in nursing homes. In addition to dealing with problems of the elderly in all courses, all students are required to take a geropsychiatry course entitled, "Mental Illness in Late Life," in which emphasis is placed on depression, hypochondriacal reactions, and psychological reactions to pharmacologic agents.

(6) At the University of Washington School of Medicine, two courses are required of all students which focus on the problem of the geriatric patient. One course is the "Ages of Man," a biological and behavioral course which is a collaborative effort between the departments of pediatrics, medicine, and psychiatry; this approaches aging as a developmental process. The second required course is "Introduction to Clinical Medicine" which, while not specifically a geriatrics course, is concerned with a variety of cognate issues including the care of the dying patient. In addition to the two required courses there are spot lectures in geriatrics throughout the curriculum as well as electives offered in the division of aging and geriatric psychiatry and the soon-to-be-created division of gerontology of the department of medicine. The University of Washington operates a geriatric research and education center in conjunction with the VA hospital; this unit directs its attention to teaching and clinical care in dementia. The University of Washington approaches geriatrics on a multischool basis and thus has collaborative programs with the schools of social work, nursing, and dentistry.

The Association of American Medical Colleges is convinced that while many of the Nation's medical schools have felt it more appropriate to address the prob-

lems of the aged developmentally, to view aging as part of the growth and development process, and to focus on the unique characteristics of each disease when manifested in the aged, the education of students at institutions that have taken this stance is just as complete and comprehensive as that received by students attending institutions where geriatrics is treated as a separate discipline. No objective evidence exists to indicate which outlook on the problem is likely to result in better and more sensitive care for the elderly.

Graduate Medical Education and Professional Practice

Despite some recent trends in curricular evolution to emphasize "tracking" in undergraduate medical education, specialization is essentially a phenomenon of graduate medical education. And just as there is variety in the ways that undergraduate medical education has responded to the unique challenges presented in the medical care of the elderly, so also have there been wide differences in approach at the graduate level, subsequently reflected in professional practice patterns.

Some physicians view geriatrics as a distinct specialty, warranting specific residency training programs and subspecially recognition while others think that it is orthogonal to all specialties and that the aged will receive better care if all appropriate specialists participate in their management. Since the AAMC does not now directly participate in the process of the creation of new specialties, this organization's preference on whether geriatrics should be a separate specialty is an academic question.

Underdeveloped Educational Opportunities

In teaching students about the problems of the elderly, it is difficult to isolate the medical from the closely interrelated economic and social needs of this group. Furthermore, the interactions of these variables becomes increasingly complex as the elderly population expands. Dr. George Maddox, director of Duke University Centre for Aging and Human Development, in describing the size of the task ahead in a recent issue of Annals of Internal Medicine, said, "Long average life-expectancy, a distinct achievement of modern societies, has proved to be an embarrassment and a current threat to existing institutional arrangements, not only for health and welfare, but also for income maintenance, transportation, housing and education. Medical education and health delivery systems in both countries (England and the United States) were designed for acute, not chronic, illness; they are therefore mismatched with the particular needs of older persons for preventive, primary and long-term care. . . . The mismatch is troublesome in the United Kingdom and dramatic in the United States." Thus, greater attention must be given to educating students in an understanding of the social milieu of the elderly. This requires emphasis not only on disease processes but on the management of the patient's social adjustment problems, an objective not easily achieved unless the medical student has the opportunity to see the patient outside the hospital setting. To truly comprehend the environment in which the elderly often reside, medical students need to spend more time in nursing homes and in ambulatory care setting, experiences that are available to a limited extent at this time.

The Importance of Research

Debate on the technical and policy issues related to the creation of a specialty, and on the appropriate approach to teaching geriatrics should not be allowed to obscure the very basic reality of how extraordinarily limited the body of knowledge about gerontology actually is. To achieve meaningful and significant solutions to this set of problems, greatly increased energy and effort must be committed to research in gerontology and a far larger fraction of the Nation's most creative aspirant scientists must be trained in this area of medical science. It is only through research that we can ever hope to understand and to solve some of the intractable problems that are unique to the aged, and to make this segment of life both healthy and productive. It is only through research that the question of whether the limit of life span is really close to the biblical three score and ten can be explored. The association, therefore, strongly supports a rapid build up of resources for the National Institute of Aging, and feels that its broad charter, which includes research in the social and behavioral as well as the medical aspects of aging, is most appropriate.

THE FUTURE OF MEDICAL EDUCATION IN RELATION TO THE ELDERLY

In the opinion of the Association of American Medical Colleges, medical educators are keenly aware of the dimensions of the educational challenge presented by the medical care problems of the elderly, and are generally responding effectively by developing a variety of educational approaches for undergraduate and graduate programs. The efforts of pioneers are under study or in the process of being adopted in the schools whose efforts to date are somewhat modest. In other schools with highly developed programs, additional innovative efforts are in experimental stages.

No absolute barriers to providing the minimally required educational experience exist and there is every reason to believe that every graduate of U.S. medical schools will soon have been exposed to the basically essential education experience.

That medical schools could do more is undeniable, particularly in terms of student-patient encounters in ambulatory settings, nursing homes, and extended care facilities. The major obstacle to this relates to the problems of financing both undergraduate and graduate medical education. Ambulatory care teaching has presented the Nation's medical schools with particularly serious financial problems. A large number of outpatients have inadequate medical care insurance or are totally uninsured. Those with coverage are often unable to pay deductibles and coinsurance. Moreover, some coverage, such as medicare, reimburses on a scale often well below customary and prevailing and excludes from reimbursement under "Part A" the costs of the education of interns and residents in out-patient facilities. Finally, when the education of students and residents is coupled with patient care, inefficiencies are introduced that increase unit costs and prevent a high volume flow of patients. All of these factors summate in a situation in which the ambulatory care services of our teaching hospitals are incurring substantial fiscal losses and will not be able to significantly expand their ambulatory educational and service programs without adequate reimbursement for them.

Thus, development of optimal pedagogic programs must await the day that medical education is on a more sound financial basis. Valuable interim assistance will be provided by the special project grants for undergraduate and graduate education in areas such as family medicine, general pediatrics and general internal medicine, authorized in the Health Professions Educational Assistance Act of 1976 signed yesterday by President Ford, especially in making possible high quality ambulatory care education for students and residents. But all medical care programs proposed in the future must reimburse the costs of educating the health professionals essential to provide the needed services, if the advances of medical science are to be brought to the beneficiaries of the programs.

In summary, the association fully supports efforts to improve education for providing the teaching of first class medical services for the elderly in the Nation's medical schools. The efforts of the medical schools can and will improve immensely as the body of knowledge of gerontology, which is now woefully inadequate, increases through research, and the financing system is modified through legislation to place undergraduate as well as graduate medical education on a solid financial basis.

Senator PERCY. We are very happy to have Sister Marilyn Schwab with us who is a registered nurse and administrator of the Benedictine Nursing Center in Mount Angel, Oreg. Sister Schwab has had special training and experience in geriatrics and formerly was the chairperson of the Committee on Skilled Nursing Care of the American Nurses Association. Sister Schwab helped to develop the American Nurses Association's report for the Senate Committee on Aging which describes problems of providing skilled nursing as presently defined by medicare and medicaid, problems relating to alternatives to institutional care, problems with supply and training of qualified personnel, and methods of reimbursement for quality care.

STATEMENT OF SISTER MARILYN SCHWAB, R.N., ADMINISTRATOR, BENEDICTINE NURSING CENTER, MOUNT ANGEL, OREG.

Sister SCHWAB. Thank you, Senator.

I have been asked to speak this evening from my viewpoint as a nurse about my experience of medical care of the aged, some thoughts about training needs in geriatrics in medical schools and about the influence that medical training has had on the profession of nursing.

It is not a new concept for this audience that health care of the elderly has to be delivered in a manner that deals with multiplicity and interrelated aspects of the elderly person's emotional, cultural, and economic problems, as well as his diseases and disabilities.

The implication for education that flows from that concept tends to support the notion that perhaps each health discipline needs to educate its practitioners to approach the elderly from a broad psychosocial-medical kind of framework. However, given the brief history of the science of gerontology and the relatively undeveloped stage of its application to the health sciences, it would seem more useful for each discipline to focus primarily on its unique contribution to the health care of the elderly.

Medicine needs to further develop and teach the medical aspects of the health care of the aged—that is, the diagnosis and treatment of disease—and at the same time medicine needs to teach its practitioners to understand and collaborate with other health care disciplines, not just to carry out their proscribed medical regimens, but to share an interdisciplinary assessment, planning, intervention, and evaluation process so essential to total health care of the elderly.

My experience with medical care of the elderly is that the interests and diligence in diagnosis and treatment has less to do with the chronological age of patients being treated than it does with the complexity and apparent hopelessness of the problems presented. The combination of old age and multiple health problems tend to cause frustration and a feeling of helplessness in the physician as it does in many other professions.

A serious problem in medical care is the apparent compulsion of many physicians to treat once a condition has been diagnosed. Doctors need to become comfortable with a patient's right to refuse treatment at the same time he recognizes the right of the patient to full information—that is, to a good diagnosis. Too often physicians are uncomfortable about making overt decisions not to treat and so they choose a route of what a physician friend of mine calls "benign neglect"; that is, "If I don't prove he has it, I don't have to feel guilty about not treating him."

We need to train physicians to make a good diagnosis on elderly patients and then be a part of good decisionmaking processes with patient and family regarding treatment or nontreatment. This demands some serious reexamination of our values and ethics and something we need to work on together.

THE ROLE OF NURSING

I would like to comment briefly on the role of nursing and its relationship to medical care of the aged. A large portion of those services

that are commonly classified as medical care services to the elderly are in fact nursing services, but the general public and other health provisions of the health disciplines still seem to see nursing only as the adjunct to medicine.

Indeed our justification for reimbursement for nursing care under medicare and medicaid, for instance, is almost always linked directly to a medical diagnosis and the need for a medically delegated service. Nursing, however, is a distinct art and science dealing primarily with the caring aspects more than the curing aspects of health care. Nursing skills are directed to assisting a person to cope with the effects of disability and disease. Nurses deal with things like immobility, confusion, discomfort, and isolation problems so prevalent in the care of the sick elderly. Nursing is also directed toward keeping people well, especially people at high risk such as the ambulatory elderly. Long-term care, whether in an institution or at home, and preventive and health maintenance services are two major kinds of needs of our elderly population, and nurses are a major underutilized resource in meeting these needs. Nurses are needed not just to extend the role of the physician but to complement medical services by providing equally important nursing services to the end that all the health needs of the elderly are served. All of the other health and social services disciplines also have special contributions to make, and together we need to learn what collaboration really means so that elderly people really see integrated, coordinated, interdisciplinary health care.

Senator PERCY. Sister Schwab, in the hospitals and nursing homes that you have encountered and worked with, how much influence do doctors have on the nurse's care of the elderly patient?

Sister SCHWAB. Well, the physician has, of course, a great deal of control in the acute care setting, particularly because it is related to the nature of the care which an individual in an acute care setting is there for, diagnosis and treatment of a condition—usually a particular condition. Long-term care, however, presents different kinds of treatment. They are receiving nursing homes or home health services for multiple reasons that may be social, psychological, economic—maybe the fact that there is no one at home to care for them.

Under present reimbursement situations in medicare and medicaid, it is very much tied up with what the physician says may not be done, so that what nursing services are performed must be ordered by the physician.

NURSE GERIATRIC TRAINING

Senator PERCY. Where do most nurses today receive their geriatric training—in special training programs, exposure to the elderly patients or, in your judgment, do they receive any special training at all?

Sister SCHWAB. Nursing schools are probably not that much better at giving geriatric exposure to geriatric and gerontological nursing than medical schools, though I think they are doing a better job. I cannot really speak with any great authority on the schools of nursing across the country, but I am aware that, for instance, the American Nursing Association is in the process of doing a survey of the content of the programs in nursing throughout the country. That data will be

ready soon as to how much is really being taught and where it is being taught.

There is an increased amount in the curricula about care of the aged. We also have a growing number of advanced practice kinds of programs concerning nurse practitioners. There is something like seven or eight programs that I am aware of and they are developing nurse practitioners around the country for care of the elderly. There are about seven or eight graduate schools that are teaching nursing in gerontology and geriatrics.

Senator PERCY. The committee has not surveyed U.S. schools of nursing since 1971 and I wonder, statistically, if you could update us now or help us get information as to what progress it has made since then. In 1971 we found that only 27 of 512 schools that responded to the survey actually had a program of geriatrics in their curricula. Do you know if there has been improvement since that time?

Sister SCHWAB. I am sure that there has been. There has been a great deal of activity in the last several years. We could see that you would get the information from the American Nursing Association's survey which is in progress. After gathering some initial data about how many schools offer anything in geriatrics, the study goes into a second phase, looking at where it is being offered, who is teaching it, what is the qualification of the instructor, and so forth.

Senator PERCY. Finally, you mentioned collaboration in your testimony. Our staff would like to know, do you know of any schools of nursing or medicine which are working toward collaboration?

Sister SCHWAB. I cannot cite you any, but that certainly does not mean that they are not. There are probably people in this audience that can give you some examples.

[The prepared statement of Sister Schwab follows:]

PREPARED STATEMENT OF SISTER MARILYN SCHWAB

I am grateful for the invitation to testify before this committee, as a nurse, on the topic of medical care of the aged and education in geriatric medicine. I speak from 15 years' experience of nursing in a nursing home, plus the opportunities afforded me in the past 4 years as the chairperson of the Division on Gerontological Nursing Practice of American Nurses Association. In the latter position, as well as during frequent lectures and workshops with nurses, I have been in contact with hundreds of nurses who work with the aged in all parts of the country, and have listened to their concerns. I hope my words can faithfully reflect the concepts and concerns of those colleagues, as well as my own.

I have been asked to speak from my personal experience of the quality of medical care of the aged, and to submit ideas about the training needs in medical schools on the subject of geriatric care. I have also been asked to reflect and comment on the relationships of medicine and nursing and how educational and practice trends in both disciplines have affected one another.

First, I would like to make a clarification between "medical care" as the diagnosis and treatment of the disease and "health care," which implies something much more inclusive and which deals with an individual person in relation to his total health and well-being. It is not a new concept, especially to this audience (the Gerontological Society) that health care of the elderly has to be delivered in a manner that deals with the multiplicity and interrelatedness of the elderly person's problems—emotional, cultural, economic—as well as his diseases and disabilities. Thus, to speak of "medical care" in isolation from other health care problems presents a woefully incomplete picture of the elderly person. To teach practitioners about medical care in isolation from other health care needs can lead to fragmentary and distorted understanding of the patient.

It would seem then, that each health discipline (in this case, medicine) should ideally educate its practitioners to approach the aged from a broad psycho-social-medical framework. However, given the brief history of the science of gerontology and the relatively undeveloped stage of its application to the health sciences, I believe it is important for each discipline to focus primarily on its unique contribution to the health care of the elderly. In other words, medicine needs to further develop and teach the medical aspects of health care of the aged—that is, the diagnosis and treatment of disease entities.

At the same time, medical schools need to teach future practitioners to understand and collaborate with other health care disciplines, not just to carry out their prescribed medical regimens, but to share in the interdisciplinary assessment, planning, intervention, and evaluation process, so essential to total health care of the elderly. We need more physicians who understand medical problems of the elderly, more geriatric medical specialists, and especially we need physicians who understand that nurses and social workers and physical therapists and many other disciplines have important contributions to make to the health care team which serves the patient together.

Medical schools need to examine values taught, in light of the challenges presented by an aged population. One such challenge is the question of how much, or whether, to treat a particular problem at a particular point in the older person's life. My experience with medical care of the elderly is that the interest and diligence in diagnosis and treatment have less to do with chronological age of the patient than they do with the complexity and apparent hopelessness of his presenting problems. It is the combination of old age and multiple health problems that tends to cause frustration and a feeling of the helplessness in the physician. In these situations, difficult ethical dilemmas are often posed. Principles of patients' rights and informed consent, as well as judgment about the relative value of treatment are frequently severely put to the test.

I feel many physicians have an apparent compulsion to treat any condition they diagnose. Too often, because they are uncomfortable about making overt decisions not to treat, they choose also not to diagnose. "If I don't prove he has it, I don't have to feel guilty." Physicians need to be taught to be comfortable with a patient's right to refuse treatment, at the same time that he recognizes the right of the patient to full information—that is, diagnosis. Elderly people, especially in nursing homes, are still put off with the excuse that almost any complaint is "due to old age," are rarely given the benefit of a good diagnosis, and even more rarely given the real opportunity to make a good decision with their physician and their families about when to treat or not treat. This demands some reevaluation of traditional ethical values in medicine.

Finally, I would like to comment on the role of nursing in relation to medical care of the aged. A large portion of those services commonly classified as medical services to the elderly are, in fact, nursing services. But the general public and other health disciplines too often see nursing only as an adjunct to medicine. Indeed, justification for reimbursement for nursing care is almost always linked directly to a medical diagnosis and the need for a medically delegated service. However, nursing is a distinct art and science dealing primarily with the "caring" more than the "curing" aspects of health. Nursing skills are directed to assisting a person to cope with the effects of disability and disease. Nurses deal with immobility, with confusion, with discomfort and isolation, problems so prevalent in the care of the sick elderly.

Nursing practice is also focused toward keeping people well, especially people at risk, such as the ambulatory elderly. Long-term care and restoration, whether in institution or at home, and preventive and health maintenance services are two important kinds of health care needs of the elderly, and nurses are a major under-utilized resource in meeting those needs. Nurses are not needed just to extend the role and services of the physician, but rather to complement his services, by providing equally important services that meet the health needs of the elderly. We must stop talking about extending the services of the physician and begin to recognize other health care disciplines as having useful and special services to offer. We must create a health care system that integrates those services in a collaborative manner rather than in our present hierarchical system. Collaboration implies autonomy of the individuals who collaborate. Thus, nurses in recent years are assuming more responsibility and accountability for their own decisions and treatments of patients.

State nurse practice acts are being revised to give legal recognition to the nurse's autonomous functions. This trend must be supported and one important way that is done is through recognition by third-party payors of nursing services as a distinct benefit. As long as medicare and medicaid benefits are related solely to medical diagnosis and medical services as defined only by a physician, the health care needs of the elderly will continue to be only partially met.

Thank you for the opportunity to share these concerns with your committee.

Senator PERCY. Thank you very much indeed, Sister Schwab.

Dr. Robert W. Berliner is dean of the Yale University School of Medicine. Prior to his appointment as dean, Dr. Berliner was Deputy Director for science at the National Institutes of Health. Prior to that position he was Director of Laboratories and Clinics at the National Institutes of Health. Dr. Berliner is a graduate of the Columbia University School of Medicine.

Dr. Berliner.

STATEMENT OF ROBERT W. BERLINER, M.D., DEAN, YALE UNIVERSITY SCHOOL OF MEDICINE, NEW HAVEN, CONN.

Dr. BERLINER. Thank you, Senator.

You have asked that I focus my attention on what I perceive to be the place of geriatric training in the education process, and specifically you asked me: Should the science of the aging process be concentrated upon during the basic science classes, during clinical studies, during special programs which many medical school curriculums have implemented, or during the years of internship and residency— or should the aging process be given specialized attention at all?

To the first of these questions I would respond: All of the above. That is, assuming that we mean more than just the science of the aging process, but mean to include the effects of aging on people, the interaction of aging with disease processes, and the medical care of aged people, there is something there for every stage of medical education. To the extent that we know anything about the aging process itself, it clearly belongs in the basic science curriculum; unfortunately we know very little about the fundamental nature of aging and it would be an unusual school that devoted a great deal of time to aging at that level.

I would expect the medical student to learn a great deal about the effects of aging upon disease processes during their clinical studies. Indeed, with the increasing age of the patients that students are exposed to, they can hardly avoid the opportunity to learn about age and its diseases, although some may profit more than others from the exposure. And finally, in my opinion, learning how to take care of aged people belongs in the post graduate period of residency.

In what I have said so far, however, I think I have avoided the question that is the real focus of this hearing, because what I have said could have been said equally well about any other process or group of diseases. What I have said merely describes the general organization of the medical curriculum. I think the important word is found in your second question, "Should the aging process be given 'specialized' attention?" and my answer to that is a qualified "no."

The diseases that are the causes of illness and death in the aged are the same as those that begin to appear in people in their thirties and

forties. There is no distinct group of diseases that occurs exclusively in older people. They have the same diseases as younger adults. The greatest difference is that they have them much more often. Of course it is also clear that the effects of the process of aging modify the way in which the individual responds to the stress of disease. The interaction of aging and illness can hardly escape the attention of any reasonably sentient student of medicine since the aging make up such a large fraction of the population who seek help in our teaching institutions, but I do not believe that this interaction of aging and illness, which is so much a part of everyday medicine, is a matter that requires separate and specialized attention.

Aging Process: An Enigma

Although I do not believe that geriatrics or gerontology warrant a special place in the medical curriculum, this does not mean that there are not a number of aspects of the aging process and of the effects of aging on people that call for serious investigative attention. Fundamental to all is a better understanding of the aging process itself. Unfortunately, perhaps because we do not yet have an adequate picture of the normal state, we do not really have an adequate theory of what aging really is. When we do, we will perhaps detect a more consistent basis for those changes which we recognize as the accompaniment of aging—changes in almost every organ system that have striking effects on the interaction of the individual with his environment and with the stress of illness.

Lack of this fundamental understanding, however, should not prevent a more direct approach to some of the practical problems, both physical and behavioral, some of which have been mentioned this evening. For example, to changes in immunocompetence with age and its possible relationship to neoplasia and to degenerative disease; the change in pharmacokinetics with age that may yield paradoxical effects of drugs in the elderly; or the basis for the doubled death rate in the newly widowed elderly. There is no lack of important investigative problems relating to age and aging.

Setting these matters aside, however, I would like to express my concern over one word that appears in the title of this hearing. The word is "neglect." My concern arises not from the conjunction of the word "neglect" with the subject of aging but from the further implication of the field of medicine. Clearly there is in our society a deplorable neglect of the aged. They are often excluded from the family, from participation in many aspects of life, and often relegated to institutions that are among the most disgraceful of our society. The use of the word "neglect" in this connection understates the case, but I am disturbed because the content in which the word appears suggests that in some way medicine is an important party to this neglect and is going to be called upon to provide the solution to this problem.

Perhaps I am taking an unnecessarily paranoid point of view and, by the time I deliver this testimony, my concerns will prove to have been groundless and this issue a strawman. But we have many precedents. Because of social and economic forces there are among our people, to say nothing of the rest of the world, many who are malnourished. But faced with the overwhelming problems of providing

adequate food, we decide that what is needed is intensified efforts in the science and teaching of nutrition.

There are many things that adversely affect the well-being and, more narrowly, the health of our people that are quite beyond the capacity or even the mission of medicine to control. Statistics relating to the health of our population are much more affected by the fact that people, eat, drink, and smoke too much and drive like fools than by what doctors can and should do. As doctors we should certainly be concerned about such matters, but we shouldn't be expected to provide the solutions. Similarly it is not going to be within medicine that we find the solution to the neglect of the aged. In short, although aging and the aged constitute serious societal problems, I do not believe they are neglected in either medical education or medical care.

Thank you.

Senator PERCY. Doctor, would just the fact that the treatment of the aging is a postgraduate course generally make it look as though, then, it is an appendage and not a real course subject?

DR. BERLINER. I was not suggesting that the teaching of aging should be a postgraduate course. What I was saying is that learning to take care of specific kinds of people, how to do it, belongs in graduate medical education rather than the undergraduate medical education, and not only aging but with everything else the doctors do.

Senator PERCY. In day-to-day contact with the faculty and students at Yale, do you find an earnest interest and desire for knowledge in the geriatric field? Be very frank.

Dr. BERLINER. As a particular field specialty, no, I do not.

Senator PERCY. It is my understanding that Yale is one of the several medical schools participating in the National Institutes of Health program for the training of medical scientists. Could you briefly describe this program and how it operates? As a former NIH policymaker, do you find that both NIH and the medical school can benefit from this joint effort?

THE FEDERAL SCIENTIST PROGRAM

Dr. BERLINER. The Federal scientist program is essentially a program which provides simultaneous training in medicine, more or less the standard medical education, and along with that an opportunity for intensive training in, usually, one of the basic sciences on which the science of medicine is founded, such as biochemistry and so on. The student obtains both the M.D. and Ph. D. during the period in which he is enrolled in this course, which is usually 6 years. I think it is an excellent way of providing the people who are going to do much of the basic research that is closely related to medicine itself. I think that the medical aspects of the education gives an orientation to the scientist which many people without such training do not have.

Senator Percy. Does the National Institute on Aging participate in this program and, if not, do you see any potential for future cooperation?

Dr. BERLINER. The program, as far as I know, is entirely supported by the Institute of General Medical Sciences. It is a noncategorical sort of program and the Institute of Aging is a noncategorical insti-

tute. I suppose there is a possibility that they could get involved in it, but I don't know that the stage in which students enter this program that they would have an idea of commitment to work on aging. This would probably not apply to students in the junior year or the senior year in college which I think, is too early for them to get committed to a field such as gerontology.

Senator PERCY. More and more medical schools are developing ties with their community health clinics and home care organizations. Can you describe Yale's effort in this area and whether the elderly patient receives attention?

Dr. BERLINER. Yes; in New Haven there are several. There is one major community center, the Hill Health Center, which is actually sponsored and partly supported by the school of medicine in which we have a close relationship with members of our faculty involved in the care of the people. They take care of a broad sample of the population, mostly of the poorer population of New Haven, including the elderly. I don't believe there is any home care involved in this particular program.

Senator PERCY. I want to thank you very much indeed for your willingness to express the points of view that are not always popular, and probably not popular with some of the people here, but I think it is provocative and helpful.

I would like to amend our format to permit anyone who might feel that someone on the panel has committed their version of the Polish faux pas to have a minute to attack one another with freedom [laughter], but we will limit it to just a minute if you don't mind.

Our next witness is Dr. Theodore Sherrod. Dr. Sherrod is a full professor in the department of pharmacology at the Abraham Lincoln School of Medicine at the University of Illinois at Chicago Circle. Dr. Sherrod has been associated with the University of Illinois in various professorships since 1940. He is a graduate of the University of Illinois College of Medicine. Jessie Sherrod, Dr. Sherrod's wife, is very active in social work in the Chicago area.

We are delighted to welcome you, Dr. Sherrod.

STATEMENT OF THEODORE SHERROD, M.D., PH. D., DEPARTMENT OF PHARMACOLOGY, SCHOOL OF BASIC MEDICAL SCIENCES, UNIVERSITY OF ILLINOIS AT THE MEDICAL CENTER

Dr. SHERROD. Thank you, Senator Percy and Dr. Binstock.

I am perhaps the least qualified of all the panelists to give my points of view regarding aging; however, I have been very interested in the phenomenon for a long time and as I get older I become more interested.

Aging is an inevitable fate of all living things. The geriatric population is constantly increasing, largely because of advancements in nutrition, sanitation, immunology, improved surgical techniques, and the effective chemotherapy of infectious diseases. Many of the so-called degenerative diseases, characteristic of the aged, are becoming increasingly more evident.

Numerous socioeconomic factors operate to preclude access of many of the aged to the kind of medical attention needed to prevent, amelio-

rate, or cure their ills. Perhaps more important, however, is the general lack of appropriate training in geriatric medicine among physicians and other health care personnel.

Geriatric Pharmacology

The field of geriatrics is, perhaps, the newest medical specialty, dealing with the oldest patient population. Training of all physicians should encompass geriatric medicine. As a pharmacologist with some knowledge of the marked difference in the response of the aged to many therapeutic agents, as compared with the young adult or middle-aged patient, it would seem advisable or desirable to have this labeled as "geriatric pharmacology," because I think there is enough difference in the response of the elderly patient to drugs to warrant this kind of special training.

There appears to be a degree of resistance by many members of the medical profession to regard the elderly patient as having medical problems more or less characteristic of that age group. It is true that while many of the diseases are the same—diagnosed by the same techniques and treated in a similar manner as in the younger patient—the rate of healing and the responses to medication in the aged may exhibit striking differences. Just as the pediatric age group have medical problems peculiar to infancy and early childhood, the elderly patient is likely to have medical problems more or less characteristic of that age group.

Aging, and the accompanying physical changes, occurs in different people at different rates and appears to be largely genetically determined. However, with age comes an increasing vulnerability to many diseases that may minimally affect the younger patient. Specific medical training in such areas should be a mandatory part of the medical curriculum.

While a department of geriatric medicine would be most welcomed and desirable, at least a division of geriatric medicine should exist in all medical schools with special emphasis on gastrointestinal, arthritic, metabolic, cardiovascular, and other diseases which so often plague the elderly. Federal and other funds should be increased to support research in geriatric medicine. Grants for such efforts should merit the status of high program relevancy. The alternative to living to the age where pain and suffering often make this an almost unwelcomed stage of life is to die young. Already much information in geriatric medicine is available. It will be applied only if organized medicine and academic medicine stimulate the needed interest in this area.

Thank you.

Senator Percy. Dr. Sherrod, how often in your normal routine, if you can call it that, as a professor of medicine are you called upon to teach about specific factors of the aging process and what does this entail?

Elderly Respond Differently

Dr. Sherrod. Just about never. However, I should emphasize the fact that in medical training we occasionally allude to the fact that the elderly patient is to respond differently because of certain path-

ological alterations that will greatly influence the way in which this patient handles drugs and we will make mention of that fact, and this is somewhat in passing. I think this attitude is almost characteristic of just about almost all people, most people below the age of 40 or 50, but once we get old we realize that there are problems that are characteristic of the aged.

What I am saying is we seem to be so youth oriented. We definitely know that there are problems that are more commonly encountered in age which I think can be handled to the extent that the elderly person could live a more peaceful existence than we make possible simply because we have not emphasized that aspect of the medical training. I am well aware of the fact that so many physicians come from medical school, go through their residency training, and are almost totally unaware, at least of the behaviors of the elderly, that we are unaware of many of their problems and get into a lot of difficulties so far as the application of drugs is concerned. Elderly patients do definitely respond differently to a large number of drugs that have so many complaints, and there may be a tendency on the part of the physician to treat every complaint as a central complaint, totally isolated from the patient with no thought of how one drug is going to react to the other. These are the kinds of things that I think ought to be taught in medical school, certainly in my profession, and be labeled "geriatric pharmacology."

Senator PERCY. As a specialist in pharmacology, do you see the need for a specialist in geriatrics, or only a specialist in pharmacology with a concentration in geriatrics?

SPECIALIST IN GERIATRICS?

Dr. SHERROD. I see the need for a specialist in geriatrics just as I see the need for a specialist in pharmacology and surgery. I think it is the recognition of such a specialty that is going to lift the thinking about the aged as having special problems. So, from that point of view I think that having a specialty with the status of some other specialties in medicine will engender the kind of support from the lay community, as well as from the institutions and what have you, so that there will be people flocking into this area as a specialty.

I think there are people—that is, people in training, medical students, and residents, perhaps interns—who have not decided where they want to go. If they see this as an opportunity that has some recognition nationally and locally, this will lift the status of that specialty, if we can call it that, and I think it should be called that.

Senator PERCY. Just to be sure I understand your view, would this specialist categorization apply to all disciplines within the medical curricula or should there be a separate and distinct department of geriatrics?

Dr. SHERROD. I certainly don't think it should involve pediatrics because I think the problems are quite different, but I think most of the problems do transcend most of the other specialties involving treatment of elderly people. There are problems that the surgeon can handle best and there are problems that the internist can handle best, and they transcend many areas.

If there were a division or a department of geriatrics, the emphasis could be placed appropriately in this area. I think one of the difficulties of not really having a specialty as geriatrics, and I think some

of the resistance so based, is because the problems do transcend so many areas.

Senator PERCY. I wonder if you could just go back into your own experience as a professional person and tell us whether you felt that you were adequately trained to deal with the elderly people in your education, or did you pick this up and develop your interest and expertise just as a matter of your own experience?

Dr. SHERROD. Senator Percy, as I said at the outset, the older I get, the more interested I become in the aged. [Laughter.]

Senator PERCY. The definition of an older person is somebody 50 years older than we are.

Dr. SHERROD. To those in their 20's, no older than 25, anybody 50 years old is really ancient. So at that time, without having appropriate leadership to stimulate them in geriatrics as a profession, we could not care less, but in all fairness to academia, occasionally statements were made to the effect that "Now when you deal with a person of this age you must look out that certain changes have occurred and that this patient requires this particular kind of procedure. You have to be careful that you don't do thus and so," but this was almost as a footnote and not as a fact.

Senator PERCY. Thank you very much indeed.

Our last panelist is Dr. Leslie S. Libow, medical director of the Jewish Institute for Geriatric Care in New Hyde Park, N.Y. He is also chief of geriatric medicine of the Long Island Jewish-Hillside Medical Center in New Hyde Park. Dr. Libow is associate professor of medicine at the Health Sciences Center, State University of New York at Stony Brook. Prior to these numerous roles he was instrumental in developing the geriatric program within the Mount Sinai Hospital Services at City Hospital Center in Elmhurst, N.Y.

Dr. Libow.

STATEMENT OF LESLIE S. LIBOW, M.D., F.A.C.P., MEDICAL DIRECTOR, JEWISH INSTITUTE FOR GERIATRIC CARE; CHIEF, GERIATRIC MEDICINE, LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER, NEW HYDE PARK, N.Y.; AND ASSOCIATE PROFESSOR OF MEDICINE, HEALTH SCIENCES CENTER, STATE UNIVERSITY OF NEW YORK AT STONY BROOK, N.Y.

Dr. LIBOW. Thank you, Senator Percy.

Senator Percy, Professor Binstock, distinguished colleagues, ladies and gentlemen, my medical work is entirely with the elderly, and I categorize myself as a geriatrician. Earlier, Dr. Butler mentioned the lack of homegrown geriatricians in the United States. Well, if I am not homegrown, I am certainly homemade. My initial training was in internal medicine at Mount Sinai Hospital of New York and in research in aging at the National Institutes of Health—the latter at the same period that Dr. Butler and Dr. Berliner were working at NIH. In the past several years, I have developed a special health care system and an approach to care exclusively focused on the elderly. This system and approach encompasses community and institutional care and is centered about a health team.

These programs served as a base for the development, at the Mount Sinai City Hospital Center in New York, of the first geriatric medical residency program in this country. We trained several geriatricians, and six more are now in training at the second established geriatric residency program, at my present campus, the Jewish Institute for Geriatric Care and Long Island Jewish-Hillside Medical Center, affiliated with the SUNY School of Medicine at Stony Brook. Those trained now lead geriatric programs in various cities; 250 to 300 other interns and residents have also been trained for 1- to 2-month periods in the discipline of geriatric medicine as a basis of whatever special area of medicine they are pursuing.

These health programs also served as a base for the teaching of geriatric medicine to medical students. These students have come to us from many medical schools, because their own schools do not offer any special courses in training in geriatric medicine.

Findings and Recommendations

The key points derived from these training experiences are as follows:

(1) Medical students have a natural and active interest in learning about and working with the elderly. My experience at three different medical schools has made this interest clear, no matter what area of medicine the student may enter later. Since my colleagues in the faculties of medicine doubt this interest, I have just completed a survey of several hundred freshman students at seven geographically and ethnically diverse medical schools to learn of their interest in this field. Of the nearly 650 students surveyed, approximately 50 percent completed and returned the questionnaire. The major questions were: Are you interested in having a course on human aging? Answer, "Yes" (75 percent). Would you take an elective in your clinical years focused on the medical and psychological illnesses of the elderly? Answer. "Yes" (75 percent).

These impressive percentages were found at all the schools and reflected the student interest at private, elitist, and State medical schools. The results speak for themselves.

(2) It is crucial to have geriatricians as role models in the medical school faculty. Physician specialists are necessary for students to identify with and to help sustain their natural interests in the elderly, in the face of the negativism toward geriatrics of the traditional faculty. Medical students will not easily identify with the social workers, economists, and psychologists who often excellently teach the few courses in geriatric medicine that now exist. We need geriatricians at every medical school and major hospital to teach the available body of knowledge known as geriatric medicine, to teach and develop the special approaches to the elderly, and to lead efforts toward furthering this knowledge and these approaches.

(3) Establish a special geriatric health care system in each medical school or hospital community and base it on a team approach. The student can then observe and participate in this approach. You can't easily teach and demonstrate human concern and clinical skills with regard to the elderly from a typically sterile classroom atmosphere.

The struggle of the ill elderly for life and self-sufficiency against the present day laissez-faire health system, must be appreciated first hand.

(4) Teach geriatric medicine in special courses and as a special discipline. The body of knowledge in geriatric medicine is vast, but usually overlooked. The 17 seminars in clinical medicine and the additional 40 individual scientific papers in clinical medicine that will be presented during the next 4 days of the Gerontological Society's meeting are but one example of this knowledge. As in all other fields, more research is, of course, necessary.

During the freshman and sophomore years, areas such as the biology, physiology, and psychology of normal aging, as well as the demography and epidemiology of late life, are emphasized. The courses and field placements should emphasize the struggle for self-sufficiency of the ill elderly, as well as the vigor of the well elderly.

In the clinical years, the student should work alongside of geriatric resident physicians in training and/or alongside of faculty level geriatricians. The clinical exposure should include areas such as frequent home visits, ambulatory care, nursing homework, and community health education. All this is part of a team of professionals, so that an appreciation develops for the need for this coordinated effort.

Physician, Patient Goals Differ

The goals of the ill elderly must be differentiated from those of the young physician. Reversal of dramatic illness is welcome at any age, but smaller, quieter victories are often paramount to the older patient while unappreciated by the young physician. The physician should also be trained in the special approaches to geriatric history taking and rapid and accurate mental status evaluation. Too often a limb is carefully evaluated and the mind is overlooked. Emphasis should be placed on appropriate dosage and interactions of multiple medications. Establishing rapport with the elderly patient and making them feel the sincere interest and concern of the physician is itself a challenge. The causes and treatment of so many common problems are different for the elderly and often cannot be usefully and safely extrapolated from the general rules for the average patient of any age. In medical school, there is constant reference to the 70 kilo man, who presumably is ageless. Examples of problems which often have different manifestations, causes, and treatments in the elderly, as compared to the middle-aged and young, are headaches, weight loss, arthritis, fevers, elevated blood pressure, cholesterol values, mental changes, use of antidiabetic tablets, treatment of cancer, et cetera.

Headaches in the elderly may be due to polymyalgia rheumatica, a problem uncommon in middle age and thus often not diagnosed in the elderly. This disease could lead to blindness or stroke if not treated properly. Decisions about treatment of elevated blood pressure, elevated blood levels of sugar or cholesterol are usually made without awareness of the specific body knowledge as it applies to the elderly. Thus, it is frequent to note lack of treatment of moderate hypertension in a 68-year-old, in spite of reasonable evidence that treatment of hypertension at this age diminishes morbidity. Also common are inappropriate treatment decisions related to elevated blood sugar and dia-

betes mellitus. There are different factors in the elderly that must be considered when deciding about treatment with diet, insulin, and/or oral hypoglycemic medication. The key factors in choice of treatment of the elderly diabetic may include subtle decline in memory, vision, appetite, or access to renewal of medications. This is in contrast to the certain factors used in decisionmaking with middle-aged patients, such as cardiovascular toxicity of the oral hypoglycemics, and the probable relationship of poorly controlled blood sugars to vascular complications occurring after many years of having diabetes mellitus. These latter factors may have a role in diabetes of the elderly, but they appear to be of secondary importance, compared to the key factors listed above.

Mental Depression of Elderly

Mental depression in the elderly is probably the most frequently overlooked diagnosis of all. When it finally is noted, it is too often treated with antidepressants at dosage levels that are correct for younger patients but toxic for the elderly. An endless number of examples exist which reflect an improper approach to the elderly.

These approaches, these facts, this sensitivity, this need for further research are not usually taught in medical school, and certainly not as a separate discipline, warranting a special approach.

(5) Establish independent full departments of geriatric medicine in all medical schools and hospitals. This special discipline needs its own identity, faculty, and budget. Otherwise, when budget and staff reductions in medical schools and hospitals are necessary, those programs dealing with the elderly are the first cut. Again, we see the prejudice called ageism at work. The environment for growth and development of this discipline will, at most, be neutral in other departments such as internal medicine. From this proposed independent department of geriatric medicine, geriatricians can affect teaching in areas such as psychiatry, family practice, internal medicine, urology, et cetera. The existing body of information, as well as the special research and clinical approaches to the elderly, must be taught to all physicians so that their approaches to the elderly will be more appropriate.

(6) Geriatric medicine must be more clearly defined though its definition will probably change with time. It is certainly a discipline of scientific and clinical facts and approaches which treats aging, late life and the elderly, as special. The geriatrician is the physician specialist in this generalist area. The geriatrician leads the development of the health care approaches in the community and institutions and leads the teaching and research efforts. The geriatrician also delivers primary care in those areas where it is particularly not being delivered—specifically, in the convalescent and nursing home area, in-home care, in organized long-term ambulatory care and, finally, as clinical consultant to patient and family who cannot obtain satisfactory response to their problems. The physician has been given the legal authority to lead the improvement of care of the elderly. We must now teach the medical student and physician to properly exercise this authority and leadership.

The issue is not one of "Do we need another specialty called geriatric medicine?" The issue is clearly that there is a group called elderly

who need special medical approaches and there are places called medical schools and hospitals that must train young physicians to meet this unmet need.

Thank you.

[Applause.]

Senator PERCY. That's one thing I like so much better here than the Senate hearings down in Washington—we just never allow applause there. [Laughter.] I am going to change the rules of the Senate; I rather like it. It is a great tribute to our panelists, I think, all of whom have been absolutely marvelous.

I would like to ask Dr. Libow a question about the research that will be reported on later this week by Dr. Shanas. She has been doing a great deal of study on premedicare and postmedicare, and her figures will show that when you take into account that there are more than twice as many housebound and bedfast people 65 and over as there are in institutions today—and this is exactly the same proportion as existed before with medicare—what are the implications for schools of medicine or the medicare program when you come to see these statistics?

Dr. LIBOW. Well, the implication seems fairly clear. A good deal of medicare money is used for the training of physicians in all specialties of medicine, but regrettably, very little is used for training geriatricians or for training medical students about geriatrics. Some of the problems of the elderly require a team approach and special community health systems and I feel a distinct clarity that a physician must be a strong part and a leader of these special programs. Such special approaches, now lacking, would reduce institutionalization and the present trend toward physical dependency and homebound status.

As a second point I feel that medicare is, in a way, an enemy of the elderly. It sounds paradoxical, but the point is clear. Medicare has made the older person a wonderful client—a client for the practitioner—and that does not include only the medical practitioner, but I say that to my colleagues in all fields—a wonderful client too, for the hospital and the nursing home. So there are many vested interests that hold on to the organ ailments of the elderly and perhaps even the bodies of the elderly without really approaching the human being.

Senator PERCY. I think you have very aptly summarized months and possibly years of hearings that we have held on this subject. We could have saved an awfully lot of research and time.

I believe you did say that you had trained a dozen geriatricians. What happens to a trained geriatrician? Are they snapped up by the medical profession for positions of responsibility? Tell us what they are doing now.

Dr. LIBOW. One of the outstanding clinical medical journals in the United States, "Annals of Internal Medicine," will be publishing an article next month from our center answering your question. I will briefly summarize that for you.

TRAINED GERIATRICIANS IN DEMAND

First of all, we regularly receive phone calls and letters from many of the people in this audience and from many deans at many medical schools asking if these geriatricians are available.

Of the 12 that have been trained, I can briefly tell you where they now are. One is now leading a geriatric program at a leading hospital and its community nursing home in the county of Westchester, N.Y. Another is working with us, expanding our program in our communities of Nassau and Queens in New York. Another has returned to Kyoto, Japan, where he has established the first geriatric medical program in that city at the Kyoto-Katsuru Hospital, part of the Kyoto University Medical Schools. Others are leading other geriatric programs. So there is a tremendous market for these people and a tremendous need.

Senator PERCY. One last question to you. You have mentioned that there has been a development and interest shown by students and we are glad to hear that. You have also been instrumental in the development of geriatric programs in several medical facilities. How were you able to secure the budget and identify roots that you suggest as "musts" in your statement? What advice would you give to other interested medical professionals who would want to develop similar programs?

Dr. LIBOW. Well, to start with, I hope that support from Dr. Butler and the increasing involvement of the Administration on Aging will afford other universities and other centers the opportunity to do what we did and with less financial constraints. There is certainly a need for more financial support for this new field. But I am quite proud of using a different approach. What we did, Senator, was utilize some of the wasteful dollars spent on medical care in long-term institutions and convert these dollars into high-quality physician care and leadership, while simultaneously providing these physicians with geriatric medical residency training.

This approach has also been very cost effective. We pay $9,000 per year less to the resident physician than was paid to the unskilled "house doctor" who previously worked at our facility. Thus, we have enormously improved patient care while reducing salary costs by $50,000 to $75,000 per year. There is so much money available in the care of the elderly that what we really need to do is redirect our use of the money.

Senator PERCY. With the permission of our audience, we are going to adjourn promptly at 10 o'clock. We have secured permission to keep the room until 10:15—I trust without time and a half payment for an extra 15 minutes more, having followed the President's $1,000-a-plate dinner held in this room last night.

We really have only 20 minutes, and we have enough questions up here for 20 days. If any member would like to respond who found objection or would like to challenge something said by someone else, please do so as briefly as possible. If not, we will go right to the questions.

Dr. Butler, did you want to comment?

INADEQUATE PHYSICIAN TRAINING

Dr. BUTLER. Yes. Actually, I think, at the time I signified a desire to speak, Dr. Libow had not spoken, and I think he has expressed much of what I wanted to say. Maybe to repeat, if we know so little about aging, then we must create and maintain conditions that are favorable

to our building new knowledge and new information—and not the opposite—namely, to avoid it. If we do have some valuable information and knowledge which is not known to many people, and I am afraid it is not, then we must indeed teach it and apply it. I must say that one of my great disappointments insofar as the National Institute on Aging is concerned is that less than 4 percent of the grants have come from investigative medicine. That says quite a lot when you consider the enormity of the problems.

I would also like to say that unless the schools of medicine have created favorable catalytic atmospheres, then departments within those departments of medicine are not apt to address their attention to aging.

I am homemade, too, and I had not realized that. I did want to stress the fact that my own remarks come from clinical, as well as research, experience. When I talk about my colleagues, I don't do it lightly in saying that, indeed, there is a credible absence of knowledge. No one mentioned the older people themselves and I would like to point out that they have many, many complaints about the care they receive.

There is not only SAMA—the Student American Medical Association—but I had an occasion recently to spend an evening with a dean of a medical school, I will not name, who spoke proudly of how well trained his students were. The next morning I had occasion to meet with his students, senior medical students, who spontaneously spoke about how ill-prepared they were to work with older people, how little knowledge they had, how little education they had of epidemiology and pharmacology. I would like to remind you that 75 percent of practicing physicians have expressed the lack of proper training. There are diseases which are new, such as diseases which make a difference clinically with broad vulnerabilities.

I would just like to suggest that it would be very, very rewarding if our medical students had a greater exposure to different aging populations. If our medical students saw only children with irreversible conditions and there were no well-baby clinics, how many medical students would be interested in pediatrics? We have to give them a broad based exposure.

Finally, I would love to see, as one way of showing medical interest, our National Board of Medical Examiners include a couple of questions about the elderly for our medical students as one way to stimulate interest.

Now if you really want to answer the question without getting scientific, it would also be interesting to test the 300,000 practicing physicians in the United States and see if indeed they do know what we know exists in the corpus of knowledge about geriatric medicine.

Senator PERCY. Thank you very much.

Any other panelists?

If not, then, Mr. President, I turn the questioning over to you. As I look at this, I wonder how you are going to select, out of all those questions; I don't know.

Dr. BINSTOCK. All I can say, Senator, is that I am glad I am not standing for reelection for president of the Gerontology Society. [Laughter.] In selecting from this collection of audience questions, I have just probably made 5 friends and 300 enemies in the process.

However, I can say that what I have tried to do is select brief questions that reflect many thoughts expressed in many questions and to hit sharply several points that were not covered directly in the testimony or that bring issues to a head.

Are Specialties Necessary?

First, a question combining two questions which were directed to Drs. Berliner and/or Cooper. One person expressed it, "Why does the medical profession recognize a need for a specialty in pediatrics and not in geriatrics?"

The other person expressed it, "According to the logic of Dr. Berliner, does it not seem appropriate to discontinue the specialty of pediatrics?"

Dr. Berliner. In fact, it does. [Laughter.] There is one aspect of pediatrics which deals with the new born and the first 6 months to a year of life. There are problems which are unique in that age group. Beyond that I see no reason why pediatrics should be separate. Of course, my pediatric friends don't agree with that. In fact, I do not believe that there is very much logic in the separation of the remainder of pediatrics on internal medicine.

Dr. Binstock. Dr. Cooper, how do you feel about that? Should pediatrics as a specialty be abolished?

Dr. Berliner. I think he should be excused from answering this question; he will get into much trouble. [Laughter.]

Dr. Cooper. I would like to say, as I did in my written testimony, that the association has nothing to do with the designation of specialties. That comes from a liaison committee on specialties which has joint membership with the American Medical Association and the Board of Medical Specialties.

Senator Percy. We accept that disclaimer.

Now would you like to comment further?

Dr. Cooper. I think I would agree very much with what Dr. Berliner has said. As a matter of fact, I think that the development of family medicine is a move in the direction toward the fact that there is not this differentiation on an age basis. There are special problems, as I think there are in geriatrics, but I think those are minor in comparison with the communality of problems.

Dr. Binstock. Thank you, Dr. Cooper.

The next question is for Dr. Libow. Are there any cogent reasons why a specialty of geriatrics should not be instituted in the United States? I am looking for brief responses, you understand.

Dr. Libow. No. [Laughter.]

Dr. Binstock. A question for Senator Percy. Do you feel there might be some parallel between the resistance of organized medicine, represented by the American Medical Association's resistance to health insurance for the aged, and the resistance of organized medical education to the need for special attention to geriatric education?

Senator Percy. I don't notice any difference in the inertia about changing an existing status, and I have noticed in the Senate we have the same problems with the adaptation and change and acceptance of concepts. As a result of this kind of hearing, and as a result

of the wide dissemination of the views of our panelists, I would hope that we are going to move the immovable and make some progress; I think that we can.

Dr. BINSTOCK. Thank you, Senator.

TRAINING FOR GERIATRIC NURSES

Dr. Butler, is the National Institute of Aging concerned for educational programs for other health care professionals; namely, professional nurses?

There is a dearth of professional nurses prepared in gerontological nursing. It is true in nursing also that there is a lack of adequately prepared faculty in the field of gerontological nursing.

Who are the clients of the National Institute on Aging?

Dr. BUTLER. It should be clarified that the National Institute on Aging cannot train for purposes of service. We are only permitted by legislative authority and mandate to train for research. Certainly research nursing, research for medical social work, research for any of the variety of health professions and scientific professions is perfectly welcome. People can submit proposals toward that end. Unless the law changes, we cannot train.

Dr. BINSTOCK. Dr. Libow.

Dr. LIBOW. I think that is an important point. It would be important that either the mandate of the National Institute on Aging be changed or that within the Government one new agency be established to combine all the other agencies so that for service and training of professionals in this field of geriatrics, those of you in this audience and others in this field would know where to turn.

Dr. BINSTOCK. Thank you.

Now a question for Dr. Cooper. You have identified the lack of money as a key reason medical schools have not adequately responded to geriatric medicine. Is the problem, rather, one of priorities set by the medical schools relegating geriatric medicine to the lowest level?

USE OF MEDICARE FUNDS

Dr. COOPER. Many of the sources of support are not fungible. Dr. Libow has talked about the fact that he has State lines which he can use in residency training. The medicare law does not permit you to collect under part A for residents while they are in the outpatient department or in an ambulatory care setting. Unless an institution has the kinds of funds that the State apparently has provided Dr. Libow, you cannot just convert the support for residency training under medicare into ambulatory care, home care, nursing home care, and so on, because there simply is no part A for that aspect of medicare.

Dr. BINSTOCK. Dr. Libow, you seem to be ready to respond to that.

Dr. LIBOW. If interns and resident physicians work in the outpatient department and/or emergency room of an institution with an approved teaching program, then the cost of their services is reimbursed through part A of medicare. If it is not an approved teaching program, then the expense is covered under part B of medicare.

Dr. BINSTOCK. I think we have time for about two more questions. The next question is to Dr. Cooper. The tradition of the medical profession is to follow social prestige and the economics of income. The aged are not one of the elite groups in both respects. How do you propose to break this mismatch of medical needs of the elderly and the traditional focus of the medical profession on social prestige and the economics of income?

Dr. COOPER. Well, I am sure that the AMA would not feel that I had the authority to speak for the medical profession—they have pointed that out on several occasions.

I think that there is a mismatch between reimbursement in a variety of areas in care and the need for care. The association has recommended, as a matter of fact, that a reexamination be made of the methods of reimbursement for care so that care is reimbursed appropriately and that the larger amount of reimbursement that is given for procedures is more equated, with the two or more evenly equated. So as far as we are concerned, there is a mismatch, there is no question, and the whole reimbursement system in this country does favor the carrying out of procedures rather than delivery of care.

Dr. BINSTOCK. I gather the question is: How would you propose to break that cycle?

Dr. COOPER. We think it is to be broken by having medicare reexamine its reimbursement procedures.

Dr. BINSTOCK. Finally, a question for Senator Percy. Would you please comment on this?

AFFIRMATIVE ACTION IN MEDICAL SCHOOLS?

Discrimination on the basis of race, color, and national origin is proscribed behavior for medical schools receiving public dollars. Discrimination on the basis of age is more subtle, but nonetheless devastating. Perhaps the time has come to require, first, affirmative action on behalf of training physicians in aging and, second, imposition of disincentives, like loss of funds, for failure to have clear identifiable didactic and clinical training programs in geriatric medicine. Isn't the time for cajoling and pleading long past?

Senator PERCY. I hope not. I am really quite reluctant to go into a field—where you really want institutions and individuals to go into a field because they feel compelled to do so because of the need. I am not sure we have done the most effective job that we can of trying to sell the need for this. I would want to exhaust that first before we went into compulsion, which has all sorts of backlash aspects to it.

I think we have got a solid body of evidence if we could get this before the medical schools and if we could carry it to the AMA. I intend to start right in my own State with the State medical society, and I intend to work through our medical schools to do everything I can and to get other members of the committee to do it also. If we find we totally fail, then there is something wrong with us. I think we have enough of a story to tell—if we can get it across and then have the enthusiasm, rather than have it just one of the programs of the Federal Government, which comes in with a hammer and a carrot, or whatever it may be, and compels us to do it.

Now I feel inclined to try it that way before I go the other way. I just think rationality is much better than compulsion. In this case I think we can make a solid case for it. I think the enthusiasm of this group, as we go out, will help us with that job. That would be very much my preference.

Dr. BINSTOCK. Thank you. There is one last question here for me. "Can we have a copy of the testimony presented tonight before the society meeting ends this week?"

I am informed that the answer is "No." The hearing record will be kept open for 1 month. If you want the printed copy of the hearing, check the box on the blue sheet, fill in your address, and hand it to the staff or mail it to the committee in Washington as indicated on the blue sheet.

I also remind you that if you wish to have a statement submitted for the record, also mail it in on the blue sheet to the Senate Committee on Aging in Washington.

Senator Percy, I would like to thank you so much for holding this hearing with us this evening. It has been a great experience.

Senator PERCY. I would like to express appreciation on behalf of the very able staff who, I think, is one of the finest and the most educated staff we have in the Senate—Bill Oriol, John Guy Miller, Pat Oriol, Debbie Kilmer, Alison Case; and from the Select Committee on Nutrition and Human Needs, Wayne Fletcher; and Annabelle Short, our court reporter. I express deep appreciation to them but, I think, on behalf of them I can say that this never would have been possible without the initiative, the encouragement, and the fine cooperation of Dr. Binstock. It has been an honor to have been with you.

This is a brilliant panel, one of the finest in 10 years in the Senate that I have ever been privileged to meet with. We will benefit for a long time to come from what you have shared with us. We hope that all of you will go forward with a renewed feeling that you have appeared before a committee that has been able to get an awfully lot of things done, the U.S. Senate Committee on Aging, which I represent and feel to be the consensus of this particular group.

Thank you very much indeed for your participation.

[Whereupon, at 10:17 p.m., the hearing was adjourned.]

APPENDIXES

Appendix 1

STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF CARTER C. OSTERBIND, CHAIRMAN, PUBLIC POLICY COMMITTEE, ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION, WASHINGTON, D.C.

In response to Senator Percy's general invitation at the hearing, the board of directors of the Association for Gerontology in Higher Education (AGHE) has instructed the chairman of the public policy committee to submit this written testimony so that the views of AGHE may be a part of the hearing of the Senate Special Committee on Aging which was convened in New York October 13, 1976, re: "Medicine and Aging: An Assessment of Opportunities and Neglect."

It is appropriate first to very briefly state the purpose of the Association for Gerontology in Higher Education.

With growing public interest in aging during the past several years, many colleges and universities have instituted gerontological education and research programs. The number of programs continues to grow. A directory, prepared by AGHE under a grant from the Administration on Aging, lists 1,200 educational institutions with programs in gerontology. The Association for Gerontology in Higher Education was established to better represent these institutional programs nationally. The specific purposes of the AGHE are: (1) to unite in common organization educational institutions which conduct research, provide academic or professional training or other educational services in gerontology, and to provide a network of communication among such institutions; (2) to promote and encourage the education and training of individuals preparing for research or service careers in gerontology and to increase the awareness of the general public of the need for such education and training; (3) to provide a public forum for members to exchange ideas and knowledge which advance gerontology in higher education; (4) to provide an effective base for continuing cooperation with public officials, voluntary organizations, individual membership associations, and other groups interested in aging and education. The current membership of AGHE includes 4-year colleges, graduate universities and consortia, as well as other institutional affiliates with academic programs and interests in gerontology.

The members of AGHE have strongly endorsed the legislation creating the National Institute on Aging and the purposes for which it was created as set out by the Congress in Public Law 93-296. The president of AGHE, in his report to the membership in 1975, reaffirmed the support for NIA and voiced the strong hope that in addition to research support, the Congress would make additional funds available to NIA for training and for NIA staff support. At the annual meeting of the AGHE in Washington March 3, 1976, the program plan of AGHE called for effective liaison with NIA. A representative of NIA was invited to meet with the membership of AGHE so that views could be exchanged, and the support and interest of AGHE made clear. In appointments to the public policy committee, the president of AGHE designated a committee member as the liaison with NIA.

The stated mission of NIA as set out in the National Institutes of Health publication No. (NIH) 76-1129 was unanimously endorsed by the executive committee of AGHE at its meeting in New York on October 15, 1976. This mission is stated as follows:

"The National Institute on Aging was established for the conduct and support of biomedical, social, and behavioral research and training related to the aging process and diseases and other special problems and needs of the aged.

"The motivation of Congress in establishing the Institute was that: (1) The study of the aging process, the one biological condition common to all, has not received research support commensurate with its effects on the lives of every individual; (2) in addition to the physical infirmities resulting from advanced age, the economic, social, and psychological factors associated with aging operate to exclude millions of older Americans from the full life and the place in our society to which their years of service and experience entitle them; (3) recent research efforts point the way toward alleviation of the problems of old age by extending the healthy middle years of life; (4) there is no American institution that has undertaken comprehensive, systematic, and intensive studies of the biomedical and behavioral aspects of aging and the related training of necessary personnel; (5) the establishment of a National Institute on Aging within the National Institutes of Health would meet the need of such an institution."

The board of AGHE endorsed that statement and the following one, which appears later in the same publication:

"In order for society to keep elderly people independent and functioning members of society, we must know more about the relationship between social functions and health. Toward this goal, the Institute will conduct research in areas such as the effect of mandatory retirement, the problems of transportation to community and medical care facilities, and the stigma attached to old age."

Through training and research, AGHE has, as one of its central purposes, the focusing of educational resources on all aspects of aging and the aging process.

The testimony submitted by Dr. Robert Butler, the Director of NIA, very cogently states, in language that can be understood by all professionals in the medical, health-care, and related fields, as well as by all citizens, the importance of NIA's role—a role which is strongly supported by AGHE. In addition, AGHE is committed to the position that research in the field of aging, both basic and applied, should be fully coordinated with training and service and that the need for educational programs in aging should be clearly identified as having a high priority in the programs of post-secondary educational institutions in the United States.

Throughout the hearings it became increasingly clear that there is a strong need to deal with the mismatch between the funds committed to training students about the medical and health-care needs of older people and the large amount of health-care dollars that go to the care of older people. If health-care of older persons is to be effective in the United States, then unique medical and health-care needs of older people must be incorporated into the training programs for medical students.

Knowledge generated through our educational institutions has contributed to the increase in the average life span, and AGHE holds the view that these same educational institutions have the opportunity through research, training, and service to make this longer life meaningful to society and to each of us who is privileged to have a long life. AGHE members think it is of overriding importance that educational programs bring the full resources of educational institutions—all involved professions and disciplines—to bear on this educational challenge. It should be noted that the involved areas include the allied health fields—dentistry, podiatry, public health, etc., as well as the social and behavioral disciplines. It is the view of AGHE additionally that there is an important role to be played by educational institutions at all levels of training, and AGHE is specially concerned that the resources of post-secondary educational institutions embracing public and private community colleges, public and private degree-granting institutions, including universities and professional schools, be fully drawn upon in this effort.

The policy and program of AGHE accord with the educational needs that Senator Percy, the chairman of this hearing, and Dr. Butler, Dr. Leslie S. Libow, and Dr. Theodore Sherrod have so clearly stated. AGHE will work with each of its members to implement educational programs responsive to the medical and health-care needs that have been identified today in this hearing.

This very informative hearing, according leading medical educators the opportunity to present views before the Senate Special Committee on Aging and also affording the members of AGHE and the Gerontological Society with the oppor-

tunity to provide input on the very searching question of medicine and aging, is further evidence of the significant service of the U.S. Senate's Special Committee on Aging. The executive committee of AGHE voted to strongly urge the Members of the Senate to continue this useful committee when the Senate considers the question of committee reorganization.

ITEM 2. STATEMENT OF ERIC PFEIFFER, M.D.,[1] CHAIRMAN, CLINICAL MEDICINE SECTION, THE GERONTOLOGICAL SOCIETY

THE NEED FOR CURRICULUM AND FACULTY DEVELOPMENT IN GERIATRIC MEDICINE

These remarks are presented as an outgrowth of accelerating activity and mounting concern about mechanisms which will assure America's most experienced citizens the kind of health care which is specifically responsive to their needs and circumstances. While the advent of medicare and medicaid have already decreased the financial barriers, and while any of the proposed programs of national health insurance will undoubtedly move us further in that direction, the development of specially trained health manpower to meet the health needs of the elderly is in no way addressed by these programs. For this reason, the leadership of the clinical medicine section of the Gerontological Society of the American Geriatrics Society and the Council on Medical Education of the American Medical Association have been striving to focus on specific additional barriers to good health care for older Americans and to recommend administrative and legislative remedies for this problem. The specific issue which we have identified is the need for curriculum development and related faculty development in the field of geriatric medicine.

The central issue is this: The basic professional curricula of the core professions providing medical care to aging patients (family medicine, internal medicine, psychiatry, and nursing) contain little or nothing specific to working effectively with the specialized aspects of care of the aging. In view of the growing number of elderly persons in this country (this is the fastest growing segment of our population) and in view of the greatly increased requirement for medical services on the part of older patients (in dollar terms, three times as much as for persons under age 65), this present situation must be changed on a high priority basis.

How can this change be accomplished?

There are many possible responses to this question, several of which are being pursued by individual professionals working in the field of aging and by organizations like the Gerontological Society, working alone or in concert with other associations such as the American Geriatrics Association, the American Medical Association, medical specialty groups, medical specialty boards, the media, and consumer groups. These efforts include giving greater visibility to the field of aging; continuing education efforts and/or requirements; the inclusion of gerontological content in general or in specialty qualifying examinations; media and consumer pressure for more readily available specialized professional and paraprofessional personnel to serve the medical needs of the aging.

But these efforts alone are not enough, and their effects will not be felt soon enough. For this reason, a new legislative initiative is recommended to redress a critical situation.

It is recommended that the Congress enact legislation for a new program to stimulate curriculum and faculty development in the field of geriatric medicine.

Specifically, it is recommended that funds be appropriated for the development of faculty trained and experienced in geriatric medicine to serve as educators to future health care providers. At a minimum, the creation of 40 new faculty positions, 10 each in the field of internal medicine, family medicine, psychiatry, and nursing, is recommended. Funding for such new provision shall be awarded on a competitive basis, with awards being made to those institutions who have, through the utilization of their own resources, already demonstrated the capability and commitment to the teaching of geriatric medicine. The anticipated

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[1] Dr. Pfeiffer is associate director for programs, Center for the Study of Aging and Human Development, Duke University, Durham, N.C., and currently on sabbatical leave from Duke University as acting director of the Davis Institute for the Care and Study of the Aging, Denver, Colo.

cost of such a program is estimated to be approximately $2 million per year. Funding for a period of at least 5 years is recommended.

The anticipated benefits of the recommended program are: (1) reduction in the number of visits by the elderly to physicians who lack expertise and skill in diagnosis and treatment of diseases of the elderly; (2) decreases in the length of hospital stay through more efficient management of acute and chronic illnesses of the elderly; (3) decreases in the likelihood of medical complications through early detection of disease, using comprehensive assessment procedures prior to the onset of complications; and finally (4) a major upgrading of the quality of medical care delivered in long-term care institutions.

Mr. Chairman, I know that the Senate Special Committee on Aging has long been working toward these last several goals. Prompt implementation of this recommendation can move us a long way toward their accomplishment.

ITEM 3. STATEMENT OF WILLIAM E. ARNOLD, MULTIDISCIPLINARY COMMITTEE ON AGING, ARIZONA STATE UNIVERSITY, TEMPE, ARIZ.

The Value of the Old

To assess the needs in the area of aging and medicine, several key research projects need to be undertaken. We need to understand the role of the aged in American society. An examination of the research to date suggests that the issue of attitudes toward the aged and knowledge about the aged needs further clarification. Kilty and Feld (1976) brought this point home when they examined the attitude scale toward older people. Research needs to be done to determine the effect of factual information on beliefs and opinions. It would also be useful to know on the basis of demographic information which groups have more knowledge about age and the aging process. As a corollary, it would be desirable to find out what knowledge older persons in our society have about the aging process.

Once we can make a distinction between information and knowledge on resulting attitudes, we should also make a distinction between the old as a generic group and individuals within the group. Since most attitude scales discuss older people as a classification, we know very little about how individuals feel about specific older people that they might know. We tend to discuss generalized attitudes rather than personalized attitudes. Therefore we need research to determine the differences and similarities in our views toward generic groups as well as individuals within that group. For example in a pilot study, students consistently rated their grandparents higher on a credibility scale than they did old persons in general.

Finally, we need better ways to describe our attitudes toward the old. As indicated by Arnold (1976), we have tended to view the image of the old by asking such questions as whether or not old people are generally stuck in their homes and that they are only interested in putting in their hours. On a positive side, we ask such questions as "Do old people love life and do they grow wiser with the coming of age?" This may tell us something of the social-psychological attitude toward the old but it does not truly reflect credibility as defined in the communication literature. Thus, we need to consider the image of the old from a multidimensional standpoint viewing them on the dimensions of character, competence, dynamism, and sociability. In doing so we would have a better understanding of what images we hold for either the generalized old or the old individual.

With the need with the new knowledge of attitude and credibility, it would be useful to replicate the study conducted by the National Council on Aging in 1975. We need to explore the differences between the young and old including social economic background, rural-urban, and education. It would even be useful to explore this on an international level.

Research needs to be undertaken on the relative contribution of several societal factors on the old. If the mandatory retirement law is truly one of the major causes of the conditions for the elderly, then further research needs to be instituted which would give us a better perspective on the relative contribution of retirement. Does retirement, for example, force the suicide rate up for the older population? What contribution does industrialization or urbanization in a youth-oriented society play in creating an image for the old?

One of the major needs in aging research is for a greater exploration of behavior rather than the traditional analysis of beliefs and attitudes. For example, the National Council on Aging (1975) studies suggested rather negative attitudes toward the aged. Does this manifest itself in our treatment of the old? The presentation by a retirement home architect at the 1975 conference on human values and aging suggested that behavior did follow attitudes toward the old. If the old were viewed as unable to manipulate corridors without simplistic presentation of colors, then the retirement home was designed accordingly. We know very little about the behavioral manifestation of attitudes. It would be useful to explore historically the treatment of the old with expressions of attitudes and beliefs on the elderly at that time.

CONCLUSIONS

Far more research needs to be conducted on our attitudes and behaviors toward the aged in our society. If we are to understand the needs and areas of neglect with regard to medical care for the aged, we need to do some of the basic research which precedes the medical area.

One is left after listening to the statements about the aged that the old are simply a group of guinea pigs on which we can try all kinds of techniques and apply all kinds of research skills. On the contrary, it is hoped that the research done with and about the old will have societal value and that conditions may be improved for the elderly in America. If we have created a condition in which the old are viewed as ugly and undesirable, it is only through research that we can find the reasons and the means to change this condition.

ITEM 4. STATEMENT OF SAUL KENT, EDITOR, *AGING TOMORROW*, NEW YORK, N.Y.

Several witnesses have testified to the need for a separate department of geriatric medicine in our medical schools. They have argued that the elderly have specific medical problems requiring special attention. Other witnesses have testified that there is no need to single out the treatment of the elderly in our medical schools because aging is a developmental phenomenon and there are no diseases that strike the elderly alone.

Both these arguments are essentially correct, but the contrasting proposals for which they are given are equally inadequate to meet the health care needs of older adults. In my opinion, these needs can best be met by shifting our attention from the treatment of specific diseases to treatment of the normal aging processes that underlie the onset and expression of degenerative disease and the general loss of strength, vigor, and well-being that occurs in all of us with advancing age. While it is true that the elderly have specialized medical needs, these needs are direct consequences of lifetime patterns of normal aging exacerbated by poor health habits, exposure to environmental pollutants, and excessive stress.

I therefore propose the creation of a department of clinical gerontology in all medical schools which would encompass all age groups but would deal exclusively with the deleterious effects of aging and such age-dependent diseases as heart disease, stroke, maturity-onset diabetes, most forms of cancer, arthritis, and organic brain syndromes.

This department would focus entirely on preventive health care in childhood and young adulthood, with special emphasis on the development of therapies to delay the onset of senescence. In treating older adults the department would continue its commitment to preventive health care, but would also pursue therapies to reverse aging processes and rejuvenate the aged.

An important division in the department of clinical gerontology would be devoted to basic biological research aimed at developing anti-aging therapies. Another division would concentrate on measuring the rate of aging in human subjects to facilitate the testing and evaluation of anti-aging therapies.

Such a department would be well equipped to do battle with the true adversary of all older adults—the time-dependent decline in physiologic function that we call aging and the degenerative diseases engendered by this process.

ITEM 5. STATEMENT OF NONA BOREN, M.S.W., MICHAEL McCALLY, M.D., AND L. THOMPSON, M.D.,[1] OF THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES, WASHINGTON, D.C.

The Need for Curriculum Development and Geriatric Care Activities in Gerontology in Schools of Medicine

These remarks are presented to underscore this institution's recognition of the need for medical schools to address the needs of the elderly. They are also intended to inform you and your committee about a major new program at this institution made possible by a grant from the Administration on Aging, designed to impact the training programs of medical, nurse practitioner, physician's assistant, social work and allied health students, and to provide for faculty development activities.

The new program at the George Washington University grew out of a concern and awareness on the part of this institution regarding the neglect of the elderly, the scope of the problem, the implications of neglect, and the need for medical institutions to take a lead in correcting the neglect.

The health and mental health problems of the aged in our society continue to be neglected not because of ignorance, but in spite of the increase in knowledge about the aging process and major advances by the medical profession that offer prolonged life.

The nature, extent, and reasons for this neglect can no longer be dismissed by citing failures in policies at the national level. The neglect is reflected in the goals and priorities of the institutions, including medical schools, that are responsible for training our health professionals and in the attitudes held by persons responsible for teaching and for the delivery of care to the elderly.

The problem is grave and pervasive. While there have always been people who lived to a great age, there are more people living into old age than ever before and this trend is likely to increase. Since 1900, the over 65 population in the United States has grown much faster than the rest of the population. At that time this age group numbered approximately 3 million. By 1940 it had nearly tripled to approximately 9 million and again by 1970 had more than doubled to 20 million. If the present trend continues, it is estimated that by the year 2000 there will be 31 million persons over 65 in the United States. During the present decade, 1970 to 1980, the older population is expected to grow by approximately 23 percent compared with an expected 8 to 9 percent increase for the total population.

The implications of neglect for health care delivery are very real. Older persons experience more acute and chronic disease than the younger population; psycho-pathology in general, and depression in particular, increase with age; suicide sharply increases with age in elderly white males; and while a little more than 10 percent of the population is over 65, they use 27 percent of the health dollar. Yet little attention is given to the promotion of health and the improvement of the quality of life for the elderly—efforts that would work to alleviate the complications of chronic disease and depression that frequently results from inevitable losses and isolation.

Much of the neglect in provision of adequate training or health care delivery is the result of attitudes on the part of practitioners based on myths about aging and their own fear of the aging process and of dying. The neglect and stereotype attitudes toward aging and failures in delivery of adequate health services to the aging are reflected in and reinforced by educational institutions responsible for the training and education of professional personnel who could play a part in redressing the neglect and discrimination. In professional training programs for the helping professions (medicine, allied health, social work, nursing), generally little attention has been given in the formal curriculum or in field experiences to the aging process and to problems of the elderly. The human development sequence in the most professional schools typically begins at birth and ends at young adulthood. The situation is no different in medical schools. Here again the human development instruction typically neglects the period of life relating to middle age and aging. Course offering with a specific focus on problems of

[1] The George Washington University School of Medicine and Health Sciences. Dr. Bowles is the dean for academic affairs, Dr. McCally is associate dean and principal investigator, the Gerontology Program, and Ms. Boren is the director, the Gerontology Program.

the elderly are rare. An example of this neglect on the part of medical institutions is derived from a survey of the Association of American Medical Colleges Curriculum Director which reveals a large disparity in electives given for credit among the 15 different categorical areas listed. During the 1972, 1973, and 1974 academic years, not one of 119 medical schools reported electives which focused on problems of the elderly. Even by 1975, only 32 schools or 27 percent offered such electives. This can be compared to the categorical areas of drug abuse and human sexuality where electives were offered in over 60 percent of the schools for all the years (1972 through 1975). In addition, the literature demonstrates that few medical schools and teaching hospitals provide adequately for clinical experiences in geriatrics for undergraduate students or for post-graduate training in geriatric care.

The failure of medical institutions to provide adequate curriculum content and field experiences in the area of gerontology and geriatric care is compounded by the fragmentation of education experiences for a variety of health professions who must work together, but seldom learn together. Few medical schools are so organized as to offer opportunities for inter-professional training and collaboration. Equally neglected is multidisciplinary approach to teaching about health care for the elderly, their problems and society's responsibilities in addressing these problems. The result is that not only are health practitioners poorly informed about the health care needs of the elderly, but equally uninformed about the competencies and roles of other professionals in providing services and influencing policies that impact on needs of the elderly.

The George Washington University School of Medicine and Health Sciences has received a grant for the fiscal year 1976–77 from the Administration on Aging to introduce and improve gerontology and geriatric care content in educational programs within the George Washington University School of Medicine and Health Sciences. The program is based on a commitment to a multidisciplinary effort on the part of several major departments within the school of medicine and health sciences and other schools and departments in the University.

We anticipate that such multidisciplinary collaboration will have a number of desired outcomes: (1) Multidisciplinary curriculum development activities will influence the curriculum of the school of medicine and health sciences affecting undergraduate students as well as post-graduate physicians; i.e., residency training programs. These activities will also impact on undergraduate programs in sociology, recreation therapy, and on graduate level programs in sociology, recreation therapy, health care administration, and social work; (2) Multidisciplinary collaboration will provide a unique opportunity for health and health-related professionals to work and learn together. In doing so, it is anticipated that they will discover new potentials for professional growth in the field of gerontology and develop instructional expertise in activities focusing on faculty development such as multidisciplinary faculty seminars. This will, we hope, promote this institution's development of a permanent program with financial commitment to gerontology and the field of aging.

In summary, the George Washington School of Medicine and Health Sciences is moving to actively address the problems of training for better health care for the elderly. Our goals are to provide for all our students structured opportunities to examine attitudes toward aging and older persons, knowledge and information about health-related aspects of aging, and clinical skills appropriate to the management of the illnesses of older individuals. Our model for such a program is one of interprofessional education. Our capability resides in the fact that George Washington University has only a school of health sciences and programs for students of medicine, allied health fields, physician's assistants, and post-graduate physicians, which takes place in one facility with one faculty. Age-ism and gerontology is properly taught in schools of medicine and of health sciences.

ITEM 6. STATEMENT OF THE UNIVERSITY OF CINCINNATI GERONTOLOGY COUNCIL, CINCINNATI, OHIO

Gerontology at the University of Cincinnati

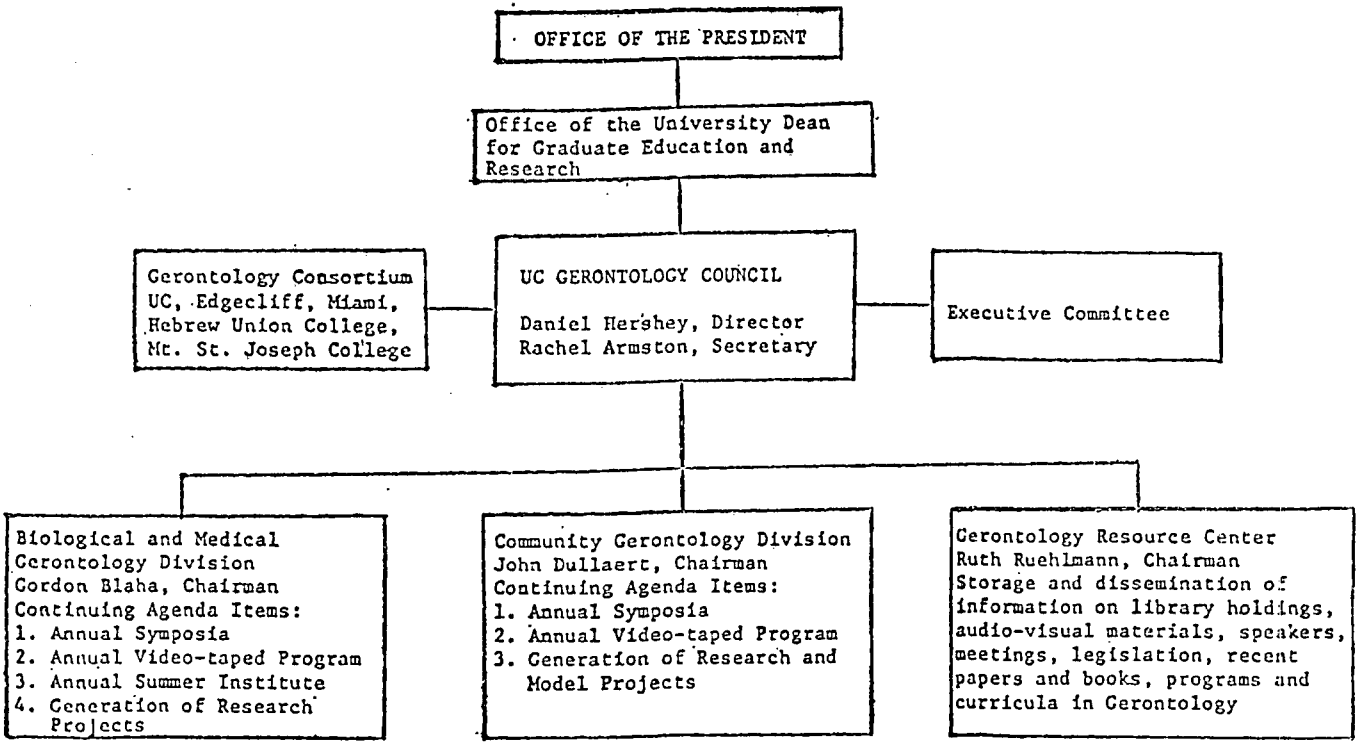
Gerontology is the discipline and practice that deals with the aging process and the special problems of aging persons. It is related to sociology, psychology, physiology, family practice medicine, nursing, community services, and even

business administration and engineering. The University of Cincinnati, through its gerontology council and associated groups, is committed to programs in gerontology which will lead to a better understanding of the developmental changes which occur as we grow old and how we might enjoy a long life with good health. Recent demographic data show that the 10 to 24 and 24 to 35 years of age groups are diminishing in proportion to the older population. Thus, we need to prepare for the future, as the elderly become numerous and insist on their right to a decent old age.

The establishment of a University of Cincinnati Gerontology Council in 1973, composed of recognized scholars whose teaching and research were related to gerontology marshalled the university activities in this field and focused them so that distinct areas of excellence could develop. There is much good work to be done, only requiring people and institutions to commit themselves. The University of Cincinnati has committed itself. In 1975, a gerontology interest group was formed, to function as the public forum for the dissemination of information on aging. Membership in this interest group spanned the full range, from the lay public to professionals working full-time in agencies providing services for the elderly. In 1976, the gerontology interest group was merged with the gerontology council in order to more closely coordinate our academic and public functions. In 1976, the gerontology resource center was organized, which serves as a clearinghouse for gerontological information. The staff of the gerontology resource center advises senior centers, agencies, and others on speakers, films, books, college programs and curricula, job opportunities and legislation pertaining to aging and the care of the elderly.

On the following pages we present the organizational structure of the U.C. Gerontology Council, our objectives, and a narrative describing the essence of our present and future activities: the teaching, research and public service functions of the U.C. Gerontology Council. We hope to contribute on many levels, from the pragmatic, community-based efforts at analyzing the services available for the aged to the intellectual, more esoteric attempt to understand the cellular changes which we call the aging process. We'll help employees find more satisfaction on the job and provide guidance for those in the vicinity of retirement. Perhaps we'll discover universal parameters which measure the age of persons, corporations, universities, and countries. And if we understand all these things, will we be able to assist in providing the blessing of long life in good health? We hope so.

ORGANIZATIONAL STRUCTURE OF THE UNIVERSITY OF CINCINNATI GERONTOLOGY COUNCIL



OBJECTIVES OF THE UC GERONTOLOGY COUNCIL

(a) Recruit and train personnel at the professional and subprofessional levels.
(b) Conduct basic and applied research on work, leisure, and education of older people, living arrangements of older people, social services for older people, and the economics of aging.
(c) Serve as a repository of information and knowledge and provide consultation to people and voluntary organizations with respect to the needs of older people and in planning and developing services to them.
(d) Stimulate the incorporation of information on aging into the teaching of biological, behavioral, and social sciences.
(e) Help to develop training programs on aging in schools of social work, public health, health care administration, education, and in other units.
(f) Create opportunities for innovative, multidisciplinary efforts in teaching, research and demonstration projects.

TO MEET OUR OBJECTIVES

To Recruit and Train Physicians

The University of Cincinnati, through its department of family medicine in the medical center, is embarked on a program of enlarging the experience of physicians, sensitizing them to the needs and care of elderly patients. Dr. Kenneth Frederick, associate director of the department of family medicine, responsible for the conduct of the model family practice unit, is the liaison between the medical college and the U.C. Gerontology Council, serving on the executive committee of the council and a member of its biological and medical division.

The department of family medicine has two main activities. First is the development and maintenance of an accredited residency training program in family medicine. Second, the department has the responsibility for establishing a family medicine track for students in the college of medicine. Both activities are dedicated to the task of producing well trained family physicians who can provide continuous, humanistic, accessible comprehensive care for all members of the family in an ambulatory setting.

Along with a model family practice unit to train residents in the management of the common medical problems of the family, the residency program has access to a voluntary, church sponsored, philanthropic home devoted to the long-term care of the aged. This facility is for 350 people whose average age is 84 years. The home offers three levels of care: (1) Independent living with medical care provided on a need basis; (2) a sheltered care area with partial daily medical supervision; and (3) a nursing unit with complete daily medical supervision. This provides for the resident physicians the opportunity to deal with aging people and their families in a micropopulation that is representative of the entire spectrum of long-term care of the aging.

For physicians in the Cincinnati area, in order to improve and maintain the quality of care for elderly patients, we propose to offer an annual summer institute, which would be four 1-day sessions in geriatric medicine. For each 1-day program, a nationally known physician identified with the clinical practice of geriatric medicine will be brought to the University of Cincinnati Medical Center. Along with university physicians, physiologists, and others, a coherent program will be arranged, whereby the attending physicians will hear and discuss the physiologic basis for the problems of old age and the clinical consequences (reflecting the expertise of the visiting physician). The second, third, and fourth 1-day sessions will be arranged similarly, differing in emphasis, as expressed by the interests of the visiting physicians. ConMed credits will be awarded for those physicians who complete the summer institute program. Our aim is to increase skills, change attitudes and provide information. There will be a comparing of notes and an updating of basic physiology as applied to the clinical physicians.

To Recruit and Train Nurses

The college of nursing and health, through its master's degree program in gerontological nursing, headed by Professor Janet Froome, director of the gerontological nursing program, and Dr. Rosalee Yeaworth, director of graduate programs, began offering masters level preparation in gerontological nursing in the fall of 1973. The purpose of the five- to six-quarter program is to prepare a nurse who can function in the area of primary care of the elderly. There is emphasis on the development of biophysical and psychosocial skills and the

knowledge needed to care for other persons in acute settings as well as in health maintenance, ambulatory care settings.

To Conduct Basic and Applied Research

The changes that occur in the various tissues and organs of the female reproductive system furnish a model of aging which may be applicable to other systems of the body as well. Measurement of circulating levels of hormones and uptake of these hormones is an important aspect of this study. Changes in the responsiveness of the tissues (ovaries, uterus) may occur even though their basic hormones are present.

Individuals who have worn an immobilizing cast or have been bedridden for extensive periods of time suffer a loss of motion when they again become ambulatory. Research is underway to determine whether or not heat applied to a casted joint during the period of immobilization will prevent the tissue changes characteristic of joint construction.

The heat given off by the human adult is measured directly in a whole-body calorimeter of simple but unique design. Measurements of the basal metabolic rate (BMR) are currently being made on elderly subjects every 3 months. To be tested is the hypothesis that there exists a critical level of BMR, below which the body does not possess sufficient vitality and senescent death may occur.

Long-term investigation of the immune function in nonhospitalized volunteers 80 years of age or older is proceeding. Some results of these studies suggest a subtle abnormality of T-cell regulatory function. It is anticipated that these clinical and laboratory studies will enhance understanding of allergic reactions and diseases beyond the age of 50.

The lifespan of systems such as single cells, multicellular organisms (the human body), corporations, and civilizations are being studied to elicit the factors affecting lifespan, the parameters which measure it, and definitions of birth and death. From this may develop a more meaningful measure of age, expressed not in years, but by some other intrinsic property.

Workshops are planned to sensitize grade and high school educators in relation to: stereotypes of the aged, the care and problems of aging persons, and attitudes of the young toward the elderly population.

The problems of adult children with respect to their elderly parents are being studied. The first stage would entail a series of in-depth interviews with a representative sample of adult children concerning the relationships they have with their elderly parents. The second stage would consist of workshops for the adult children in which information focusing on these problems would be stressed. In the third stage, a follow-up would be undertaken to determine if the workshop aided the relationship, and hence improve the quality of life for the elderly and their grown children.

We have organized two physiology of aging symposia in the last 2 years and the third annual physiology of aging symposium is being planned. Another program, normal aspects of aging, was presented in 1976.

To Service as a Repository of Information and Provide Consultation

We have recently formed a gerontology resource center under the aegis of the U.C. Gerontology Council. This center collects information on gerontology meetings and workshops around the State as well as films, video tapes, pending and passed legislation on the local, State, and national levels, dealing with aging and the care of the aged.

In cooperation with the Greater Cincinnati Gerontology Consortium of Colleges and Universities and the Cincinnati Council on Aging, the gerontology resource center provides advice and information to senior centers, agencies, and others in the community interested in gerontology. The center publishes a newsletter, maintains a composite mailing list, catalogs the gerontology library holdings in the Cincinnati area, and provides information on college programs and curricula in gerontology.

To Stimulate the Teaching of Gerontology

We teach the following courses at the University of Cincinnati in the area of gerontology: Aging Theories in Gerontology; Consumer Economics; Geriatric Nursing; Gross Anatomy; Investment Policy; Microscopic Anatomy; Old Age and the Community; Organic Medicinal Chemistry; Psychology of the Aged; Psychology of Death and Dying; Psychosocial Aspects of Aging; Social and Economic Security; Social Gerontology; and Stock Markets and Investments.

Because of our research and workshops, and with an active lobbying campaign by U.C. Gerontology Council members, we are helping to introduce basic information on aging into our curricula. We are members of the Ohio Network of Educational Consultants in Gerontology as well as the Greater Cincinnati Gerontology Consortium and the Association for Gerontology in Higher Education. We know what to teach: what remains is to convince others that their curricula are incomplete without gerontological content.

To Develop Training Programs on Aging

Our department of family medicine and the geriatric nursing program have training components. In addition, the University of Cincinnati's program in community health planning/administration offers graduate and undergraduate programs to help prepare those interested in careers in community health planning, organization, and administration.

To Create Innovative, Multidisciplinary Efforts

The U.C. Gerontology Council has undertaken cooperative curriculum arrangements whereby students at the University of Cincinnati may take courses free of charge at the other schools which, with the University of Cincinnati, make the Greater Cincinnati Gerontology Consortium. Thus, we share the best of the consortium schools. Through the consortium, we are investigating the possibilities of team teaching a basic sequence of courses in gerontology.

Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND QUESTIONNAIRE SENT TO DEANS OF MEDICAL SCHOOLS IN THE UNITED STATES BY SENATOR CHARLES H. PERCY

DEAR DEAN: As you may know, I have a strong and continuing interest related to problems of the elderly. I have served on the Senate Committee on Aging for several years; currently I am the ranking minority member of the Subcommittee on Long-Term Care. Our plans call for me to chair a hearing of this subcommittee in conjunction with the annual meeting of the Gerontological Society to be held in New York City during the week of October 14.

Our hearing will examine the emphasis placed on geriatrics in schools of medicine and the consequences in terms of physician's sensitivity to the special problems of the elderly.

In this connection, I would appreciate your taking a few moments to answer the following questions:

(1) Do you have geriatrics as a specialty in your curriculum?

(2) Do you have programs in which students, interns, or residents can serve nursing homes?

(3) Do you have programs which help serve the elderly in any other way?

I would appreciate having your response to each of the above questions by September 30.

With best wishes,

Sincerely,

CHARLES H. PERCY.

RESULTS OF QUESTIONNAIRE SENT TO 114 MEDICAL SCHOOLS BY HON. CHARLES H. PERCY

(1) Number of questionnaires returned—84. Percent return—74.

(2) "Do you have geriatrics as a specialty in your curriculum?"

Number answering "Yes"—3. Number answering "No"—81. Percent answering "Yes"—3.6.

(3) "Do you have a program whereby students, interns, or residents can fulfill requirements by serving in nursing homes?"

Number answering "Yes"—37. Number answering "No"—47. Percent answering "Yes"—40.4.

(4) "Does your medical school serve the elderly or those in nursing homes in any other way?"

Number answering "Yes"—47. Number answering "No"—37. Percent answering "Yes"—56.

Of the ways medical schools served the elderly or nursing home patients included: treating the elderly in university, county, or municipal hospitals (mentioned by 15 schools); operating outpatient clinics (mentioned by 8 schools); and research noted by 7 schools. Five schools boasted offering electives in gerontology (the research side of aging) and three noted offering electives in geriatrics (the clinical aspects of treating the elderly).

ITEM 2. LETTER FROM EARL C. COOKE, HOUSTON, TEX.; TO SENATOR CHARLES H. PERCY, DATED OCTOBER 29, 1976

DEAR SENATOR PERCY: I would like to express my sympathetic support for your efforts in the current hearing on "Medicine and Aging." In my work I have had much contact with medical schools and nursing homes and have seen many of the problems which you are concerned about.

80-581—77——5

I strongly share your feelings that geriatrics should be taught in the curriculum of medical schools and that this should involve service to nursing homes.

Much success to you in your efforts to get medical students further enlightened and interested in the care of geriatrics.

When available, I shall greatly appreciate your being so kind as to send me a copy of the hearing.

Very sincerely,

EARL C. COOKE.

ITEM 3. LETTER FROM TERRENCE T. KUSKE, M.D., ASSOCIATE DEAN FOR CURRICULUM, MEDICAL COLLEGE OF GEORGIA, AUGUSTA, GA,; TO SENATOR CHARLES H. PERCY, DATED SEPTEMBER 24, 1976

DEAR SENATOR PERCY: In response to your questions regarding programs for the elderly at the Medical College of Georgia, we do not currently have geriatrics as a separate subspecialty in our curriculum. Our curriculum is divided on more classic lines in which geriatrics would be covered predominantly within the specialty of internal medicine.

In response to your second question, we do have programs in which residents can serve nursing homes, specifically our own large nursing home facility. We have a very large immediately attached nursing home facility, the Georgia War Veterans Home, and medical care is provided by the university health clinics as well as night-call coverage being provided by our resident staff. In addition, a portion of the Veterans Administration Hospital is concerned with long-term care for many aged patients, and this is similarly staffed by our own residents.

As regards other programs which serve the elderly, assessment of the nutritional training programs of the elderly has been conducted on a regular basis as part of the nutrition electives for clinical students as well as the nutrition elective components of the students in the basic sciences.

I hope that this provides information that will be of use to you.

Sincerely yours,

TERRENCE T. KUSKE.

ITEM 4. LETTER FROM BERNARD E. NASH, PRESIDENT, INTERNATIONAL FEDERATION ON AGING, WASHINGTON, D.C.; TO SENATOR CHARLES H. PERCY, DATED OCTOBER 22, 1976

DEAR SENATOR PERCY: With reference to the very stimulating hearing you held on medical care for the elderly during the annual meeting of the Gerontological Society in New York, September 13–17, 1976, I would like to offer some observations about how geriatric care is organized in other countries, in the thought that these insights may be useful in our own case.

As you will recall, the hearing centered on the extent of the need for geriatric medicine in the United States. I was particularly struck, however, by the fact that after the hearing some members of this highly professional audience seemed confused about what geriatric medicine could encompass. Several people thought that geriatric medicine would end up being a specialty much like pediatrics whereby an individual would see a specialist solely based on the criterion of age. Not surprisingly, this alternative did not seem very appealing for fear that it would further perpetuate the segregation of the elderly from society.

In fact, a geriatric specialty operating much like pediatrics is just one alternative to organizing better care for the aging. It is an extreme alternative that, as far as I know, exists nowhere in the world. The existence of this confusion among members of the audience makes me fear that the whole concept of geriatric care may become politically unfeasible because of a widespread misunderstanding as to what it can represent. If professional gerontologists are confused about this issue, what will be the reaction of the general public whose support is necessary to any measures for improving medical care for the elderly?

The confusion arose in my estimation from the fact that no clear distinction was made by the speakers about the various levels of geriatric care that can be introduced. For example, at a minimum one can introduce courses in medical schools on physiological, psychological, and sociological aspects of aging; these

could either be mandatory or elective. At the next level, one could establish geriatric consultantships. Geriatric consultants would be called in by a general practitioner when the latter is puzzled by an older person's symptoms or when an older patient shows a complex interaction of symptoms. Such consultants could also oversee the teaching of geriatric medicine in medical schools. This is very much the model now in existence in the United Kingdom. (It should be noted that in the United Kingdom no more than about 20 percent of the elderly ever see a geriatrician; the remainder are treated by the general practitioner. In part, this may be due to a shortage of geriatric consultants but, in large measure, this is due to the fact that many older persons' ailments are quite similar to those of younger age groups, and no need to call in a geriatric consultant manifests itself.)

At a third and extreme level, one could create the specialty of a geriatrician who would serve much as a pediatrician does and automatically see all individuals over a certain age bracket. As stated before, as far as we know, such a practice does not exist in any country in the world. In short, we are setting up a strawman in focusing our thinking and debate around this issue and ignoring the merits of less radical alternatives.

For an excellent discussion of how geriatric care is organized in countries other than the United States, I recommend "Geriatric Care in Advanced Societies," edited by John C. Brocklehurst, one of England's foremost geriatric consultants. I would like to close with a quotation from Brocklehurst's book. According to him, geriatric care is desirable because, for older people:

". . . progressive care through departments (or facilities) providing acute, intermediate (rehabilitation), and then either long-stay or domiciliary care is likely to be needed most commonly. To achieve a smooth passage through these various stages implies a unified or coordinated administration and is perhaps one of the best arguments for a specialist service of geriatric medicine which can assume responsibility for the ill old person at an early stage and steer him through all the subsequent stages until his resettlement in the community, or in the most appropriate type of long-term care. By this means a uniformity of approach and a continued flow of information about the patient should have the best chance of happening. . . .

"The overwhelming arguments in favour of a specialist service would seem to be (a) the size of the problem, (b) the neglect it suffers where there is no such service, (c) the many clinical and organizational improvements that have occurred where a service has been established, and (d) the fact that those who engage in it find the work exciting, stimulating, and worthwhile."

With best wishes,

BERNARD E. NASH.

ITEM 5. LETTER FROM R. WILLIAM BURMEISTER, M.D., MEDICAL DIRECTOR, MOUNT ST. ROSE HOSPITAL, ST. LOUIS, MO.; TO SENATOR CHARLES H. PERCY, DATED NOVEMBER 17, 1976

DEAR SENATOR PERCY: Pursuant to your request at the recent Gerontological Society meeting for information concerning geriatric care programs and potential training approaches in this field, I wish to submit:

—A brief introduction to a program of geriatric hospital care demonstrating cost-efficient rehabilitative care of the elderly.

—Some background of the proposed expansion of these services into a day-hospital system of delivery.

—Identification of the possible role such an already-developed model could play in the teaching and demonstration of geriatric clinical medicine in a university-related program provided adequate teaching support is available.

The responses of the 150 participants from five Midwestern States attending a recently completed seminar (brochure enclosed),[1] along with the knowledge of the present deliberations of the Senate Committee on Aging and the National Institute on Aging, have served to reinforce my desire to respond to your request. The following then represents brief explanatory material concerning the points above. I should be most happy to supply additional material as deemed appropriate.

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[1] Retained in committee files.

(1) Mount St. Rose Hospital in St. Louis, Mo., has developed, over the past 8 to 10 years, an active rehabilitative service for the elderly employing a full complement of rehabilitative service personnel—physical therapy, occupational therapy, speech therapy, recreational therapy, nursing service—in a hospital environment—all supervised by a hospital-based group of internists which cares for the patients during their hospital course. The experience accrued from this program I believe supports the following:

(a) Destruction of a valuable capital resource such as this old (1901) tuberculosis hospital is poor stewardship of funds if a quality use for it can be identified.

(b) Responses from our patients and referral sources indicate this service has met a real need in the community.

(c) This need is further supported by the increasing demands for service which has resulted in an occupancy rate of 95 percent in 125 beds and a continual waiting list of 40 to 50 patients.

(d) The medical and rehabilitative needs of this geriatric population can be consistently delivered in a quality manner at about 50 percent of the local acute-care hospital per diem costs.

(e) The medical needs of this multiproblem geriatric patient demand special insights of physician and other health personnel not readily developed by training resources in the area. This has consistently required careful choice of physicians and other personnel and considerable on-the-job training to achieve the approach desired.

The background experience and the insight developed in regard to the critical elements required in this type of geriatric medical care has led this facility into close cooperation with the Joint Commission on Accreditation of Hospitals Quality Resource Center (for which the writer is on the faculty and advisory board) and CEMPROC, the local PSRO, to develop the unusual criteria necessary to identify admission needs and care patterns for the population in such a medically oriented rehabilitation environment. Since this background experience and the data developed in this project at Mount St. Rose Hospital seems worthy of appropriate exploitation to me, I offer any assistance this may give you in deliberations to secure the best and most cost-effective care for our elderly patients.

(2) The perceived needs of the community, the high occupancy and waiting list, and an interest in delivering these services in a cost efficient manner has precipitated a planning program for expansion at Mount St. Rose Hospital. This is fully defined in the enclosure,[1] but centers upon an interest to develop a day-hospital which is projected to cost 50 percent of our present in-patient costs. Active efforts are now in process to bring this to fruition.

(3) The medical personnel supervising this program at Mount St. Rose Hospital are all actively engaged in teaching at St. Louis University. Certain chosen members of the medical house staff have been utilized for service during the past 6 to 8 years. It has been the experience that usually 2 to 3 months of on-the-job training and supervision is necessary for new personnel to appropriately and cost-effectively manage the needs of these geriatric patients.

The potential value of this program for demonstration and teaching geriatric medicine seems obvious. Appropriate support for this with teaching dollars rather than care dollars would allow this geriatric resource to develop a role in training of medical personnel without falsely raising cost of care to do the job.

Considering the increasing age of our population in the United States, a commitment to expanded clinical knowledge of geriatric medical care is an identified need and should be an appropriate activity of internal medicine departments in our schools of medicine. This need is notwithstanding that of efforts directed at broadening our understanding of the aging process through well-founded research. The feasibility and costs of such teaching support seems worth exploration and the model available here could be of invaluable help in defining the necessary parameters for wider application.

If you should so wish, I would be most willing to expand on any of the above material personally or by letter. I thank you for your consideration and interest in geriatric care.

Sincerely yours,

R. WILLIAM BURMEISTER.

[1] Retained in committee files.

ITEM 6. LETTER FROM WILLIAM REICHEL, M.D., PROJECT DIRECTOR, AMERICAN GERIATRICS SOCIETY, INC., NEW YORK, N.Y.; TO SENATOR CHARLES H. PERCY, DATED NOVEMBER 23, 1976

DEAR SENATOR PERCY: Thank you for your letter of November 8, 1976, which contained your opening statement for the hearing on "Medicine and Aging: An Assessment of Opportunities and Neglect." I appreciate your inviting the American Geriatrics Society to submit a written statement for the hearing record describing the recent activities of the American Geriatrics Society Conferences on Geriatric Education which focus upon educational policy and geriatrics.

The American Geriatrics Society was awarded a contract in 1976 by the National Institutes on Aging (NIA Contract No. 263–76–C–0496) for the purpose of conducting two conferences on geriatric education. The first conference took place on October 22–23, 1976. Participants at the first meeting served as an advisory committee for the purpose of developing alternative approaches and models in geriatric education. These approaches and models were to be defined and crystallized for the purpose of presentation to representatives of major physician organizations at the second conference to be conducted on March 4–5, 1977.

The list of members of the Advisory Committee to the American Geriatrics Society Conferences on Geriatric Education is enclosed.[1]

RECENT DEVELOPMENTS AND BACKGROUND INFORMATION

Recent developments which have led up to this meeting include resolution 16 which was introduced to the American Medical Association House of Delegates at the Portland, Ore., meeting in 1974. Resolution 16 called for an increased effort to train physicians in geriatrics. Specifically, it called for incorporating geriatrics into residency programs in family practice, internal medicine, and psychiatry, and into continuing medical education curriculum at both State and National levels. This was adopted by the AMA House of Delegates in June 1975 as Report M, Adequate Training in Geriatric Medicine (A–75). The report indicated that "The Council on Medical Education, together with the AMA Committee on Aging, will continue to review the activities of AMA and other organizations in the field of geriatric medicine. Both committees will explore ways of encouraging the teaching of geriatric medicine in medical schools, residency programs, and postgraduate education, so that appropriate training is available to all physicians responsible for the care of the Nation's elder citizens."

On July 31, 1976, representatives of the American Geriatrics Society (Dr. William Reichel), the Gerontological Society (Dr. Eugene J. Towbin), and the National Institute on Aging (Dr. Robert Butler) met with the Advisory Committee on Undergraduate Education of the AMA Council on Medical Education. At the July 31 meeting, it was the feeling of the three representatives that the subject of geriatric medicine should be included in the curriculum of all American medical schools. Also, the chairman of the Advisory Committee on Undergraduate Medical Education, Dr. Robert Stone, indicated his interest in participating at the two forthcoming American Geriatrics Society Conferences on Geriatric Education.

At the October 22–23 meeting, the advisory committee clarified three models of geriatric education—A, B, and C. The A model comprises an increased emphasis on geriatrics in existing residency programs, such as family practice, internal medicine, and psychiatry, and the B model consists of a 1- to 2-year specialized period in certain residencies, such as internal medicine and psychiatry. This type of subspecialty program is being carried out by Leslie Libow in New York and Dodda Rao in Oak Forest, Ill. Model C is a full, board-certified specialty of geriatric medicine as typified by the British experience.

It was the consensus of the group that model C should be rejected. All of the group felt that this would be an important step in clarifying that there is no attempt to create another board-certified specialty. This might relieve certain anxieties and misunderstandings that might develop from the possibility of another full fledged specialty.

Dr. Libow commented that model B is necessary in order to develop leaders in the field and his program is attempting to do exactly that. Dr. Pfeiffer noted

[1] Retained in committee files.

that at Duke University, the fourth year fellowship in geriatric psychiatry exists. Both Dr. Libow and Pfeiffer expressed the need for trained subspecialists in geriatrics in order to teach residents in internal medicine, family practice, and psychiatry.

Dr. Pfeiffer indicated that a possible strategy would be to support geriatric faculty development in internal medicine, psychiatry, and family practice programs.

Dr. Reichel summarized some of the efforts of family practice residency programs which include geriatrics in their training (model A). These include University of Texas at Lubbock; University of Wisconsin; Medical College of Georgia; Duke University; University of Maryland; University of Iowa; University of Minnesota; Franklin Square Hospital; and St. Margaret's Hospital in Pittsburgh.

Dr. Gotterer, dean of predoctoral programs at Johns Hopkins, suggested that the group must have a clear definition of educational objectives, whether they be to sensitize family physicians to geriatric issues, or to develop a specialist teacher in geriatric medicine. Different models of curriculum for the undergraduate student were discussed. One type of model might be a core knowledge of basic facts about geriatrics; another model might be a more intensive curriculum taught by a research faculty.

A positive approach for effecting change in medical schools utilized by the American Geriatrics Society is to emphasize that aging is already being taught and that this teaching can be expanded upon—in other words, to form a matrix between a geriatric interest with an already established core curriculum. Examples of utilization of already established programs include the curriculum utilized at the New Jersey College of Medicine and Dentistry under Dr. Otto Neurath, or the developing group of faculty who have participated in the Maryland continuing education series of the American Geriatrics Society and Franklin Square Hospital of Baltimore. The same group has contributed to the American Geriatrics publication, *Clinical Aspects of Aging*, and the recent *Hospital Practice* series, "The Geriatric Patient." In these cases, sophisticated faculty were asked to develop a lecture or chapter which represented a matrix between their own existing area of interest and geriatrics. This approach utilizes the best in any given medical community, making use of already existing expertise and talent.

It was the consensus of the conference on geriatric education that research leaders are needed to back up clinicians, residents, and students with their knowledge. However, the research or investigative model for the support of geriatric education is not the only one available. In fact, there is a possibility that in pursuing the research route to stimulate geriatrics, that clinical geriatrics might be lost.

In many situations, it may be desirable to bridge or marry the research components and the service and humanistic components of geriatric education. However, there are clinical areas, such as in family practice, where it may not be necessary to utilize a research-oriented faculty in training programs. The trainee in family practice does not necessarily need to be exposed to research developments in geriatrics and gerontology. However, trainees in medical school or residencies in internal medicine, psychiatry and family practice might very well benefit from exposure to a research-oriented faculty.

Dr. Stone questioned whether the physician should be involved in all aspects of geriatrics. Could other health professionals assume certain roles necessary in geriatric care? Dr. Leslie Libow asserted that geriatrics goes beyond patient care and involves development of health care delivery systems in the community. Dr. Libow also noted that the physician is in the best position to make this system work. A general discussion of the physician's role in present-day society ensued. Dr. Roy noted that she is not able to know everything about her patient's lives, and for practical reasons, cannot be expected to do so. Dr. Libow countered that the social, psychological, and economic aspects of social medicine have been underemphasized in medical education; medical education has been too disease-oriented. He also discussed the survey of seniors attending eight medical schools asking if they wished they had had more special training in geriatric problems. He received many positive responses to this survey which will appear in an upcoming issue of the *Annals of Internal Medicine*.

Dr. Roy and others discussed the practical situation of private practitioners and the difficulty of making ends meet. Dr. Roy made a special point of the increased time which proper care of the elderly patient requires. She indicated

that we should not overpromise what we can do as physicians in the context of the present day realities of delivering medical care to the elderly.

Dr. Libow noted that health systems agencies (HSA's) and other planning and policy groups do not consult those concerned with geriatrics for a geriatric point of view. To make progress in this area, he suggested that those with a special interest in geriatrics should be consulted to develop effective systems of care.

PLANS FOR MARCH 1977 MEETING

Regarding goals for the March meeting, it was hoped that the representatives of major physician associations would be instructed or informed about geriatric medicine—what currently exists and ideas concerning geriatric education. A second goal would be that those attending the March meeting would go back to their own organizations with positive suggestions for action. It is hoped that the physician organizations would also provide support for addition of training in educational programs according to model A or model B.

The next meeting will take place on Friday, March 4, from 12 noon until 2 p.m.; Saturday, March 5, in Baltimore. Physician groups which are being invited, in addition to the American Geriatrics Society and the Gerontological Society, will include the American Medical Association, American Academy of Family Physicians, Association of American Medical Colleges, American College of Physicians, American Society of Internal Medicine, American College of Cardiology, American Psychiatric Association, and the National Medical Association.

Position papers on a number of subjects will be prepared by members of the advisory committee for the March 4–5 meeting. These one- to two-page papers will include:

Undergraduate geriatric education—Ralph Goldman, M.D.
Graduate Education:
A Model—William Reichel, M.D.
B Model—Leslie Libow, M.D.
Rejection of C Model—William Reichel, M.D.
Postgraduate education—Knight Steel, M.D.
County and State Medical Society Committees on Aging—Shirley Roy, M.D.
Economics of geriatric practice—Shirley Roy, M.D.
Medical director concept—Mr. Herman Gruber.
Faculty development—Eric Pfeiffer, M.D.
Curriculum development—William Reichel, M.D.
Long-term care facilities as training sites—Jerry Solon, Ph.D.

In summary, the first Conference on Geriatric Education has clarified three models of geriatric education—A, B, and C. The consensus of the Advisory Committee of the American Geriatrics Society Conference on Geriatric Education is that we should reject the C model. In the discussion of educational models, it was the feeling of the group that it would be an important step in clarifying the position of this advisory committee that another full board-certified specialty is not being called for. This would allow geriatrics to flourish under the existing specialties—internal medicine, family practice, psychiatry, and others—with increased educational contents incorporated into each training program (model A) or 1- to 2-year specialized period of training in certain residencies (model B).

Hopefully the American Geriatrics Society Conference on Geriatric Education will throw additional light on this important subject. It is the intention that these two meetings will allow all viewpoints to be clearly expressed and heard. The American Geriatrics Society is delighted in the interest of the U.S. Senate Special Committee on Aging. With a sense of concern on the part of the American Geriatrics Society, the Gerontological Society, the American Medical Association, and other major physician organizations, in addition to the activities of the U.S. Senate Special Committee on Aging, it is our hope that solutions will come forth in order to improve the health care of our senior citizens.

Again, thank you for your interest in the recent American Geriatrics Society Conferences on Geriatric Education.

Sincerely yours,

WILLIAM REICHEL.

ITEM 7. LETTER AND ENCLOSURES FROM RAYMOND HARRIS, M.D., CENTER FOR THE STUDY OF AGING, INC., ALBANY, N.Y.; TO WILLIAM E. ORIOL, STAFF DIRECTOR, SENATE SPECIAL COMMITTEE ON AGING, DATED OCTOBER 28, 1976

DEAR MR. ORIOL: As you requested at your Special Senate Committee on Aging hearing on October 13, 1976, at the Gerontological Society convention, I am happy to be invited to submit the following:

As president of the Center for the Study of Aging and a long active physician engaged in the practice, teaching, and research in the field of aging, it is my opinion that the time has come for further expansion of geriatric educational training programs in the medical schools of the United States. I am clinical associate professor of medicine, Albany Medical College; chief of cardiology, subdepartment of cardiovascular medicine, St. Peter's Hospital; former vice president of the Gerontological Society; and the author of "The Management of Geriatric Cardiovascular Disease," and editor of the forthcoming volume, "Guide to Fitness After Fifty." The enclosed curriculum vitae and bibliography testify to my experience in research in aging, cardiovascular disease, and community leadership in the field of aging.

The three enclosed reprints on, "Model for a Graduate Geriatric Program at a University Medical School," "Some Observations on Geriatrics as a Specialty," and "Geriatrics as a Specialty," among my writings are the most pertinent to the question at hand. I wish to include these pertinent reprints into the record, since they do represent a well thought out program indicating the necessity for and the type of geriatric education that is so essential in the medical schools of the United States. I have also been involved in planning for the geriatric centers in the Veterans Administration program, the Chicago Medical School geriatric program, and the University of Arkansas Medical School program.

Thank you for this opportunity and invitation.

Sincerely yours,

RAYMOND HARRIS.

[Enclosures.]

As the urgency for services and programs increases over the next quarter century, geriatrics will become an acceptable, highly developed specialty, and geriatric education in medical schools will expand to match the progress in undergraduate programs in gerontology, providing more qualified physicians fully trained in the diagnosis and care of older people. In turn, subspecialties such as geriatric cardiology, geriatric endrocrinology, and geriatric psychology will develop. Such specialties and programs will be more necessary to make best use of monies allocated for the health needs of older people.

Model for a Graduate Geriatric Program at a University Medical School[1]

Raymond Harris, MD[2]

The decade between the first White House Conference on Aging in 1961 and the second in 1971 saw the coming of age for gerontological programs in university undergraduate and graduate departments, particularly in human development, social science, and health sections. Contributing to this growth were the powerful pressures built up by the expanding challenges of aging, the belated recognition by politicians of the political importance of aging voters, and the advocacy measures exerted by senior citizens and their organizations to make more money available for such programs.

During this same period, a similar growth was not experienced in medical schools and other educational facilities concerned with the medical training and education of physicians, nurses, and other members of the paramedical professions concerned with care of the aged. The USA lags behind other countries which have recognized the need and urgency for such training in geriatric and allied fields. This lack was recognized by the Clinical Medicine Section of the Gerontological Society and led to the appointment of a Postgraduate Geriatric Medical Education Committee, which was charged with trying to expand geriatric education facilities in universities and medical schools. An excellent geriatric curriculum model for a short-term training program was recently developed by Rodstein (1973) and this committee.

Interest by Future Physicians

Need for programs in clinical gerontology and geriatrics is beginning to be more widely recognized. A senior premedical student at the Univ. of Colorado recently wrote to me:

> As a senior pre-medical student at the University of Colorado, I am very much interested in exploring the field of gerontology. . . . In the attempt to establish gerontology as a separate subspecialty, I realize the difficulties involved, primarily from the educational standpoint, mainly that very little is understood about the process of aging and that to train physicians in this area would mean concentration in the areas of general medicine and psychiatry. The unappealing aspect of gerontology is that the patients are seemingly unproductive members of society and often have a bitter outlook on today's events. The aged seem to have in common a useless role in a world whose scientific achievements result in the prolongation of life. While older people are continually forming a larger segment of the American population, they must be supplied adequate rehabilitation and medical care. I feel that there will be a great demand for geriatricians in the near future, and I would like to devote much time working in this field if I enter medical school next year. I would be very much interested if you could throw any further insights on the subject of gerontology as well as any existing programs at Albany Medical College, especially at the undergraduate level, as I am not yet in medical school.

1. Presented at a Workshop on Geriatrics: A New Model for the Medical and Dental Schools, annual meeting of Gerontological Society, San Juan, Dec. 21, 1972.

2. Clinical Associate Professor of Medicine, Albany Medical College; Chief, Subdept. of Cardiovescular Medicine, St. Peter's Hospital; President, Center for the Study of Aging, Inc., 196 Shaker Rd., Albany 12211.

Reprint from The Gerontologist, Vol. 15, No. 4, August 1975—Printed in U.S.A.

A senior medical student at Georgetown Univ. School of Medicine expressed similar interest:

> I have decided to do my internship and one or two years of medical residency before pursuing any further training in geriatrics per se. By that time I am hoping that fellowships in geriatrics will be available in this country. If not, then I may pursue my training abroad, e.g., at the University of Glasgow. However, the possibility of receiving early training and guidance in this field, as for example at the Albany Medical Center, appeals to me considerably. In any event, please keep me informed of any progress you make or are informed of about formal training programs in clinical geriatrics in this country and abroad.

This same physician wrote me more recently:

> Now I am a first year resident in Internal Medicine at the Rhode Island Hospital, one of the Brown University affiliated hospitals in Providence, Rhode Island. I am very interested in doing a fellowship in geriatric cardiology if such will be available at the Albany Hospital in July, 1974. My career interests include the practice of general internal medicine and geriatrics, with an emphasis on geriatric cardiology.

These are only a few samples of correspondence received from interested premedical and medical students concerning the lack of programs in geriatrics and clinical gerontology in this country.

There is a need for geriatric consultants thoroughly versed in the diseases of aging patients and the age-related changes which occur in the absence of disease. Such specialists are necessary to identify the gaps in our knowledge about aging, to obtain the clinical and research information concerning the age-related changes in disease and normal old age, and to promote and activate modern preventive and therapeutic measures that keep old people healthy and improve their health when disease intervenes. They are essential to develop the concepts of wellness in old age which can come only from determined efforts by a well-organized, well-informed group of physicians who are intimately and vitally concerned with all the aspects of aging and disease in people who are growing old.

Steps in Planning

(1) *Identification of subject matter.*—Courses in geriatric medicine must systematically identify, organize, integrate, and make available all appropriate information on the aging processes, aging-related disease processes, and other data concerned with the clinical, social, preventive, and remedial aspects of illness and health maintenance in the elderly.

(2) *Profile of the geriatrician.*—The specialist in geriatric medicine should have specialized training in diseases of old age and in the care of the elderly. Other practitioners and specialists can and must help care for the aged. Hopefully, they will become more knowledgeable and wise about the problems of their elderly patients. Very likely, they, too, will have to seek the assistance of the geriatric specialist when problems arise, just as the geriatric specialist will require their services for the care of aged people with special heart, gastrointestinal problems, and so on. The geriatric specialist is expected to know much more about aging and the diseases of the aged than his medical confreres. Although the Royal College of Physicians has recommended that after three to four years of general hospital training, four more years should be devoted to medicine or geriatrics before a doctor can be considered a specialist in geriatrics, one must ask if this lengthy period is still necessary. With the current shortage of physicians, perhaps this period may be shortened by "lifetime learning" (McIntosh, 1974).

(3) *Graduate geriatric education models.*—Models for graduate geriatric education may be modified according to the situation and strategies that must be employed.

In May, 1970, I had occasion to draw up one such model program in clinical gerontology at a university medical school and associated Veterans Administration Hospital in the Southwest (Fig. 1). The geographical situation of this medical school made it a central focal point for state and regional programs in aging. The university medical school had an interesting variety of scholarly and community resources, including the Veterans Administration health facilities, the university hospital, community hospitals, nursing homes, other institutions for the aged, and the state university itself, which also included a

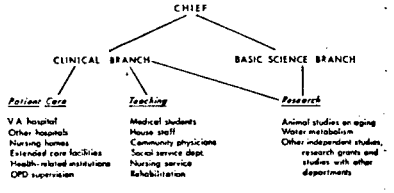

Fig. 1. Organization chart for a Division (Center, Institute, or Department) of Clinical Gerontology.

school of social work. It also had other essential components for an innovative successful gerontological teaching division, including (besides the excellent geographical location) sufficient patients and facilities for treatment, education, and research in aging, undergraduate and graduate students, and, most importantly, a devoted faculty interested in the possibilities of geriatrics and clinical gerontology.

Discussions with the Chief of Staff of the Veterans Hospital, the dean, and the other professors and administrators at both the university medical school and the Veterans Administration readily showed that a program in clinical gerontology, strengthening the teaching faculty by the addition of highly qualified clinical and research-oriented gerontologists and providing additional teaching, research, and patient-care facilities at the university hospital, the Veterans Administration Hospital facilities, and the community institutions, would improve the exposure and education of medical students, house staff, and postgraduate students and area physicians, and allied health personnel and nurses, to comprehensive programs in aging and chronic disease.

If physicians are to become more interested and proficient in caring for the aged, it is important that interns and residents during their training be exposed to the management and treatment of normal and sick elderly patients.

Development of outpatient clinics in the downtown section of the city and other types of comprehensive health centers, including halfway houses and a projected neighborhood health center, and the introduction and extension of home-care programs would offer a variety of new therapeutic and preventive care techniques for the delivery of health services in the community.

The Division of Gerontology would encourage and support fundamental research into the processes of aging, develop new scientific knowledge in the field of aging, and introduce courses in gerontology throughout the university medical school and its affiliated institutions. On the undergraduate level, it would introduce instruction in gerontology into the basic medical science course for medical students during their pre-clinical years and into the regular courses of instruction during the clinical years. On the graduate level, it would be involved in the gerontological training of house staff and postgraduate physicians. Such a center would also implement and develop geriatrics and clinical gerontology as a future subspecialty.

Such a clinical gerontology center can be organized into clinical and basic science branches (Fig. 1), both conducting research, teaching, and education. The clinical branch would, in addition, be concerned with the development and delivery of health services to aging patients, including patient care, supervision, research, and administration. The clinical branch in conjunction with other services at the university medical school could also initiate and direct in-service gerontological training for social service, nurses, volunteers, rehabilitation, and other paramedical personnel involved in aging.

The division would also develop affiliations with extended care facilities, chronic disease hospitals, research centers, nursing homes, and other institutions for the aged where in-service training and practice in geriatrics and clinical gerontology can be developed and taught. A special gerontological-social work committee could be established to supervise and conduct improved community programs such as home care, halfway houses, preventive services, and the other community measures so essential for the delivery of health care for the elderly. Such community programs would involve physicians in the county medical society and other professionals and volunteers in the county health and social services departments, senior citizen centers, United Fund, Red Cross, and other voluntary agencies.

The basic science branch would be primarily concerned with basic investigations in aging and would cooperate with the clinical branch in research with humans. Its focus would be the physiological, nutritional, metabolic, and central nervous system changes with aging, depending upon the interest of the investigators and the other members of the faculty at the medical school. Animal facilities at the university medical school should be available for such basic and clinical research.

Personnel

The development of a Division of Clinical Gerontology (Center, Institute, or Department) at the university medical school should initially require a chief and two associates. The chief should be a properly qualified physician and a recognized authority in gerontological education, training, teaching, and research. He would, in turn, work with the other clinical and basic science associates who would be responsible for the supervision and implementation of the appro-

priate programs within their branches. These associates should also be supported and assisted by appropriate faculty, secretarial, and research assistants to enable them to conduct and implement the programs in aging.

The development of a Division of Gerontology within the Dept. of Medicine at the university medical school would provide the university medical school with a much needed new treatment, education, and research center for aging. Such a Division of Clinical Gerontology, emphasizing the medical, scientific, and social needs of elderly people, will help the medical students and house staff at the university and the practicing physicians in the community to learn more about normal growth processes and human development from birth through senescence. It would also improve the delivery of health care to the old people of the area it serves, conserve their financial and other resources, and promote better understanding among the medical and paramedical professions of the impact of an aging population on health, medicine, social structure, problems of work, retirement, leisure, income, and other socioeconomic problems.

Conclusions and Predictions

As the segment of the population 65 years old and older expands to an estimated 21.5 million by 1975, 25 million by 1980, and 28.2 million by the year 2000 (Harris, 1970), the increased number and proportion of older people in the general population of the USA will establish the aged as a truly strong political force pushing this nation toward a gerontocracy and capable of demanding its "right to health" and more adequate programs and services to improve the length and quality of life. More national organizations, in addition to the Gerontological Society, will become more committed and provide extensive training, programming, and leadership as has the US Veterans Administration with its extensive health system and built-in interest in aging. The American College of Cardiology, which recently established a Committee on Geriatrics, will establish liaison with the Veterans Administration and other concerned groups to correct inequities and problems in providing better health care for the aged. Other organizations not already identified with aging will have to measure up to their societal responsibilities.

There will also be much more research on aging and age-related diseases, hastening the conquest of cancer and heart disease already predicted for the 21st century and extending longevity above the age of 80. Much publicized current advances in medical research and patient care have not yet been proved worthwhile in prolonging life expectancy of a person 30 years old or older. Whereas a 30-year-old in 1900 could expect to live 31.2 more years, in 1972 his life expectancy was only 31.7 more years (McIntosh, 1974).

A variety of model programs in gerontology and clinical geriatrics will also develop, based on centers of specialization on cerebral studies, geriatric cardiovascular research centers, and other areas and perhaps following the model and prototype outlined in this paper. Such centers will at the same time provide spin-off benefits in better community care, geriatric hospital and nursing home care for older people.

I predict that by the 21st century the aged will have either been put out of their misery, or the ravages of aging will have been radically corrected.

Addendum

Since this paper was presented, additional support for geriatric programs in medical schools includes the introduction by Senator Frank Moss of Senate Bill 764, which would provide direct funding of up to six medical schools with up to $500,000 each to support geriatric medical programs, the creation of the National Advisory Council on Geriatric Medical Programs with the help of Dr. T. R. Reiff of the Univ. of North Dakota, and the establishment and funding of several geriatric research and clinical center programs by the Veterans Administration.

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Some Observations on Geriatrics as a Specialty

R. HARRIS

Albany Medical College, Albany, NY

There is nothing more powerful than an idea whose time has come! I concur with Professor ANDERSON that Geriatrics' time has arrived and I cannot quarrel seriously with the sum and substance of what he says from his extensive experience in geriatric medicine. There is a need for geriatric consultants who are thoroughly versed in the diseases occurring in aging and in the age-related changes that occur in the absence of disease. At present diverse opinions exist concerning the value of specialists in geriatric medicine. However, time and an aging population are on the side of those, like me, who favor the development of a specialty in geriatrics. I belong to these partizans not because I feel the general practitioner and organ specialist should not treat older people, but because I maintain specialists in geriatrics are necessary to continue to identify the gaps in our knowledge about aging, to obtain the clinical and research information concerning the age – related changes in disease and normal old age, and to promote and activate modern preventive and therapeutic measures to keep old people healthy and to improve their health when disease intervenes. Such specialists are essential to develop the concepts of wellness in old age which can come only from determined efforts by a well organized, well informed group of doctors who are intimately and vitally concerned with all the aspects of aging and disease in people.

What must be done to make geriatric medicine a true specialty-more acceptable and palatable to its peers – the medical establishment of the world? Briefly, let us consider (1) Subject matter, (2) The relation of the geriatric specialist to his confreres, and (3) The education and research activity of the geriatric specialist.

1. Subject matter. Professor ANDERSON defines Geriatrics as 'the branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness in the elderly'. I am sure he would not object to the insertion of 'health' into this definition, so that Geriatrics may be re-defined as 'the branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness and the maintenance of health in the elderly.' Bearing this definition in mind, we must then systematically identify, organize, integrate and make available all the significant information in a format easily acceptable to the seeker of more knowledge on geriatric medicine. Much work has already been done in this area, but books and other teaching aids have not yet appeared in sufficient numbers to impress our medical brethren on the validity of Geriatrics as a specialty, to show them how much geriatric medicine differs from regular medicine, or to interest them more in geriatric medicine. There is much information currently concealed in the archives of the world medical libraries, but this information is scattered and not unified. At this time the presentation of such information in book form appears most feasible, but lectures, movies, tape recordings, film strips, and programmed instruction should not be overlooked as ways of rendering information on aging more available to the interested physician. This material naturally will include data on aging processes, aging related disease processes and other allied information on the clinical, social, preventive and remedial aspects of health and illness in the elderly.

The codification of such knowledge, wisdom and skill will establish a solid basis for Geriatrics as a specialty. It will not be sufficient merely to present such information to improve the general state of knowledge of geriatric medicine among its practitioners. It will be necessary to elevate the state of wisdom of geriatric medicine and to raise the standards of skills and arts in the management and treatment of older people.

2. Relationship of the geriatric specialist to his medical confreres. Now as to the relationship of the geriatric specialist to his medical confreres, I see no real conflict. As Professor ANDERSON points out, the geriatric specialist has specialized training in diseases of old age and in the care of the elderly. As in other specialties, the existence of a geriatric specialist does not preclude treatment by the general practitioner, the internist, the organ specialist like the cardiologist, gastroenterologist and so forth. They, too, can and must help care for the aged. Hopefully, they will become more knowledgeable and wise about the problems in their elderly patients. Very

likely, they, too, will have to seek the assistance of the geriatric specialist when problems arise, just as the geriatric specialist will require their services for the care of the aged in people with special heart, gastrointestinal problems and so on. The geriatric specialist is expected to know much more about aging and the diseases of the aged than his medical confreres.

3. Education, training and research activities. I will not elaborate on the many aspects of aging that Dr. ANDERSON suggests the geriatric specialist should know and practice. But I believe it is of utmost importance that we discuss the education, training and research activities of the specialist in geriatric medicine. We should identify the profile, the special skills and abilities of this specialist. Dr. ANDERSON mentions the 1964 report of the Royal College of Physicians which recommended 'after three to four years of general hospital training, four more years should be devoted to medicine or geriatrics before a doctor can be considered a specialist in Geriatrics.' Is this lengthy period necessary? With the current shortage of physicians, should not this period of training be shortened by pursuit of what we in the U.S. now call 'lifetime learning?'

And what curriculum should be set up for the education of the would-be specialist in geriatrics? What kind of training should he get? What research activities may be expected from the geriatric specialist? And finally, at what point does the geriatrician become a clinical gerontologist? Should the geriatric specialist and the clinical gerontologist have similar training? This question is important enough to warrant further energetic discussion. From my viewpoint both should have similar training so that they can continue to communicate and understand each other. It is the environment in which they work that will distinguish the geriatrician from the clinical gerontologist. The former will pursue his interest and activities in old age on the battleground of clinical medicine, the hospital and the community. The clinical gerontologist, on the other hand, will tend to withdraw more and more into the academic aspects of aging, and conduct his activities within the cloister of the academic and research institutions. Very likely, at some point, each may sally forth into the other's domain with benefit to both and to the specialty of aging. The profession of geriatric specialist will often merge almost imperceptibly into that of clinical gerontologist. Both have a place in gerontological research centers. Both will undoubtedly work together in teams. Eventually the specialist in geriatric medicine will become a true clinical gerontologist concerned with all aspects of aging. The geriatric specialist with a good

education and a mind disciplined by the logic of reason, characterized by unity and method, and tempered by wide experience and equanimity will be able to choose to remain a geriatrician or to become a clinical gerontologist. After all, as SHAKESPEARE asked, 'What's in a name?'

Author's address: Prof. Dr. RAYMOND HARRIS, Albany Medical College, 706 Madison Avenue, *Albany, NY* (USA).

[From the *Geriatric Times*, August 1970]

Geriatrics as a Specialty

There is nothing more powerful than an idea whose time has come! There is a need for geriatric consultants who are thoroughly versed in the diseases of aging patients and in the age-related changes that occur in the absence of disease. At present, diverse opinions exist concerning the value of specialists in geriatric medicine. However, time and an increasing aging population are on the side of those, like me, who favor the development of a specialty in the field of geriatrics.

Specialists in geriatrics are necessary to identify the gaps in our knowledge about aging, to obtain the clinical and research information concerning the age-related changes in disease and normal old age, and to promote and activate modern preventive and therapeutic measures that keep old people healthy and improve their health when disease intervenes. Such specialists are essential to develop the concepts of wellness in old age which can come only from determined efforts by a well organized, well informed group of doctors who are intimately and vitally concerned with all the aspects of aging and disease in people who are growing old.

What must be done to make geriatric medicine a true specialty more acceptable and palatable to its peers, the medical establishment of the world? Briefly, let us consider (1) subject matter, (2) the relations of the geriatric specialist to his confreres, and (3) the education and research activity of the geriatric specialist.

1. Subject matter. Geriatrics may be defined as "the branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness and the maintenance of health in the elderly." Bearing this definition in mind, we must then systematically identify, organize, integrate, and make available all the significant information in a format easily acceptable to the seeker of more knowledge on geriatric medicine. There is much information currently concealed in the archives of the world medical libraries, but this information is scattered and not unified. At this time the presentation of such information in book form appears most feasible, but lectures, movies, tape recordings, film strips, and programed instruction should not be overlooked as ways of rendering information on aging more available to the interested physician. This material naturally will include data on aging processes, aging-related disease processes and other allied information on the clinical, social, preventive, and remedial aspects of health and illness in the elderly.

The codification of such knowledge will establish a solid basis for geriatrics as a specialty. But it will not be sufficient merely to present information to improve the general state of knowledge about geriatric medicine among its practitioners. It will be necessary also to elevate the standards of skill, art, and wisdom in the management and treatment of older people.

2. Relationship of the geriatric specialist to his medical confreres. Now as to the relationship of the geriatric specialist to his medical confreres, I see no real conflict. The geriatric specialist has specialized training in diseases of old age and in the care of the elderly. Other practitioners and specialists can and must help care for the aged. Hopefully, they will become more knowledgeable and wise about the problems in their elderly patients. Very likely they, too, will have to seek the assistance of the geriatric specialist when problems arise, just as the geriatric specialist will require their services for the care of the aged people with special heart, gastrointestinal problems, and so on. The geriatric specialist is expected to know much more about aging and the diseases of the aged than his medical confreres.

3. Education, training, and research activities. I believe it is of utmost importance that we discuss the education, training, and research activities of the specialist in geriatric medicine. We should identify the profile, the special skills and abilities of this specialist. The 1964 report of the Royal College of Physicians recommended "after 3 to 4 years of general hospital training, 4 more years should be devoted to medicine or geriatrics before a doctor can be considered a specialist in geriatrics." Is this lengthy period necessary? With the current shortage of physicians, should not this period of training be shortened by pursuit of what we in the United States now call lifetime learning?

And what curriculum should be set up to educate the would-be specialist in geriatrics? What kind of training should he get? What research activities may be expected from the geriatric specialist? And finally, at what point does the geriatrician become a clinical gerontologist? Should the geriatric specialist and

the clinical gerontologist have similar training? This question is important enough to warrant further energetic discussion. From my viewpoint both should have similar training so that they can continue to communicate and understand each other. It is the environment in which they work that will distinguish the geriatrician from the clinical gerontologist.

—RAYMOND HARRIS, M.D., *Albany Medical College, Albany, N.Y.*

ITEM 8. LETTER AND ENCLOSURES FROM THEODORE R. REIFF, M.D., HEAD, DIVISION OF GERIATRIC MEDICINE, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, N. DAK.; TO SENATOR CHARLES H. PERCY

DEAR SENATOR PERCY: Since my reply of September 30, 1976, a copy of which is enclosed, to your inquiry regarding our geriatric program at the University of North Dakota School of Medicine, I am pleased to let you know that the president of this university has committed some limited funds to help us keep our program in operation for the time being.

There is, however, a need for additional funds and that is why we are hopeful that the efforts of you and your colleagues on the Special Committee on Aging of the U.S. Senate will develop legislation to provide funding for gerontology and geriatric medical education in the medical schools of this country.

Attached is another copy of a position paper adopted by the National Advisory Council on Geriatric Medical Programs, a list of whose founding members is enclosed, endorsing and urging gerontology and geriatric curricula in the medical schools of the United States.

We would hope that S. 1156 to fund geriatric programs in the medical schools will be reintroduced into the next session of the Congress and passed by the Senate with concurrent action on H.R. 7364 by the House of Representatives.

For the interest of you and your committee, enclosed is a copy of a paper, written at the request of the American Medical Association, originally entitled, "Medical Care of the Aged—A National Scandal," but changed by the A.M.A. to, "We're Doing A Third Rate Job for the Aged." In it is expressed some of the deplorable aspects of geriatric medicine in this country.

Finally, some of the proposed solutions to improving medical knowledge and interest in geriatrics are incorporated into the enclosed proposal for a Gerontology and Geriatric Medical Institute of the University of North Dakota, components of which we are attempting to implement.

My colleagues and I are willing to provide you and your committee with all professionally appropriate assistance in improving the health care for older persons.

With continuing admiration for your efforts and highest professional regards.

[Enclosures.]

THE UNIVERSITY OF NORTH DAKOTA,
Grand Forks, September 30, 1976.

HON. CHARLES H. PERCY,
Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR PERCY: I have been asked to respond to your recent letter concerning the meeting in New York of the subcommittee of the Senate Committee on Aging that you are to chair during the week of October 14 in conjunction with the Gerontological Society.

I have been informed by Dr. Leslie Libow, chairman of the Clinical Medicine Section of the Gerontological Society, and Dr. Robert Butler, Director of the National Institute on Aging, that your Senate subcommittee meeting will be on Wednesday, October 13, during which time you will be inquiring into efforts of U.S. medical schools in geriatric education for medical students.

In this regard, I have been requested to present the work done by the University of North Dakota and am scheduled to present this material in a panel on Thursday evening, October 14, and on Saturday, October 16, at the Gerontological Society meetings.

I am glad to supply your committee with this information and am enclosing copies of some material describing programs operational and planned at this university. In specific response to your three questions, please be informed that:

(1) Yes! We do have geriatrics taught in our curriculum through the division of geriatric medicine.

(2) Yes! We do have programs in which students can be taught in nursing homes. We are now planning for opportunities for residents and fellow to participate in geriatric medical exposure in nursing homes during their family practice residency and possibly during their internal medicine residency.

(3). Yes! We do have programs which help serve the elderly in other ways and are planning more extensive efforts in conjunction with our senior citizens center, construction of which is underway to be completed within the next 8 months. Please refer to "Operation Re-Ed" in the enclosed material. This is a program to re-educate older persons for vocational and avocational pursuits.

For your interest, enclosed is a copy of a position paper adopted by the National Advisory Council on Geriatric Medical Programs, endorsing and urging inclusion of gerontology and geriatric curricula in the medical schools of the United States. Your committee's endorsement of this paper would be well received and helpful to our efforts.

Please let me know if you would like more information concerning our program. I congratulate you for your interest in this vital but long neglected field.

With highest professional regards.

Sincerely,

THEODORE R. REIFF, M.D.,
Professor of Medicine,
Head, Division of Geriatric Medicine,
Director of Health Education.

[Attachments.]

POSITION PAPER: NATIONAL ADVISORY COUNCIL ON GERIATRIC MEDICAL PROGRAMS

By the end of this century there will be over 25 million people in the United States over the age of 64. Many of these will have multiple and complex interacting illnesses that require much more care per capita than younger patients. This care requires expertly trained physicians.

At the present time the medical input to a good part of the geriatric institutions in this country is quantitatively as well as qualitatively inadequate. This is not to say that there is not involvement by competent and interested physicians, but it is not an overstatement to say it is rarely sufficient.

It is generally acknowledged that the medical care of older people in this country leaves much to be desired. Geriatric medicine is, to a large extent, a neglected area of medical education and allied health professional training.

Geriatric medicine has not received the stature it should have in this country's medical training programs. Understandably, this makes it exceedingly difficult to attract physicians in training to work in this area.

Actually geriatric medicine provides an excellent opportunity for the in-depth study of human disease and for the training of physicians and allied health care personnel.

Steps to provide solutions to the inadequacy of geriatric medical care are urgently needed. Attention should be directed to developing high caliber programs in geriatric medicine that will serve as models of excellence. These programs should be of such caliber as to attract a significant body of medical students, young physicians, and allied health personnel.

Excellence in geriatric medicine, like any other clinical discipline, must rest on a solid scientific foundation. It is essential that training programs in geriatric medicine include fundamental research in the problems of the aged as well as in the process of aging.

A National Institute on Aging has recently been established within the National Institutes of Health. The time is opportune to support the development of programs in geriatric medicine in the medical institutions of this country.

PROPOSAL

The national advisory council on geriatric medical programs encourages the medical schools in the United States to establish interdisciplinary programs in geriatric medicine. These programs should serve as the basis for geriatric educational experience at all levels of education and training for physicians and allied health care professionals.

FOUNDING MEMBERS, NATIONAL ADVISORY COUNCIL ON GERIATRIC MEDICAL PROGRAMS

Robert L. Grissom, M.D., professor of medicine, University of Nebraska College of Medicine, Omaha, Nebr.

Alexander Leaf, M.D., Jackson professor of clinicial medicine, Harvard Medical school, chief of medical services, Massachusetts General Hospital, Boston, Mass.

Russell V. Lee, M.D., Consultant, Palo Alto Clinic, Palto Alto, Calif.

Henry M. Lemon, M.D., professor of medicine, head, section of Oncology, University of Nebraska College of Medicine, Omaha, Nebr.

Abraham Lilienfield, M.D., professor and chairman, Department of Epidemiology, the Johns Hopkins University School of Hygiene & Public Health, Baltimore, Md.

Ephraim Lisansky, M.D., professor of medicine, University of Maryland School of Medicine, Baltimore, Md.

Sherman M. Mellinkoff, M.D., dean, school of medicine, University of California, Los Angeles (UCLA), Los Angeles, Calif.

Theodore R. Reiff, MD., chairman, professor of medicine, head, division of geriatric medicine, director of health education, University of North Dakota School of Medicine, Grand Forks, N. Dak.

Eugene Towbin, M.D., Ph.D., professor of medicine, associate dean, University of Arkansas School of Medicine, Little Rock, Ark.

Irving S. Wright, M.D., professor emeritus of medicine, Cornell University Medical College, New York, N.Y.

A PROPOSAL TO ESTABLISH DIVISIONS OF GERONTOLOGY AND GERIATRIC MEDICINE AT MEDICAL SCHOOLS IN THE UNITED STATES

It is generally acknowledged that the medical care of older human beings in this country leaves much to be desired. As a corollary to the above the area of geriatric medicine is, to a large extent, a very neglected area of medical training.

Actually geriatric medicine provides an excellent environment for the in-depth study of human disease and for the training of physicians and allied medical personnel.

At the present time the medical staffing of a good part of the geriatric hospitals in this country is quantitatively as well as qualitatively inadequate. This is not to say that there is not representation by competent and interested physicians but it is not an overstatement to say they are in a minority.

One of the reasons this sorry state exists is because geriatric medicine has not received the stature it should have in this country's medical training programs. Understandably this makes it exceedingly difficult to attract new and well trained physicians to work in this *area*.

It is our opinion that an attempt at solution of this problem is in order and that attention should be directed to developing high caliber programs in geriatric medicine that will serve as models of excellence. It is hoped that a significant body of medical students and young physicians in training would be attracted to such programs and make possible the development of this important area of medicine as an attractive field for newer well trained physicians to work.

The scientific base of any good geriatric medicine program must rest on a solid foundation of the science of gerontology. There are a few centers of research gerontology in this country, the most notable of which is the Gerontology Research Center of the National Institutes of Health, located in Baltimore, Md. However, the close integration of research gerontology with geriatric medicine has not taken place to sufficient degree. With the explosion of knowledge in molecular biology that has taken place in the last decade and with newer knowledge of the basic physicochemical mechanisms of life, the potential for a fundamental understanding of the aging process is already existent. With this knowledge, intervention to extend the healthy and productive lifetime of human beings becomes possible.

It is our considered opinion that the time is now ripe to forge ahead in one of the greatest enterprises this country could undertake—the support of gerontologic and geriatric medical programs in the medical schools of the nation.

PROPOSAL

That a select number of medical schools in the United States obtain endowments for chairs in gerontology and geriatric medicine which would form the

nucleus of interdisciplinary divisions of gerontology and geriatric medicine. Each of the selected schools should have an endowed chair in gerontology and one in geriatric medicine, both of whose professional occupants would be members of the single division of gerontology and geriatric medicine that would cross all departmental lines.

The professor of gerontology should be a scientist of excellence and the professor of geriatric medicine should be a clinician of excellence, both of whom would be responsible for the development and expansion of the division as well as for the interdigitation of their respective programs with each other and with the existent programs in the rest of the school. Members of the division of gerontology and geriatric medicine would be encouraged to hold appointments in other appropriate departments of the school.

It would be the responsibility of the professors of gerontology and geriatric medicine to develop programs for scientists and physicians at the undergraduate and graduate levels and to develop training programs for allied health professionals such as physician's assistants and nurse practitioners who should play significant roles in the optimal in-patient and ambulatory care of the elderly.

Support of this type and the medical and scientific enthusiasm it would engender would make a significant contribution to the prolongation and betterment of human life.

THEODORE R. REIFF, M.D.,
Chairman, Subcommittee on Geriatric Medical Programs,
Health Action Council of the Maryland Commission on Aging
and the Johns Hopkins University School of Medicine
and School of Hygiene and Public Health.

[From *Prism*, December 1973]

WE'RE DOING A THIRD-RATE JOB FOR THE AGED

(By Theodore R. Reiff, M.D.[1])

In a recent interview in which the high costs of home dialysis and the type of patient eligible for such care were discussed, the director of a renal dialysis unit in a major hospital was quoted as saying, "Rehabilitation is one of our yardsticks of success. Can the patient go back to his previous work? One girl went back to training and jumping horses." He concluded: "We'll put any person on dialysis if he shows a potential for health. But an older person, say he's 75 and looks his age, well . . ."

This attitude regarding the suitability of elderly patients for renal dialysis is only one example of the ways in which many of the elderly are denied the best medical care. Another is the bizarre switch of intent made by government officials in administering medicare.

In an attempt to provide a bare minimum of physician attendance to nursing home patients, U.S. medicare policies initially provided that nursing home patients covered by medicare be seen at least once a month by physicians. When fiscal constraints became the determinants of this policy, the government, and other third-party carriers, interpreted the provision to mean that medicare would provide for only one visit per month by the patient's physician. The reason for this perversion of intent has been the low priority given to the medical needs of geriatric patients.

Although the circumstances and degree are certainly not directly comparable, it may be worth pointing out that the people of Germany were once led to accept financial priorities in making decisions concerning the right to life.

In the 1930's, the Nazis began a program of "euthanasia" in which nonproductive, "senile" Germans were institutionalized and then put to death by medical personnel. Although much of the German populace was unaware of this medical perversion, the philosophical acceptance of this "pragmatic" practice had been very subtly laid by a number of techniques.

In the mid- and late-1930's, a very interesting change was found in some of the arithmetic textbooks used in German primary schools. For example, the usual problem of finding out how many eggs, at 12 marks per dozen, a person could buy with 100 marks was changed; the question became. "How many

[1] Theodore R. Reiff, M.D., was formerly the medical director of a geriatric center and hospital and a biomedical researcher on the faculties of the Johns Hopkins University School of Hygiene and Public Health and the School of Medicine. He is now the director of health education and chief of the Division of Geriatric Medicine at the University of North Dakota School of Medicine.

Aryan couples can be subsidized to have a child for the Third Reich, at 10,000 marks per couple, for the 40,000 marks it costs each year to keep alive in a nursing home one elderly, senile person who cannot be rehabilitated back to useful work and is of no value to the Reich?'

The above examples may be used to point out the very low order of priority given in a materialistic society to the continued existence of "nonproductive" individuals and, in part, explains the general lack of interest in and the neglect of geriatric medical care in our society.

This neglect extends not only to geriatric medical care, but to all areas of aging, including research. Indeed, a number of this country's leading gerontologists have pointed out the general neglect and lack of support for such research.

The Gerontology Research Center of the National Institutes of Health in Baltimore, directed by the world-renowned gerontologist Dr. Nathan W. Shock, considered by many the "father" of gerontologic research in this country, has undergone major cutbacks in funding that have played a strong role in preventing the development of the center to its greatest potential.

The bill passed by Congress last year to establish, within the National Institutes of Health, a National Institute for Aging Research was vetoed by President Richard M. Nixon.

The Baltimore Gerontology Research Center, which is presently under the National Institute of Child Health and Human Development, receives only a miniscule portion of that institute's funds, most of which goes to child health.

One of the nation's leading gerontologists, Dr. Bernard L. Strehler, professor of biology at the University of Southern California, stated at a conference on aging, sponsored by the Center for the Study of Democratic Institutions, that "the amount of money spent in this Nation to uncover the sources of aging and to determine what can be done about it constitutes a scandal of neglect."

Strehler went on to say, "The national commitment to research on this most universal of human afflictions amounts to about $14 million per annum, perhaps less now that biomedical research in this country has been sacrificed to other 'more urgent and meaningful' goals. That is equivalent to about 8 cents per person per year—the price of one candy bar. It is one-hundredth the cost of a moon shot, one twenty-fifth of a fighter bomber, about 3 miles of metropolitan freeway."

The neglect of geriatric medical care and geriatric training for physicians and allied health professionals and the effect of such neglect on the care of elderly human beings in this country is no less scandalous. And it will assume ever increasing quantitative importance because of the growing percentage of aged persons in our society.

In the summer of 1970, this neglect was starkly dramatized when an outbreak of salmonellosis in a Baltimore nursing home involved 107 out of 140 elderly patients and 30 of the nursing personnel. The disease contributed to the death of at least 25 patients.

The investigation of that outbreak was conducted jointly by the city and State health departments, the Baltimore office of the U.S. Food and Drug Administration, and by personnel from the Center for Disease Control of the U.S. Public Health Service, resulting in the reiteration of the need for appropriate public health and sanitary measures by all agencies concerned. The Governor of Maryland appointed a commission to investigate the matter.

The findings of that commission included statements noting that the nursing home in which the tragedy occurred had no major defects. It had been licensed and approved for care for patients, and that, compared to other nursing homes, it was above average in its facilities, cleanliness, and overall operation.

After the tragedy, I was asked to inspect that nursing home and found nothing to contradict the above commentary. But an analysis of the events leading up to the catastrophe made clear that one of the important reasons for the high number of stricken patients and deaths appears to be that, when the initial symptoms and early deaths appeared, insufficient attention was paid to precise diagnosis and eliciting an accurate cause of death.

Unfortunately, this deficiency is not unusual in the treatment of nursing home and other geriatric patients. It is, in fact, quite common in the overwhelming majority of elderly deaths. Somehow, when older people die, there is a general expectation and acceptance of their death, without interest in the mechanisms or inquiry into possible prevention. This attitude is commonplace among both health professionals and laymen, including family and friends of the patient.

FATALISTIC ATTITUDE

If a younger person dies, both physician and family want to know what happened, why it happened, and what could have been done to prevent it. Physicians ask for, and frequently receive, permission to perform a postmortem examination—an indispensible tool for acquiring precision in the inquiry as to cause of mortality and preexisting morbidity.

Frequently, the information gained is helpful in preventing similar deaths, in providing information to families about hereditary illness and about communicable diseases important from a public health point of view.

On the other hand, if an older person dies, there is generally little interest in finding out what happened, not only on the part of the professional, but also the family, both of whom accept the cause of death as being due to "old age," and they show little interest in the mechanism that brought it about.

This is not to say that there is no importance in the emotional and philosophical acceptance of the inevitability of our own mortality, but such acceptance should not include a hopeless and fatalistic attitude regarding any investigation of the reason for death. The goal of such investigation is the improvement in the quality and duration of life for all elderly people, in fact, for all human beings.

I had the opportunity, for a limited time, to investigate the cause of death in patients at a geriatric center and hospital where the average age was about 85. Many of the deaths were of patients in their 90's and even older. One finding of great interest and importance was that the two most important underlying causes of death were malnutrition, with its attendant debility and lowered resistance, and infection related to debility and presumably to the now-well-established decrease in immunocompetence that takes place with aging. It is worth considering, however, that both malnutrition and infection are, in part, preventable and treatable.

Malnutrition in older people is a well-documented problem, and social and community services in various parts of the country have expressed interest in providing better nutrition for elderly people. Services such as group dining rooms for the elderly and meals-on-wheels have been helpful. The dental profession has been aware of the importance of proper dental care and dentures in mastication, the initial alimentary process. However, with few exceptions, there is little known about digestion and absorption of necessary nutrients from the alimentary tract.

But Paul H. Guth, M.D., of the Wadsworth Veterans Administration Hospital in Los Angeles, has shown that there is a decreased absorption of xylose with advancing age, and there have been other studies indicating that not only carbohydrates but other essential nutrients are poorly absorbed in older people.

The classic studies by Dr. Shock and his colleagues at the Gerontology Research Center have shown clearly that age-dependent decreases occur in almost all organ functions; so it should not be surprising that significant decreases in the alimentary absorption of essential nutrients usually take place. But further definition of this phenomenon is necessary so that corrective measures may be taken. Perhaps older people should take food supplements in the form of amino acids and medium-chain triglycerides. We might also consider the possibility of parenteral hyperalimentation in the debilitated elderly.

One of the major tragedies in the care of geriatric patients is that they are often institutionalized because services and resources are inadequate to provide proper care in the patient's own home. In years past our State mental hospitals became warehouses of senescent people for whom there were insufficient services to allow them to stay relatively independent in their own homes.

Then, too, many State mental hospitals during the past decade prided themselves on the degree to which they reduced their geriatric populations by "returning them to their local communities." But in the majority of instances, the patient ended up in a local community nursing home; so the warehousing took place locally rather than on the State level. The truth of the matter is that we have not developed our community health and personal care services for the elderly to the extent needed to prevent unnecessary institutionalization, with its attendant high morbidity and mortality.

OPTIMAL CARE

With few exceptions, we have not developed in our acute-care hospitals the special medical, nursing, and allied health care necessary for optimal treatment of elderly patients. This is especially true in large public hospitals where understaffing and budgetary problems generally lead to neglect of the geriatric patient, who, as we have seen, is on the low end of the priority scale.

The decubitus ulcer that starts in the geriatric patient in the acute-care hospital because of insufficient position changes and the use of improper bedding is often the start of the downhill course to mortality.

It is common practice in many hospitals to "staff" geriatric wards with lower levels of nursing care when, in fact, the geriatric patient can care for few of his own needs, is dependent, and, thus, actually needs a higher level of nursing care. In many instances, the geriatric patient needs a level of dependency care greater than the pediatric patient, especially since the complexity of illnesses and their complications are greater in the geriatric patient. In addition, the margin for correction of therapeutic error and recovery from disease is much lower in the geriatric patient.

It has been pointed out that the medical care of older persons in this country leaves much to be desired. As a corollary to this, the area of geriatric medicine is to a large extent, a very neglected area of medical training.

At present, the medical staffing of a good number of the geriatric medical care institutions in this country is quantitatively, as well as qualitatively, inadequate. This is not to say that they have no competent and interested physicians, but it is not an overstatement to say that they are in a minority.

One of the reasons for this sorry state is that geriatric medicine is not accorded the stature it should have in this country's medical training programs. Understandably, this makes it exceedingly difficult to attract new and well-trained physicians to work in this area.

Actually, geriatric medicine provides an excellent environment for the in-depth study of human disease and for the training of physicians and other health personnel. We need to turn our attention to the development of high-caliber programs in geriatric medicine that can serve as models of excellence to attract medical students and young physicians in training.

Lately, the seeds of geriatric training programs have begun to be sown. A National Advisory Council on Geriatric Medical Programs has been organized to provide information and to stimulate the development of geriatric medical training.

A geriatric medical program has recently been established at a city hospital affiliated with the Mount Sinai School of Medicine in New York City. The program offers fellowships in geriatric medicine under Dr. Leslie Libow. The New Jersey College of Medicine now offers an elective course in gerontology for its undergraduate medical students, and a community hospital in Baltimore has an on-going geriatric training program in its department of family practice under Dr. William Reichel. This year, Harvard University established a commission for the study of aging, chaired by Dr. Alexander Leaf, which, according to Dean Robert H. Ebert, will serve as a steering committee to oversee a university-wide survey of interest and facilities in the broad area of aging. Moreover, several other schools are considering the initiation of geriatric programs.

"HIGHER PRIORITIES"

The Veterans Administration (VA) has expressed interest in improving geriatric medical training and care, but a modest proposal to fund geriatric centers at five different VA hospitals, at a total cost of $3 million, was not carried out because of Federal cutbacks in medical funding and because of the attitude that there are "higher priorities" in the VA system. It is hoped that the VA proposal will be revived.

Another possible source of support for these needed programs is bill S. 764, proposed by Senator Frank Moss of Utah, which provides for the funding of up to six medical schools with a maximum of $500,000 each for the development of physician training programs in geriatrics. A number of medical schools have expressed keen interest in developing interdisciplinary programs in geriatrics, and there is an urgent need for professional and lay support to encourage the passage of S. 764.

Someone once said that people can be judged by how they treat their pets. Moreover, Federal regulations for the care of laboratory animals are far more stringent and "humane" than are current State and Federal regulations for the care of geriatric patients in our nursing homes. Let us hope that, through support of improved geriatric medical training and care, we will not be afraid to judge ourselves by how we treat our elderly ill.

Appendix 3

MATERIAL DESCRIBING STUDENT EDUCATION PROGRAM

(By Joseph A. Stewart, assistant director, New York University Medical Center, Office of Urban Health Affairs, and director, Geriatric Services and Research Division; and Linda Libow, program planner, Geriatric Services and Research Division)*

A Model for Medical Student Education in Geriatric Medicine and Gerontology

This presentation will be a descriptive report covering 2 years of pilot work in establishing a training program in geriatrics for medical students at New York University School of Medicine.

New York University Medical Center is located in an area of Manhattan that has a considerable population of persons 60 and older. This age group constitutes 16 percent of the total catchment area population or approximately 7,000 persons.

Two years ago, supported by a series of grants from private foundations, N.Y.U. School of Medicine through its Office of Urban Health Affairs began feasibility studies of a coordinated program of geriatric services and research. Two major programmatic ideas have emerged from these studies: (1) The establishment of a demonstration primary care clinic located in a neighborhood setting in an already existing social service agency; and (2) curriculum pilot studies to lead to a training program in geriatrics for medical students.

THE STUDENT PROFILE

In the first year of the pilot training program (1975) 25 applications were received from first and second year N.Y.U. medical students. After personal interviews with student applicants, 6 students were selected: 2 females (both first year students), and 4 males (2 first year and 2 second year students).

In the second year of the pilot training program (1976) 18 applications were received; 16 from New York University School of Medicine and 2 from Albert Einstein College of Medicine. After student interviews six were again accepted, all first-year students: one female and five males, including one student from Albert Einstein.

All students were offered an $800 stipend. The stipend policy is uniform to all programs offered by the Office of Urban Health Affairs. Students have an opportunity to apply for 20 stipends offered in summer electives such as: Adolescent medicine, infant death syndrome research project, medical education research project, floating hospital well-baby clinic, smoking health education project, and another geriatric project studying the effects of social networks among the elderly on health variables. Therefore we suggest that the notion of stipend as sole motivation for interest in geriatrics becomes severely unreliable considering the wide range of stipended choices available.

There are three major goals to our program:

(1) To interest and expose medical students to the health care needs of the elderly, with special emphasis on clinical needs.

(2) To ascertain and affect the attitudes of medical students regarding the person and care of an older individual.

(3) To emphasize the need for holistic treatment of the older person rather than the organ disease.

*This paper was first presented at the 29th Annual Scientific Meeting of the Gerontological Society in New York City on Oct. 16, 1976, and then at the 26th Annual Southern Conference on Gerontology, Feb. 16–18, 1977, sponsored by the Center for Gerontological Studies and Programs, Division of Continuing Education, University of Florida, Gainesville, Fla.

Our specific objectives are:

(1) To provide physician role models in the field of geriatric medicine.

(2) To establish effective field placements where medical students can observe and work with an interdisciplinary team in a hospital or community under the supervision of a physician/geriatrician.

(3) To provide a learning approach to geriatrics and gerontology which is interdisciplinary.

(4) To increase introductory cognitive learning in geriatric medicine and gerontology.

(5) To develop interpersonal skills of the medical student in relating to, interviewing, and diagnosing the older patient.

(6) To acquaint the student to basic literature in the field.

(7) To encourage the research interests of students in geriatrics and gerontological issues by means of a term paper on a subject of their choosing.

There are five major components to our training efforts:

(1) The lecture/seminar series.

(2) The field placement.

(3) The interpersonal skill laboratory.

(4) The evaluation/feedback session.

(5) The independent research paper or project.

The program is a full-time 6-week summer elective which runs Monday through Friday from 9 a.m. to 5 p.m. Each of the 6 weeks is based on the following format:

THE WEEKLY FORMAT FOR THE GERIATRIC SUMMER PROGRAM, NEW YORK UNIVERSITY SCHOOL OF MEDICINE

Session	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Lecture/seminar	Field placement	Field placement	Interpersonal skill laboratory.	Evaluation/feedback session.
Lunch	Luncheon/seminar				Luncheon/seminar.
Afternoon	Lecture/seminar	Field placement	Field placement	Interpersonal skill laboratory.	Independent research project/paper time.
Evening	Independent research project work				

(A) *Lecture/Seminar:* The students have 12, 2-hour lecture/seminar sessions which are based on the following topics:

(1) Who are the elderly? What is geriatric medicine?

(2) Normal aging.

(3) Psychological aspects of aging.

(4) Geriatric psychopharmacology.

(5) Specific geriatric problems.

(6) An approach to dealing with the multiple diseases of the elderly.

(7) An international comparison of geriatric health care.

(8) Geriatric rehabilitation.

(9) Sex and aging.

(10) Death and dying and the older patient.

(11) Medicare/Medicaid.

(12) Forms of long-term care: The nursing home, day care, and home care systems.

(13) Formal and informal support systems for the older person.

(14) Nutrition and aging.

(15) Law and aging.

The format for each lecture/seminar is 1 hour for presentation and 1 hour for questions and discussion.

(B) *Luncheon/Seminar:* This segment of the program provides the students with the opportunity for more informational types of learning and also for follow-up learning to the lecture/seminars; e.g., if students wanted further information about psychological aspects of aging, an additional speaker or the same lecturer can be brought back. Also, these sessions will allow broader issues of geriatric care to be reviewed.

Examples of luncheon seminars are:

(a) The political structure and aging concerns.

(b) The press and aging.

(c) Interesting research projects in aging.

(C) *Field placements:* Each student is placed in a geriatric health care program. We look for the following elements in choosing the field placements.

(1) An interdisciplinary team and approach to the care of the older person.

(2) The quality of the care offered is exemplary.

(3) The placement institution is willing to take and teach the student in the mechanisms of care within the facility, under direct supervision of a geriatrician or a physician director.

(4) The facility agrees to participate in the evaluation of the placement and to assist the student in his/her independent research needs, in the field of geriatrics or gerontology.

Examples of the facilities which have offered good field placements are:

(a) Jewish Institute for Geriatric Care, Long Island Jewish Medical Center, New Hyde Park, N.Y.

(b) Bellevue Hospital Center, Geriatric Unit, New York, N.Y.

(c) St. Joseph's Hospital and Nursing Home, Yonkers, N.Y.

Placements are selected after personal interview with the medical director at the facility. A physician preceptor is assigned to each student. The preceptor is expected to monitor the students learning while in the field placement setting. He/she will also be expected to provide an evaluation of the student and the placement at the conclusion of the 6 weeks. The usage of the physician as preceptor is seen as critical for role modeling. Such modeling has two purposes: (1) To show to students types of physicians active in the field of geriatrics; and (2) To show students how physicians work closely with other professionals in a team setting. The students also evaluate the experience after the completion of the placement.

THE INTERPERSONAL SKILL LABORATORY PROGRAM

The decision to develop a day around interviewing skills came from our first year's experience with the program. We found that the students needed and wanted to learn more about their abilities to interview and in particular to learn about the skills necessary to interview the older person. This component of the program introduces the students, through the use of videotape, to their abilities and weaknesses as an interviewer. Then each student is assisted in analyzing, changing, and developing their strengths in the role of a physician interviewer. This is how the first year of our laboratory program worked:

(1) Each student interviewed two older patients presenting different types of problems at the beginning and end of the program. The older patients were two older male and female actors. Videotapes were made of the interviews and these were used as the basis for the skill building sessions that followed.

(2) The tapes were reviewed and evaluated by the actor/patients, the student himself, a peer, the program preceptors, a clinical psychologist from the Department of Psychiatry, and a speech therapist.

(3) Weekly skill building sessions were developed around topics such as:

—Listening.

—Prescription giving.

—Interviewing techniques.

—Cultural differences in the elderly.

(4) The final interview and taping session gave the student an opportunity to see himself/herself in a similar interview situation and evaluate their development in handling the older individual in that situation.

THE EVALUATION/FEEDBACK SESSION

This session held on Friday mornings has three general purposes: (1) to allow the student to discuss and comment on his/her field placement, (2) to react to the cognitive learning in the lecture/seminars, and (3) to allow the students to express their feelings and fears about dealing with the elderly.

The sessions are led by the program's preceptors. At each session the student submits his/her log from the previous week which contains a series of questions about their field placements and completes a one page brief evaluation of the program. The log allows the student to formulate his/her plans for the coming week and reflect on how well they have succeeded in the past week. The 1-page evaluation gives us an immediate synopsis of the students reaction to the seminars and total program during the past week.

THE INDEPENDENT RESEARCH PROGRAM/PAPER

The purpose of this segment is not to produce a serious piece of research. The 6-week time limit precludes this. The purpose is rather to introduce the students to the field of the geriatric literature and allow them to become familiar with the fact that such a body of literature exists. This is important if the student is to make the link between his other clinical studies in the regular curriculum and the geriatric elective.

Students have explored a variety of areas. The following are some of the topics or titles chosen:

(1) "Fromaje: A New Short, Portable Mental Status Questionnaire for Assessment of Organic Brain Syndrome in Elderly Persons."

(2) "A Survey of 25 Geriatric HIP Fracture Patients."

(3) "Special Considerations Regarding the Medical Interview and Physical Examination of the Elderly Patient."

(4) "The Formation of Senescent Cataracts and Their Effects on the Aged Patient."

(5) "Drugs and the Elderly."

(6) "The Practice of Polypharmacy in Geriatrics."

(7) "Prognostic Factors in the Rehabilitation of Visually Impaired Older Persons."

TYPES OF LEARNING

In summary then, the total program incorporates three types of learning:

—*Academic:* Through the presentation of material on geriatrics and gerontology in the seminar/lectures.

—*Imitative:* Through the students contact with physician role models in their field placements and in the lecture/seminars.

—*Affective:* From their experiences and learning, we hope that the attitudes and feelings of the medical student have changed, developed, and improved in their approach and caring for the older individual.

As we indicated in the beginning we are not prepared to present experimental findings at this time. We have recently been funded by the Administration on the Aging to formalize our pilot work into a systematized and experimentally evaluated training program this coming summer. We are prepared, however, to provide some overall descriptive program data based on our pilot instruments to date. First of all, an indication of the testing points we used might be helpful.

Demographic form.
Kogan OP scale.
Field placement log.
Weekly review.
Interview evaluation session, student form.
Interview evaluation session, faculty form.
Interview evaluation session, par rating form.
Field placement evaluation.
Supervisors field placement evaluation.
Final evaluation.
Followup questionnaire (4 months later).

In a preliminary look at the evaluation materials the following points can be made: In answer to the question "What did you like most about the geriatric summer program?" the field placements, the Friday feedback/evaluation, and the lectures ranked high with both the 1975 and 1976 students.

In addition, all of the 1976 students liked the interpersonal skill laboratory. (It was only presented in the 1976 pilot program).

Other areas of high ratings related to the student's affective reactions and experiences such as:

(1) The opportunity to examine and work on the patient/physician relationship and specifically related to the older person.

(2) The holistic approach of the training program.

(3) Learning in small groups.

(4) Opportunity to discuss learning experiences openly with professor and students.

(5) Patient contact.

The areas the students felt should be modified or changed included: Limiting of lecture time on Mondays; and more group symposiums on matters such as polypharmacy problems and the role of the drug companies.

Some data was contradictory. The first year's group felt the field trips should be dropped and the second wanted the field trip experience added to the program.

The areas that the students felt needed to be dropped varied each year and focused on visits or field placements which they did not like as opposed to program thrust and content.

In summary, it is suggested that a workable model of preclinical geriatric instruction is possible provided the designer adequately deals with the following points:

(1) Clear clinical relevance of material presented.

(2) Contact with physician models who are actually working in geriatric medicine.

(3) Supervised patient contact on appropriate level of student understanding.

(4) Curriculum mechanisms to tap on-going progress and/or regress of student learning.

Appendix 4

ANNOUNCEMENTS RELATED TO GERIATRIC TRAINING IN MEDICINE

ITEM 1. ARTICLES FROM THE AMERICAN GERIATRICS SOCIETY NEWSLETTER, FEBRUARY 1977

Professorial Chair in Geriatrics Established at Cornell

The New York Hospital-Cornell Medical Center has announced the establishment of a professionship in geriatrics to be known as the Irving Sherwood Wright Professorship in Geriatrics, Dr. Wright, a renowned specialist in vascular disease and professor emeritus at Cornell University Medical College is a past president of the American Geriatrics Society and the recipient of two of the society's gold medal awards, the Edward Henderson Lecture Award and the Thewlis Award. A search committee is being formed to choose the first holder of the new professorship.

This professorship, believed to be the first endowed chair in geriatric medicine in the United States, is made possible by a gift of $1 million from the Gladys and Roland Harriman Foundation. The Wright professorship is expected, the foundation states, "to meet one of the most important needs of the times: the development, analysis, study, teaching, and dissemination of knowledge relating to aging and the application of that knowledge in the prevention and treatment of the illnesses, disabilities, and diseases of the elderly members of society." It is stipulated that "the professorship will be associated with both teaching and research at Cornell University Medical College and with patient care at the New York Hospital, so that both institutions and the people whom they serve will benefit."

AGS Conference on Geriatric Education

The American Geriatrics Society was awarded a contract in 1976 by the National Institute on Aging (NIA Contract No. 263–76–C–0496) for the purpose of conducting two conferences on geriatric education. The first meeting took place on October 22–23, 1976. Participants at the first meeting served as an advisory committee for the purpose of developing alternative models of geriatric education. These approaches and models were to be defined and crystallized for the purpose of presentation to representatives of major physician organizations at the second conference to be conducted on March 4–5, 1977.

There have been many inquiries from these involved in geriatric medicine and geriatric education concerning this meeting. Actually, the purpose of the meeting is not to convene those already in the practice of geriatrics, but rather to have a dialog with leaders and representatives of major physician organizations. The conference is relatively small with only 17 participants at the October session, and approximately 34 participants will attend the second conference.

At the October 22–23 meeting, the advisory committee clarified three models of geriatric education—A, B, and C. The A model comprises an increased emphasis on geriatrics in existing residency programs, such as family practice, internal medicine, and psychiatry, and the B model consists of a 1- to 2-year specialized period in certain residencies, such as internal medicine and psychiatry. This type of subspecialty program is being carried out by Dr. Leslie Libow in New York and Dr. Dodda Rao in Oak Forest, Ill. Model C is a full board-certified specialty of geriatric medicine, apart from internal medicine, family practice, or psychiatry.

It was the consensus of the advisory committee that model C should be rejected. The group felt this would be an important step in demonstrating that

there is no attempt to create another full-fledged, board-certified specialty. Instead, the group supported examples of model A type of program calling for increased emphasis on geriatrics throughout certain specialty training programs, and the model B type program consisting of a 1- to 2-year specialized period in certain residencies. For example, the internist, with an additional 1- to 2-year specialized training, would in a sense be a medical subspecialist in geriatrics. The psychiatrist with an additional 1- to 2-year residency or fellowship would be a geropsychiatrist.

The above stated concepts reflected the thinking of the advisory committee at the October meeting. The thoughts represent a starting point in defining workable models for advancing geriatric medical education.

Views of the readership of the newsletter on this subject are welcome. Please send your views to Dr. William Reichel, project director, Conference on Geriatric Education, 9000 Franklin Square Drive, Baltimore, Md. 21237.

ITEM 2. ABSTRACT OF THE GERONTOLOGY PROGRAM OF THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES

With a grant made possible by the Administration on Aging for fiscal year 1976–77, the Office of the Dean for Academic Affairs is responsible for the administration, conduct, and coordination of a multidisciplinary program in gerontology. This program is designed to introduce and improve educational programs within the George Washington University and its School of Medicine and Health Sciences, and to encourage research and student involvement in the field of aging The program is based on a commitment to a multidisciplinary effort on the part of several major departments within the school of medicine and health sciences and other schools and departments in the university. It is proposed that the gerontology content and geriatric care activities to be developed will impact the training programs of medical, nurse practitioner physician assistant, social work and allied health students, psychiatric and primary care residents, and students in recreation therapy, sociology, psychology, health care administration, and law.

The program objectives call for:

—Introduction of materials in aging in existing curriculum in the School of Medicine and Health Sciences; introduction of health related gerontology content in existing courses in various schools and departments throughout the university including health care administration, sociology, psychology, education, and law;

—Development of new courses, field placements, and clinical experiences in aging that will support training in existing professional and paraprofessional programs such as the paralegal training program in the National Law Center, the nurse practitioner, physician assistant, and psychiatry programs in the School of Medicine and Health Sciences, the clinical psychology program in the department of psychology, the master's program in recreation therapy in the school of education, the graduate programs in health care administration and long-term care in the school of government and business;

—Development of multidisciplinary seminars in gerontology open to faculty, staff, and students interested in aging;

—Identification and stimulation of universitywide faculty interest and involvement in teaching gerontology and in aging research;

—Identification of resources in gerontology in the university and community for the implementation of program objectives.

With the approval of their advisors and the dean for academic affairs, students in the school of medicine and health sciences and in other schools in the university may select courses in gerontology and geriatric care to either explore gerontology as a career option or develop a field of concentration within various disciplines.

The long-range goal of all these activities taken together is to promote this institution's development of a permanent gerontology center in the school of medicine and health sciences committed to the conduct of multidisciplinary educational research, consultation, and service activities.

For further information contact the gerontology program staff: L. Thompson Bowles, M.D., Dean for Academic Affairs; or Nona Boren, M.S.W., Director, the Gerontology Program.

ITEM 3. NORTHWESTERN UNIVERSITY MEDICAL SCHOOL ANNOUNCEMENT OF A NEW DOCTORAL TRAINING PROGRAM IN THE CLINICAL PSYCHOLOGY OF THE LATTER HALF OF LIFE

To: Chairman, Department of Psychology.
From: David Gutmann, Ph. D., Chief, Division of Psychology.

The Division of Psychology of Northwestern University Medical School, in collaboration with the Committee on Human Development of the University of Chicago, is initiating a doctoral program in the clinical psychology of middle and later life. This 5-year program will entail an integrated agenda of formal classwork, doctoral research, and a graded series of intensively supervised clinical experiences with older patients. Participants in the Northwestern program will share course and supervisory experiences with students in the adulthood and aging program of the Committee on Human Development. While the University of Chicago students will seek clinical training to round out their academic curriculum, the Northwestern participants will be primarily trained as clinical psychologists, particularly knowledgeable about functional, dynamic issues in the psychology of middle and later life, and capable of initiating innovative research and treatment programs in this field.

Required course offerings in the Northwestern University Medical School's Division of Psychology will stress basic clinical skills and the current conceptions of individual psychopathology, individual and group psychotherapy, dynamic personality theory, and community mental health practice. The human Development curriculum offered on the University of Chicago campus will give students an orientation to research methods, to sociobehavioral theories, and to the normal (including developmental) psychology of middle and later life. During the first 2 years, their concomitant half-time clinical training will take place on those treatment services of the Institute of Psychiatry, Northwestern University Medical School, that provide psychological services to middle-aged and older patients. There, students will have intensive contact with older patients, particularly those who have sought treatment for the first time in later life. Through case-by-case, intensively supervised exposures to such populations, the students will have an opportunity to study the psychopathologies that result from the social, somatic, and developmental changes of later life. Students will receive at least two full years of such clinical training, one of which would involve a bloc internship. This residency could be sought in any agency, on or off the Chicago campus, that is ready to continue the student's clinical training with older patients.

In these clinical settings, it is further expected that students will have the opportunity to evaluate academic conceptions of later life psychology that have been generated through studies of nonclinical populations, and to use these in developing new and testable conceptions of pathology and cure. Accordingly, the pre-candidacy exam will cover a significant topic, selected by the student, in the psychology of aging; and his doctoral research will be aimed at making a significant contribution to this literature. In sum, the goal of the program is to graduate creative specialists who can help to generate the as yet unformed field—the clinical psychology of the latter half of life—in which they practice.

CORE FACULTY

David L. Gutmann, Chief, Division of Psychology, Department of Psychiatry, Northwestern University Medical School; and Associate Director of the Joint Program in the Clinical Psychology of Later Life. (Cross-cultural research in the comparative psychology of later life.)

Morton A. Lieberman, Professor, Committee on Human Development and Psychiatry, University of Chicago; and Associate Director of the Joint Program in the Clinical Psychology of Later Life. (Research into the effects of environmental change on the aged, and the utilization of formal and informal helping systems in the last half of life.)

Benjamin Boshes, M.D., emeritus Professor of Psychiatry, Northwestern University Medical School. (Research interests in the clinical neurology of later life.)

Bertram A. Cohler, Associate Professor of Human Development, University of Chicago. (Research on the sociology and psychology of the three-generation family; and on the relations between mothers and grandmothers.)

Gunhild Hagestad. Assistant Professor, Committee on Human Development, University of Chicago. (Research on age grading systems, and on parenthood in the middle years.)

Robert L. Kahn, Associate Professor, Committee on Human Development and Department of Psychiatry, University of Chicago. (Research on relationships between depression and memory functions in the aged.)
Salvadore R. Meddi, Professor of Human Development, University of Chicago. (Research on socialization experiences in adulthood.)
Bernice L. Neugarten, Professor of Human Development, University of Chicago. (Long-time Director of the Adult Development and Aging Program at the University of Chicago; widely published in the areas of psychology and sociology of middle age and aging.)
George H. Pollock, M.D., Ph. D., Director, Chicago Institute for Psychoanalysis, and Professor of Psychiatry, Northwestern University Medical School. (Research into mourning and personality development in middle and later life.)
Harold M. Visotsky, M.D., Chairman, Northwestern University Medical School Department of Psychiatry. (Special seminars in geropsychiatry.)

Participants will be selected from the pool of applicants to the chinical psychology program on the basis of demonstrated interest in the clinical psychology of later life, and prior academic performance. Thus, trainees will have to meet the selection criteria for acceptance into the regular degree program of the Division of Psychology, as well as those set by the special program in aging. Interested students should write, with a brief description of their interests, relevant experiences, and academic accomplishment (including GPA and GRE scores) to: Dr. David Gutmann, Chief, Division of Psychology, Northwestern University Medical School, Institute of Psychiatry, 320 East Huron, Room 410–I, Chicago, Ill. 60611.

Promising applicants will be notified as to how they should complete the application process. Final applications are due February 28, 1977.

ITEM 4. LETTER AND ENCLOSURE FROM JOSEPH M. HOLTZMAN, ASSISTANT PROFESSOR, SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, TO HERMAN B. BROTMAN, CONSULTING GERONTOLOGIST, FALLS CHURCH, VA., DATED MARCH 2, 1977

DEAR MR. BROTMAN: As you requested I am enclosing a brief description of our program for undergraduates at the school of medicine. In addition, I have included a list of specific goals which we developed for the program. We are currently in the process of developing an appropriate set of goals for inclusion in the family practice residency. Undergraduates receive additional exposure to geriatrics/gerontology in their psychiatry clerkship and in an elective sequence offered jointly by health systems research and family practice. I would be delighted to provide you with more detailed material you might request.

The chairman of our Geriatrics Committee has already passed on these materials to Dr. Butler. I would appreciate it if you would pass copies on to Dick Schloss as we discussed. I will be attending the meetings Dr. Butler has arranged later this month and look forward to seeing you again.

Sincerely yours,

JOSEPH M. HOTZMAN.

[Enclosure.]

GERIATRICS/GERONTOLOGY PROGRAM: A BRIEF DESCRIPTION

The Departments of Family Practice and Health Systems Research at Southern Illinois University School of Medicine have cooperated in the development of a program in gerontology for undergraduate medical students. We believe that the SIU School of Medicine is unique in requiring all medical students to participate in the program as part of the family practice hospital clerkship.

The gerontology program occupies 5 half-days (one-half day each week) during the family practice hospital clerkship. During that period, students become familiar with the problems, care, and treatment of patients in the nursing home setting and in the community. They examine and work up patients in a nursing home setting, receive lectures on theories of aging and common clinical problems associated with old age, and become familiar with community resources available to service the aged. They are exposed to both the sick and well elderly through home visits and visits to senior citizens' centers and nutrition sites.

The undergraduate experience in gerontology is one segment of a developing comprehensive program in gerontology at SIU. Other elements include a con-

tinuous 3-year experience for family practice residents as a component of their residency training, in-service training of nursing home personnel, and an ongoing program of research and evaluation in gerontology conducted jointly by the departments of health systems research and family practice.

GERIATRICS/GERONTOLOGY UNDERGRADUATE PROGRAM

Purpose.—To enable the student to identify and discuss the physical, phychological, and socioeconomic problems of the elderly person in American society.

Specific Goals

(1) To gain knowledge of the physiology of the aging process.
(2) To gain knowledge and skills in the diagnosis and treatment of clinical problems of the elderly, including the use of medications in this age group.
(3) To gain experience in working with the health care team in the development and application of treatment plans in institutional and community settings.
(4) To gain experience in helping people with chronic or terminal illness.
(5) To gain knowledge and understanding in a cognitive and affective sense, of old age as a phase of growth and development.
(6) To become aware of whole person evaluation and family and social interactions as they affect the individual's health.
(7) To become aware of one's own attitudes and feelings toward aging and the elderly and the effects of these on overall management.
(8) To gain knowledge of the effects of institutional care on individuals.
(9) To explore the issues of community and home care for the elderly.
(10) To be exposed to administrative factors in running an institution for the elderly.
(11) To become aware of socioeconomic and political issues as they affect the older American citizen.

Program

(A) Teaching faculty and resource people:
At present, the teaching faculty consists of: full-time faculty of the Department of Family Practice, SIU, including several M.D. faculty and two behavioral sciences faculty; faculty from the department of medical humanities; and a medical sociologist from the department of health care planning.
There is a central planning and development committee centered out of the department of family practice with representation from each of the above groups and chaired by a family physician. This committee reports to the chairman of the department of family practice.
Contacts have been established with people active in community based programs with whom the students will be involved. At present this includes: Seniorama, a multipurpose senior center which provides counseling, referrals, advocacy, community service programs, home visitors, a nutrition site, a transport service, and a retired senior volunteer program. Also involved will be: a group of residents from a senior citizen's high-rise apartment building; a Project Life sponsored program of home visitors; and other nutrition sites in the community. Students will visit or meet with these groups for discussion, home visits, etc.
Also involved will be the staff of the local nursing home facility from which some activities will be centered. This will include staff from the following areas: nursing, rehabilitation, intake, staff development, activities, and administration.
(B) Learning activities:
During the 6-month family practice ambulatory clerkship each student will spend several sessions involved with the community activities. Hopefully this will reflect a noninstitutional bias to the program.
Each student also spends a 4-week hospital-based family practice clerkship during which time he will spend five afternoons dealing with issues of aging. The setting for four of these afternoons will be a local nursing home facility and the fifth will be community based.
Didactic discussions will include: the physiology of aging; medical problems of the aged from a problem oriented basis, e.g., problems of ambulation, problems of restricted activity, etc.: prescribing for the elderly; psychosocial issues of institutional and home care; physical and psychosocial rehabilitation. Students will have an assigned group of nursing home residents to help illustrate some of the above issues and to act as an experience base.
The community based afternoon will involve discussions with one or several of the resource groups and a final meeting to help summarize and process some of the student's thoughts and feelings about the experience.

Appendix 5

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR PERCY: If there had been time for everyone to speak at the hearing in New York on October 13, 1976, on "Medicine and Aging: An Assessment of Opportunities and Neglect," I would have said:

The following replies were received:

DAVID HALL BROOKS, NEW YORK, N.Y.

A study of geriatrics for medical students and nurses (and allied health professionals) should not be an elective, an option in a permissive type of curriculum, but should be a mandatory feature of the core curriculum of general medical/clinical studies toward the M.D. degree since there is a body of knowledge and an increasingly large need to know.

Just as orthopedics, rehabilitation medicine, neurology, rheumatology (with the essential anatomy and physiology) can all be brought together under the locomotor system and its problems, so can aging and its problems include pediatric, adolescent, adult, and geriatric areas of attention.

In 1943 at Oxford University (United Kingdom) there was an acknowledged need for greater expertise in the handling of pediatric problems (including neonatological) so the necessary stress was made in lectures, rounds, studies, contacts, and seminars preparatory to the inclusion of two out of six questions in each of two medical, two surgical, and two midwifery/obstetrics/gynecological papers in the final examinations.

Even then, 38 years ago, an early clinical introduction to geriatric medicine was effected by visits on a regular, organized basis to the local Poor Law Institution which was pioneering a new approach to long-term and custodial care (Cowley Road Hospital under Dr. Lionel Zelick Cosin). His enthusiasm was sufficient to light the essential spark of student interest in patient care delivery.

The essential inclusion of aging and geriatric problems in the basic medical undergraduate training (as, for example, in North Dakota's medical school) should be sufficiently stimulating to secure inspired candidates for further specialist or subspecialty training in geriatric medicine, greatly needed in the United States and Canada.

GLORIA K. BYRNES, ST. PAUL, MINN.

I agree with Dr. Butler's and Dr. Libow's position regarding the need for the inclusion of a geriatric specialization in medical schools. The emphasis on geriatric education should be placed in family practice education. The health care of the aged should be seen as part of the life cycle and thus emphasized as part of family practice in order to prevent further alienation of the elderly.

Medicare should be revised to include funding for the training of, not only medical students, but other professionals (social workers, nurses) who enter the field of gerontology in the delivery of health care services.

Attention must also be given to broader areas of medicare reform in order to overcome its deficits. Medicare reimbursement must be provided for home support systems rather than concentrating, as now, on in-patient care. Out-patient drug

coverage must be provided as well, since this comprises a large share of the elderly's medical expenses. Hearing aids, glasses, dental work, and ambulance transportation are other critical areas that require medicare funding.

In order to encourage the practice of preventive medicine, routine physical examinations should be provided under medicare.

CAROL CATLIN, CHICAGO, ILL.

Professional educators derive realistic and idealistic philosophical goals from the needs of the community they serve. Professional educators have a commitment to keep abreast of the ever accumulating knowledge of man and his ever-changing environment. The needs of communities have been changing from the concept that health care services were available to those who could afford, to the present belief that health care services are a right. Medicare was an act designed to insure that certain members of the American population received health care services. Suddenly, professional educators are faced with an older population seeking all kinds of health care services.

Providing safe health care services for older people requires special knowledge and skills. As a masters level nursing student, I evolved a philosophy of nursing applicable to the care of older people requiring rehabilitative services; I studied the biological changes of aging and pursued concepts of why we age. Finally, I studied the particular illnesses of aging while I developed new nursing skills and applied my philosophy of nursing providing health services to older residents of nursing homes. I feel there is more to learn to be a safe health care provider for older people.

Professional educators have the opportunity to provide safe health care practices in meeting the ever-changing needs of the community through the development and application of gerontological courses. Professional educators have the opportunity to increase the knowledge of gerontology through research practices.

The practitioner, the nurse, and the physician have the right to demand quality education and the latest knowledge of health care practices. They must demand courses in gerontology for they are the direct providers of health care services; their license is on the line when they serve the community.

R. KEITH COCHRAN, LUBBOCK, TEX.

I echo the timely and insightful comments of Senator Percy regarding the potential use of our health care personnel and facilities and the benefit they can afford to the elderly of our Nation. There is a phase of health care, however, which, I feel, did not receive adequate emphasis in the hearing, though it may have been one step beyond the comments and intentions of the panel of experts that were present in New York. The significance of preventive health care cannot be overemphasized when considering the topic, "Medicine and Aging: An Assessment of Opportunities and Neglect."

My involvement in the field of aging is through a title VII nutrition program for the elderly. The persons with whom I deal in the program are 60 years or older and, for the most part, are relatively active people. Daily, I see how preventive health services could be significantly advantageous, and I feel confident that others working with noninstitutionalized elderly share my perception.

Programs which would enable persons, educationally, relative not only to dispelling of medical myths, but also to making them aware of resources offered by the health care community, could make a tremendous impact on the overall level of health of the elderly in the United States. Additionally, if diseases could be determined and medically treated prior to the time when they produced a debilitating or devastating effect on the body, the implications to the physical as well as the psychological, well health of the elderly, I think, would be innumerable.

As government increasingly responds to the health needs of the elderly, as well as when medical schools and other academic institutions, which are concerned with educating health care service deliverers, begin developing their curriculum with considerations for the elderly client, they must recognize that the need is great for broadly based programs of health education together with pro-

grams designed to detect and to treat diseases early in their course. The effect of such preventive medicine can only be, if I may borrow from Senator Percy, "to keep our older citizens functioning as fully as possible for as long as possible."

ROBERT C. COMBS, IRVINE, CALIF.

In order for the medical schools to increase their activities in the field of geriatrics (we recognize our obligation to do so), funds would be necessary. I feel it would be unwise to require schools receiving such funds to form departments of geriatrics. Such departments may or may not logically evolve. To mandate their immediate existence would repeat the greatest problem experienced with family practice programs—that is, starting departments without available qualified chairmen or faculty.

It would be better to start with divisions with departments, or originally just programs.

RUTH DAVIDON, SAN FRANCISCO, CALIF.

Probably the most distressing practice to me is the setting up of programs for aging long-term care clients for 1 year and then starting new ones the following year. No program can prove its worth in so short a time either in service or cost.

An example of this type of costly and wasteful way of beginning a program which is being closed down is the senior day care center which provites support to handicapped aging clients to stay home instead of being institutionalized in warehouses distant from home, family, and friends.

SUZANNE R. DAY, ANN ARBOR, MICH.

Far more attention needs to be applied to the assistance of geriatric chronic conditions than our current medicare system permits. In particular, I am concerned that there are such limited possibilities for home health care when evidence is overwhelming that there is a demand for such service. Economic indicators are mounting in support of such care as a mechanism for reducing escalating medical expenses.

When up to 40 percent of those now in nursing homes have not been kept there for medical reasons, we must develop a more rationally graded system for services to more closely match service delivery to actual service demand. Unless we improve the choices available under our Federal funding system, we shall continue to provide incentives for institutional care requiring unnecessary construction of additional beds as the older population continues to rise.

In documentation of the supply-demand gap, and with the hope that the final section of economic policy implications will be useful to your work, I am enclosing a paper[1] prepared last year and forming a background for my continuing research on these issues.

DEBORAH DOWNEY, EUCLID, OHIO

While at this point in time it has become clear that elderly persons have special medical problems, it is also clear that they have special nursing problems which we, as nurses, thoughtfully need to consider and plan to care for. Therefore, future plans need to be made for graduate and undergraduate nursing programs to meet those needs for health delivery.

JAMES W. ELLOR, CHICAGO, ILL.

Over 95 percent of people over the age of 65 are living in the community, and generally responsible for their own medicine.

[1] Retained in committee files.

Many adults have poor self-medication habits, but older adults are particularly susceptible to the potentially resulting problem of adverse drug reactions. While people over 65 comprise 10 percent of the population, they consume 25 percent of all prescription drugs. Physiologically, the older person is at greater risk of experiencing adverse effects from his or her medicine.

Studies made during the past 15 years, as well as our experiences with the elderly, point out several common and potentially dangerous self-medication behaviors:

—a lack of knowledge of the name or action of a particular drug;
—a lack of knowledge of how a particular drug is safely and effectively taken;
—a lack of awareness of side effects;
—stretching medicine to make it last longer than it was prescribed for;
—borrowing and lending medicines;
—saving old medicines and tending to self-treat with these;
—taking medicines irregularly;
—mixing different medicines in the same container;
—overusing or inappropriately using nonprescription medicines.

Our concern centers around the resulting adverse medication actions and interactions that prevent the older person from maintaining an optimal level of health.

The seniors' health program has developed a pilot program of drug education in Chicago. Our general objectives have been: (1) to decrease inappropriate or unnecessary drug use among the elderly, and therefore decrease the number of significant adverse reactions to medication; and (2) to address the current values of society toward aging, especially as reflected in the health care system, and to foster nondiscriminatory attitudes in the community. The program includes group health education sessions, individual counseling, and the creative use of the public media.

MARGARET E. FERRY, BEAR CREEK, PA.

Persons living in nursing homes are labeled as "patients," and they are enmeshed in the medical model. In actuality, medical care occupies a very small portion of the day for those who are chronically ill (as opposed to the convalescent from an acute incident). When, and how, are we going to emphasize the home aspect, rather than the nursing, and concentrate on prolonging living rather than extending dying?

What steps are being taken to provide a working description of a good nursing home (again, for the chronically ill). The acute care values of cure are not really applicable when terminally ill people are being cared for. Some homes pride themselves on their low death rate, when in reality they discharge patients to hospitals to die. How do we provide for a "good" death—and what is it? We discuss reducing mortality from this and that disease, but it will still continue to be 100 percent mortality. How do you propose to deal with alleviating the aches and pains of the aged as compared with the seeming preoccupation with more and more esoteric means of intervention in acute episodes? One old lady told me, "I wish the government would get me dentures and a hearing aid. Then I would have enough money to buy food and I could chew it. When my time comes, let them pull the plug on all that machinery in the hospital—and they will save money and I can enjoy my life while I can still function pretty well."

SALLY FOLLETT, WALTHAM, MASS.

In 1941 I wrote a paper on the attitude of doctors—particularly those belonging to medical associations—toward low-cost care for the elderly. There has been some change, but too many old people are still not receiving the kind of good "caring" care they need (aside from the fact that medical care costs too much). Medicare may be intended for older people, but whoever wrote it doesn't know that many old people may need long-term, costly care.

JACQUELINE L. FRASER, GARDEN CITY, N.Y.

I am sorry that your latest survey was not sent to professional nursing schools across the country asking the same three questions.

There is growing concern for the health care needs of the aged on the part of the nursing profession and greater recognition of the importance of including both classroom and clinical experience in the care of the elderly in basic nursing education programs. I am pleased to learn tonight that the American Nurses Association is conducting a study similar to yours among nursing schools. I look forward to its results.

I do hope that the committee will keep in mind that the health problems of the aged—or any other age group, for that matter—require the interdisciplinary collaboration of many health professions. Their problems cannot be solved by one profession alone.

This hearing is emphasizing the need for more attention to the health problems of the elderly in the curriculae of the health professions. Although the need for advanced practitioners in gerontological nursing is certainly substantiated by facts and figures, some of which were in your statement tonight, the ability of health care facilities such as nursing homes, to employ them is greatly impaired by cuts in funding under medicare and medicaid.

The development of programs to prepare highly qualified practitioners of gerontological nursing is one matter. Providing the funding to support their employment in ambulatory programs and in health care institutions for aged, hence the utilization of their skills for the benefit of our elderly, is quite another matter.

I hope your committee will earnestly address this concern.

MICHAEL GILFIX, PALO ALTO, CALIF.

As a lawyer working in the field of law and aging, I am acutely aware of the failure of the professions to adequately address the problems inherent in aging. Other testimony has established the dearth of training in the area of geriatric medicine in our schools of medicine. Similarly, this area of neglect in the law school context has been recognized and is currently being addressed. In fact, the Administration on Aging is currently funding no fewer than three projects under title IV–A of the Older Americans Act that are designed to develop materials for the teaching of courses on legal problems of elders. The medical profession should, in this case, follow the lead of the legal profession and begin to address this apparent need and add geriatric medicine to its teaching curricula.

As the director of Senior Adults Legal Assistance, and a recipient of a training grant from the Administration on Aging, I am acutely aware of the need for a multidisciplinary approach to the problems of aging. For example, courses on legal problems of elders in law schools are incomplete if they do not simultaneously sensitize and alert students to the psychological and physiological problems that elders encounter and that often have direct legal implications. Accordingly, the materials that I am preparing for courses on legal problems of elders include necessary and relevant content on the subjects of aging and psychology, psychiatry, physiology, economics, history, and anthropology.

Courses in schools of medicine on the subject of geriatrics or aging should be similarly multidisciplinary. For example, decisions as to certain types of treatment for elders or the content of medical reports may have direct legal impact in terms of medical and income governmental benefits. They also may have direct impact in the context of a conservatorship or guardianship proceeding.

I, therefore, urge this committee to take all necessary legislative action to effect the inclusion of medical matters relating to aging in the training of doctors, both in the medical school and in post-medical school training. The content of such training should be sensitive to the interrelationships between medical, legal, and physiological factors.

ROSE GOLDFARB, NEW YORK, N.Y.

We must train more doctors to be general practitioners, and to make house calls.

Gerontology should be an accredited course in every medical school.

An older person should not be told "What do you expect at your age," but be helped to relieve his pain. Most important is passage of a national health service bill that will give protection to all age groups. I'm a member of the Gray Panthers, and we have seminars on national health, so I know that it would be the best thing.

LUCILLE D. GRESS, KANSAS CITY, KANS.

It was indeed a privilege to attend the opening session of the annual scientific meeting of the Gerontological Society in New York, October 13, 1976. The hearing of the U.S. Senate Special Committee on Aging on medicine and aging was indeed appropriate for the occasion. On the basis of the invitation extended at the meeting, I am submitting this statement to be included in the report of the hearing. In spite of efforts made to date, it seems to me the need for additional support of educational programs on human development on aging and the interdisciplinary approach is crucial to meeting the continuing and increasing needs of an aging population.

Granted, there is opportunity and need for additional content on geriatrics in the curriculum of medical schools; I submit there is also need for additional content on geriatrics and gerontology in other educational programs for health personnel—i.e., nursing. Moreover, I believe there is need for nursing students to be involved along with other students taking course work related to aging as a part of the educational experience.

Many of the needs of aging persons are multifacited in nature requiring team effort for achievement of goals. Assessing, establishing goals and priorities related to needs of the elderly necessitates input from the various team members, including the aging person and/or his significant other. In my opinion, teamwork will be more effectively carried out by health care personnel who have gained knowledge and understanding of the roles and responsibilities of others during the educational process in the student role.

Best wishes in your continuing endeavors.

ANN MARIE V. GUILLORY, NEW YORK, N.Y.

There is a tremendous need for the consolidation of services for the elderly. Medicare is failing to serve the needs of the elderly. Senior citizen centers are not reaching the socially isolated, and mental health facilities are not prepared to deal with the mental problems which are exclusive to aging.

The failure to adequately serve the health, social, and psychological needs of the elderly is largely due to the fragmentation of services. A change is needed.

JACQUE HEPPLER, BROOMFIELD, COLO.

I feel that one solution to the doctor's absence in long-term care facilities would be to facilitate the employment of specially prepared registered nurses (geriatric nurse practitioners) by third-party pay reimbursement mechanisms. Senator Percy, what is your stand on this?

LISSY F. JARVIK, LOS ANGELES, CALIF.

UCLA School of Medicine is beginning to make a commitment to aging. We are in the process of (1) starting a geriatric psychiatry ward with input from the division of family practice; (2) starting an outpatient geriatric psychiatry clinic; (3) submitting a postdoctoral training grant; (4) submitting a training grant for research in geriatrics; (5) requiring a visit to a nursing home as part

of the freshman medical course "Introduction to Human Behavior"; (6) having a close working relationship with the VA-GRECC centers in the areas; (7) the first geriatric psychiatry ward in the VA system at the Brentwood VAH; and (8) providing an elective in geriatrics for medical students including one under the auspices of the department of biochemistry.

LUCY JOSEPHSON, NEW YORK, N.Y.

All medicines, treatments, etc., for the aging should be free in every State in the Union. This includes crutches, medical needs, and dental care services.

ETHEL KESHNER, NEW YORK, N.Y.

What effort is being made to correct the many abuses of medicare and medicaid of doctors' charging for services not rendered and/or of arranging for a vast array of medical procedures more harmful than helpful to the helpless patient?

SHARON KLIESEN, ATLANTA, GA.

Medication which is prescribed for the elderly should include information about side effects of the medication, as well as precautions about taking it with other medication, especially over-the-counter medications which the older person may overlook as being important. These drugs are often not reported to the physician.

KATIE LOO, SAN FRANCISCO, CALIF.

There is a need to arouse the medical students' interest in gerontology.

M. MACHUDIS, NEW YORK, N.Y.

Much the same as the study of geriatrics medicine is relegated to passing comments, the study, teaching, training, and treatment of the needs of the elderly persons' dental problems is equally neglected.

There is a great emphasis on the needs of the elderly in all aspects of their existence—more today than ever before—but almost no regard is being given to dentistry, and especially to its relation to its interrelation to all the other medical aspects and needs.

There is great need to give careful consideration to the dental needs of the elderly.

EMILY M. MURPHY, NORTH ANDOVER, MASS.

May I suggest that some sort of printed matter of the legal aid program for older Americans, especially wills, be made available to councils on aging for distribution in their areas? The councils are a great source of outreach daily.

President John F. Kennedy's Peace Corps has been one of the world's most unselfish methods of helping mankind all over the world. So in that vein, I suggest a voluntary service for students who are to become the Nation's lawyers, with credits accumulating toward appointments for work in government programs, or even for elective office. Such credits could be added to their résumés, with adequate publicity.

These services could be paid for by grants or even colleges, who always need grants. The service could be done the year after graduation before passing the bar.

Senator Kennedy, thank you for the legal aid program, the senior aid program, title VII food, the hot lunch school program, and the home care services program.

DAVID A. OTTO, COLUMBIA, MO.

"Medicine and Aging: An assessment of Opportunities and Neglect" is an interesting topic for discussion; such topics, however, represent singular grains of sand in a sea of aging. Until such time as our society returns the "older person" to a proper position of respect and until such time as young people understand that age 40 and senility are not commensurate, it is doubtful that many of our aging problems can be readily solved. Should we not consider first, as a nation, the complete modification of formal education in our public school system so as to "gear" the minds of our children to better understand the aging phenomenon and thus produce a new aging value system? A better understanding of the aging phenomenon at all levels of our society will facilitate a more rapid acceptance of solutions to problems of the phenomenon.

MARLENE PATTERSON, PHILADELPHIA, PA.

There is a need for broadening the topic of "medicine and aging" so that recognition is taken of the existence of social and psycho-social factors impacting on health and medical treatment for the elderly. I therefore recommend that testimony be taken from practitioners in social work and social welfare who could address this perspective.

VIMALA PHILIPOSE, DENVER, COLO.

As Dr. Butler commented in his remarks, the attitude of the health professionals should change if the knowledge in geriatrics is to expand. I offered an elective course in geriatric nursing last year and requested many physicians if they could give a lecture on medical problems of the elderly. Not one of them were willing to, except some residents who were willing to say something on the subject. If Dr. Cooper wants financial aid to medical schools, the Federal Government must establish some criteria when they provide this money; i.e., that the money is utilized for geriatric medical education. This applies to nursing schools, also. There is adequate information right now in aging that medical and nursing students can learn.

Preventive medicine is also a neglected area. Dr. Berlinger, dean, Yale School of Medicine, was not only unimpressive, his information was biased and prejudiced. His comments are a sad commentary to the medical profession. If the problems of the elderly are so similar to the young adults, why should only postgraduate students be studying them? His comments were severely provocative.

The dean talked about problems of drinking, smoking, automobile accidents, etc., and said that doctors could not be responsible for these problems. Ironically, he was smoking himself—a poor role model for the layperson.

I agree with Dr. Sherrod—there is already enough information in geriatric medicine to integrate in medical and nursing schools education. Definitely, we need more research and knowledge in this area.

I agree also with Dr. Libow's comments. The pediatrics field is mandatory in all medical and nursing schools—geriatrics should also be integrated in all schools of medicine and nursing. Human development continues from infancy to senescence.

Senator Percy, I honor your personal integrity very much. It is regrettable that you did not run for the Presidency of the United States. The world would have benefited by your leadership.

JANE PORCINO, STONY BROOK, N.Y.

Funding should be made available to medical schools—especially developing schools with a clinical hospital attached (such as the State University of New York at Stony Brook)—to develop a specialty in geriatrics and gerontology to meet the needs of this growing segment of our population.

The hearing was exciting, offering many challenging ideas.

CATHERINE A. ROCKWOOD, DEKALB, ILL.

There is a crucial need for factual data and thus preparations and distributions of bulletins to the public in regard to the use of medicines, nature of reactions (possible), and the need to report to the physician/nurse questions and concerns.

One example: Aspirins and other salicylates, when given in large doses by doctors in efforts to reduce pains from arthritis, may cause hearing loss, headaches, etc., and danger when used in conjunction with other medicines.

JON H. ROUCH, WARREN, PA.

Many of the traditional State hospitals care, or used to for the past century since Dorothy Dix promoted such; now one-half their patient population is over 65. Many are psychotics of 30-plus years ago now growing old.

At Warren General Hospital, Warren, Pa., we have a $9 million geriatric patient building (500) including the above, but now also organic problems over 65. Excellent facilities, but why should "lunatics" be put out of the way in rurals? Warren, population 15,000, receives patients from 13 northwest counties of Pennsylvania, including Erie (350,000), plus other cities.

How can an almost defunct State hospital, rural, serve urban needs? How do they justify a $9 million geriatric center there?

Thank you, Senator, for your interest in aging.

ANN SCHORR, NEW YORK, N.Y.

We need national health service for everybody—young and old—financed out of general funds.

JEAN SKORONSKI, CHICAGO, ILL.

As a bridge from consideration of the community to that of the elderly in the United States and, in particular, in housing projects, it may be well to consider that the poverty, isolation, and criminal violence lead to youth lifestyles that is difficult for a middle-class adult to imagine. The isolation of youth from elderly is marked in the community. Worse, the relationship of "the gang" to the elderly is that of predator to victim.

Most adverse drug reactions can be prevented; but prevention requires attitudinal changes and this requires an educational program designed specifically for the elderly and accessible to them. Education is of a particular importance since the elderly are particularly susceptible to the advertising media which is geared to sell medications. Of course, for many elderly persons, taking no medication is better than taking a medication which is harmful rather than helpful.

LORRAINE HIATT SNYDER, SOUTH MINNEAPOLIS, MINN.

Those of us involved in multilevel care geriatric centers, serving several hundreds of people in community services and residential and health care, are deeply concerned about the availability of medical directors, trained and experienced in balanced models of aging. That is, models of aging that respond to the physical, psychological, social, and individual/spiritual needs of older persons. We are concerned that attending physicians often are not trained in more recent concepts reflecting the rehabilitative potential of older persons, on alternatives to pharmecological intervention, on treatment involving the family unit, on newer concepts of psychosocial function and elderly. We are concerned that the physician, who sets in motion the entire array of services open to older persons through medicare and medicaid certification often feels that screening is of no value to the very old, that individuals have limited rehabilitative potential, that disability is concomitant with age. Finally, we are concerned that medical services

be included in many of the home delivered services and made part of community residences specially built for older persons.

We request that quality models of service delivery, involving physicians, be communicated; that more physicians be involved in continuing and new educational programs in gerontology; and that, if necessary, new roles for professionals in medical care of older persons be developed.

Although it should not be necessary to develop geriatrics as a special area of medical practice, it may be that such steps are required to elevate this field to the potential that must be realized. Furthermore, it may be that a special field of geriatric practice is necessary before the family practice physician, internist, and specialist bridge the service and informational needs.

JOAN WALSH TRELEASE, NARRAGANSETT, R.I.

I would like to have seen someone represent the American Osteopathic Society. The D.O. is very much involved with family medicine and the new college of osteopathic medicine in Bedderford, Maine, is incorporating geriatric medicine into its curriculum.

MILDRED UMMEL, DAYTON, OHIO

There is a great need for further education in geriatrics. The opening and opinions and observations presented by Dr. Berliner and Dr. Cooper were very disturbing. Dr. Libow's attitude toward aging is refreshing.

Aging needs an advocate such as you. If ever there is a need for a worker in Ohio, I would be most happy to serve in your cause. If ever you are in Dayton, Ohio, please stop in at the nursing home care unit at the Veterans Administration Center. We would be most happy to have you as our guest.

ROBERT E. VESTAL, NASHVILLE, TENN.

As implied by Dr. Sherrod in his statement, there is an important need for both basic and clinical research in geriatric pharmacology. The older, largely anecdotal literature suggesting that drug response differs in the elderly needs to be substantiated by carefully controlled clinical and laboratory studies. At the Gerontology Research Center (GRC) of the National Institute on Aging in Baltimore, basic research in the pharmacoolgy of receptors reveals, for example, that there are fewer adrenergic and glucocorticoid receptors in cells and tissues from aged experimental animals than from younger animals. These findings may help explain differences in response to catecholamines and steroid preparations in the older patient. Recent studies of age differences in drug distribution and elimination serve to emphasize that age is an important variable when studying the pharmacology of drugs in man. Vanderbilt workers have shown this to be true for diazepam (Valium). Clinical research also suggests that drug sensitivity is affected by age. For example, while at the GCR, Dr. Robertson-Tchaho and coworkers demonstrated that older subjects are more sensitive than younger subjects to the effects of alcohol on memory, auditory attention, and reaction time. However, at the same time we showed alcohol metabolism to be unaffected by age. Much of the limited, available literature in geriatric clinical pharmacology comes from abroad where there is more interest in geriatric medicine. In this country we also need more information about drug utilization and adverse drug reactions in extended care facilities. I concur strongly with Dr. Sherrod that we need to communicate to medical students, residents, and practicing physicians ways of improving therapeutics in elderly patients. Hopefully, this can be based in part on firm knowledge of how pharmacokinetics and pharmacodynamics differ in the elderly.

CAROL WICHITA, TUCSON, ARIZ.

Physicians caring for the elderly and aging people today need to realize they are only part of the team—a very important part, but not the total picture. Aging persons today have problems that require preskills of people who will listen to, not just the physical aspects, but listen beyond the physical aspects and offer so-

lutions other than another prescription. By utilizing skills of nurses, social workers, nutritionists, many times the real problems are identified; i.e., the frustration of a relationship, the denial and anger of a terminal illness, or the fixed income with soaring prices.

People today offer a variety of physical symptoms that often go ignored because the physician does not listen, does not have the skills to solve problems other than medical problems, or uses the age-old excuse, "I don't have time."

Medical care in the United States could be upgraded with cost reduced if the practice of medicine was controlled with Federal rules and regulations to check that group of physicians that abuse the citizens of this country with their greed.

The success of health maintenance organizations in our country is testimony for the upgrading of care with lowered cost.

The last issue I would like to address is that of malpractice insurance. When physicians begin to police themselves in accordance with the code of conduct, the inadequate practitioner would be eliminated—therefore reducing and eventually eliminating the hazard to the profession. In this way the malpractice, which is the real problem, would be reduced, bringing the insurance rates into perspective. As with any other issue, it is only a few that abuse a system and give a negative connotation to the whole. Attitudes of society must change regarding aging, and one way to begin is by offering in medical schools curriculum in the area of aging.

A. KURT WEISS, OKLAHOMA CITY, OKLA.

Regardless of whether the training of experts in geriatrics is accomplished primarily by the establishment of new departments, divisions, or sections of geriatrics or whether this is done in already established departments, the necessity of having basic medical science departments in schools for health professionals staffed by at least a few individuals who have a primary interest in gerontology must not be overlooked. Since the first year or two of professional training in medicine and dentistry usually takes place in basic science departments, the task of interesting individual students and teaching all students the rudiments of gerontology must begin at this level. Basic science professors who are hired to teach and do research in other areas of a discipline cannot and will not devote the necessary time to further the discipline of gerontology. It seems mandatory, therefore, that one or more of the faculty members in the basic medical sciences have a primary interest in gerontology; these individuals can serve as resource personnel and/or coordinators for the gerontology program, which will probably cut across departmental lines of all departments in the basic medical sciences.

PEGGY MARCIA ZAKS, DETROIT, MICH.

This hearing was extremely interesting and invigorating. The major task of the Gerontological Society is to broaden participation and to heighten the Nation's consciousness level about aging related problems. In order to achieve such a demanding goal, the society must disseminate information about the aged to a number of professional and nonprofessional organizations. The fact that you, Senator Percy, have taken an interest in the society's purpose, function, and goals is a good move in the right direction of attaining this worthwhile goal. The society truly needs such catalyzing interests in order to illustrate the utility and potential of the society as a whole.

VICKI ZOOT, SKOKIE, ILL.

1. The geriatric nurse practitioner has the potential to greatly improve the care of the geriatric population. The nursing practice acts of the individual States must be changed to give recognition to this practitioner as a primary care giver.

2. The 1974 amendments to the Older Americans Act struck the requirement for a social worker in a medicare-reimbursed long-term care facility. This was a grievous error. Social workers should be required members of all interdisciplinary health teams, and have a particular significant contribution to make in long-term care.

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IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 4—WASHINGTON, D.C.

SEPTEMBER 29, 1976

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Part 3. Washington, D.C., September 28, 1976.
Part 4. Washington, D.C., September 29, 1976.

CONTENTS

IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

WEDNESDAY, SEPTEMBER 29, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 11 a.m., in room 457, Russell Senate Office Building, Hon. Edward M. Kennedy presiding.

Present: Senators Kennedy and Randolph.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Deborah K. Kilmer, professional staff member; Mark Schneider, legislative assistant to Senator Kennedy; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; Eugene R. Cummings, printing assistant; and Alison Case, assistant chief clerk.

OPENING STATEMENT BY SENATOR EDWARD M. KENNEDY, PRESIDING

Senator KENNEDY. My apologies for being late.

I know our panel is very much aware of the importance of assuring legal services to our elderly people. There is no group in our society that is affected more by what Federal, local, or State governments, or individuals do than our elderly people. Most are dependent upon social security, or railroad retirement, or other retired income programs. Therefore, their relationship with the Social Security Administration and the rest of the Federal Government is extremely important.

They are constantly in negotiations over the quality of housing, the raising of rents, and other very important consumer issues. One of the most exciting aspects of both the Legal Services Corporation and the Older Americans Act has been their contribution of assuring the elderly their full opportunities and full rights under the Constitution.

We have a strong program in my own State of Massachusetts. Its only weakness is the greatness of the need. There are thousands of elderly whom it is not able to assist.

We are very interested in ways to strengthen this kind of program.

I will include my entire statement in the record and get on to our witnesses.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR EDWARD M. KENNEDY

Today, the Committee on Aging continues its hearings on "Improving Legal Representation for Older Americans."

Earlier committee hearings—in St. Louis, Boston, and Los Angeles—have made it abundantly clear that many older Americans now find themselves in an impossible situation when a legal problem arises.

This is particularly true for moderate-income elderly persons. Their income may be too high to qualify for legal services, but they still cannot afford a private attorney.

This issue received close attention when the Congress enacted the Older Americans amendments last year. Several provisions in the 1975 amendments—measures which I helped advance—are designed to make legal representation more readily available for the elderly.

One example is the expansion of title IV to authorize funding to train lawyers and paraprofessionals. Last month I heard firsthand, in Boston, about the valuable assistance elderly paraprofessionals from the Council of Elders Legal Services program provide other seniors on many issues: Social security, medicare, housing, food stamps, supplemental security income, and other Federal benefit programs.

But they are too few. Their funding is too little. And they are not part of a comprehensive network of legal resources linking the private bar, research centers, and law schools. More must be done.

The 1975 Older Americans Amendments also made legal counseling a priority service for funding under title III.

Our leadoff witness this morning, Commissioner Flemming, of the Administration on Aging and a former Secretary of HEW, will have more to say about the implementation of the legal representation provisions in the 1975 amendments. The committee will seek answers to other questions as well:

What steps has the Administration on Aging taken to make the law schools, the private bar, and legal services attorneys more sensitive to the legal problems of the elderly?

How much funding under title II is directed at improving legal representation for older Americans, and what roles will the new State legal services offices fulfill?

Have the 11 model projects funded under section 308 yielded any innovative ideas for meeting the legal needs of older Americans?

How many attorneys and paraprofessionals does the Administration on Aging plan to train with title IV funds?

And what are AoA's long-range plans for insuring that local offices on aging are responsive to the many legal problems now confronting the elderly?

I see no reason why there could not be a systematic effort to establish legal services outreach centers at every large elderly housing project. Attorneys do not always have to be at the site. But they could have scheduled hours of service. For the elderly, we have meals-on-wheels, but we should start thinking about how we could have lawyers along riding shotgun.

Our recent hearing in Boston also emphasized that the elderly are underrepresented in the legal services program.

We shall hear later from Mr. Thomas Ehrlich, president of the Legal Services Corporation, on this matter.

Let me state at the outset that the resources available to the corporation to serve the poor are inadequate generally. The administration proposal to deny the corporation 25 percent of its appropriations through a rescission is totally unacceptable.

But the elderly are a far larger portion of the adult poor than the present distribution of legal services resources indicates.

A Legal Services Corporation survey—and I am well aware it was a very limited survey—revealed that persons 65 or older only accounted for about 7 percent of all clients in the legal services program. Yet, older Americans represent nearly 24 percent of the total poverty population among persons 18 or older.

The committee believes the elderly should be equitably represented in the legal services program. They also have special needs and special problems. We want to insure that their legal problems receive thoughtful, careful, and competent attention. They deserve no less.

Last month's hearing in Boston raised fundamental questions about the responsibility of the private bar to elderly clients. We want to know what is being done now to fulfill this role. And what more should be done?

We are also concerned about impediments to attorneys who want to represent aged clients.

The Boston hearing further underscored the need for law schools to develop courses which can prepare the lawyers of today and tomorrow on issues of direct concern to older Americans.

Most older Americans typically have had very little contact with Government during their preretirement years, except perhaps to pay taxes or perform their military obligation. But upon reaching age 65, they become dependent upon Federal income maintenance programs—social security, railroad retirement, SSI, VA pensions, VA compensation payments, civil service annuities, and others.

Yet, most attorneys have had very little, if any, training concerning legal issues affecting these programs. The net impact is that older Americans are forced to fend for themselves when a legal problem arises—whether it involves litigation, understanding the technicalities of Federal programs, or planning their personal affairs.

They deserve better treatment. And I am hopeful that our hearing this morning can provide the spark for comprehensive and coordinated action on several fronts to make effective representation more readily available for older Americans.

Our final witnesses this morning will be Mr. Paul Nathanson, executive director of the National Senior Citizens Law Center, and Mr. David Marlin, director of Legal Research and Services for the Elderly. They will provide examples on the dimensions of the elderly legal problems and of what can be done when competent representation is available.

[End of prepared statement.]

Senator KENNEDY. We are delighted to have Dr. Arthur Flemming, distinguished Commissioner of the Administration on Aging and HEW Chairman of the Civil Rights Commission. I want to commend you on your extraordinary record of public service. We have always benefited from your testimony. Mr. Thomas Ehrlich is the president of the Legal Services Corporation; and Mr. William Wharton is

from the Memphis and Shelby County Legal Services, Memphis, Tenn.

STATEMENT OF HON. ARTHUR S. FLEMMING, COMMISSIONER, ADMINISTRATION ON AGING

Dr. FLEMMING. Senator Kennedy, I appreciate very much the opportunity to testify. I would like to say, as Chairman of the Commission on Civil Rights, I sure hope you win on the matter that you have been working on and that delayed your appearance here.

In the interest of conserving time, I will not go into the history of the concern on the part of the Congress for legal service as reflected in the development of the Older Americans Act, but I will come right down to 1975–76.

When the Senate considered the 1975 Labor-HEW appropriations bill, a $9 million increase for the title III program for funding State and community services programs was added. This increase was agreed to by the House of Representatives.

LEGAL SERVICES MODEL PROJECTS

The Labor-HEW Appropriations Subcommittee of the Senate made clear that it intended that $1 million of this additional funding for title III should be used for model projects to strengthen legal representation for older Americans. Once these funds were appropriated, the Administration on Aging took steps to implement the clear congressional intent.

In July 1975, 11 legal services model projects were funded at a total level of $1.2 million to foster the improvement of legal service programs for the elderly by increasing the capability of State and area agencies on aging to increase the availability of legal services and to improve the quality of those services.

I will submit for the record a listing of these individual projects and the level of funding of each project.[1]

The overall objectives of these Administration on Aging legal service projects were to inaugurate a process which will hopefully lead to a decision on the part of area agencies on aging to include, subject to the approval of the State agencies, a legal service component in their annual plans and budget, and to initiate a process which will help insure that such legal services activities designed to meet the needs of older persons will have available adequately trained professional and paraprofessional personnel.

Up to now the primary focus of most of the legal service grantees has been the provision of technical assistance to State and area agencies on aging.

LEGAL SERVICES: A PRIORITY CONSIDERATION

At the same time that these legal service model projects were being implemented, further consideration was being given by the Congress to this area in connection with its consideration of the 1975 amendments to the Older Americans Act. Legal assistance was identified as

[1] See appendix 1, item 3, p. 346.

one of the four areas which are to be given priority consideration by State and area agencies. States must spend a minimum of 20 percent of their title III allotment in one or more of these four priority areas.

To assist and encourage the States to develop legal service programs for older persons, the Administration on Aging has given each State the opportunity to establish, during fiscal year 1977, a legal service model project. States that request funds for this purpose will be expected to develop a statewide program that will support the area agencies on aging in strengthening of legal service activities on behalf of older persons at the community level.

The State agency on aging in developing this program will obtain counsel and advice from, among others: Other components of State government, local legal services organizations, legal aid societies, State and local bar associations, voluntary organizations, community services organizations, law schools, and other educational institutions.

Total funding for these projects, which will begin on January 1, 1977, will be $1.125 million.

In order to provide the State agencies and, through them, area agencies with adequate technical assistance for this effort, the Administration on Aging will continue support of five national legal services model projects. These model project grantees will provide assistance to State agencies on aging in developing and implementing their legal services programs in their States. These projects are funded at a total level of $872,918. Six other model projects, designed to test innovative ways of providing legal services to older persons, have also been funded, totaling $425,505.

The Administration on Aging has just awarded grants under the title IV–A training program for improving the quality of training for attorneys and paraprofessionals on the problems of older persons. Such efforts were recently authorized specifically for legal services by the 1975 amendments to the act. Projects supporting these activities will be funded at a total level of about $700,000.

Working Agreement With Legal Services Corporation

The last of the activities that the Administration on Aging plans to undertake in the area of legal services is the development of an interagency working agreement with the Legal Services Corporation. Staffs of these two entities have been meeting to discuss the terms of the agreement and Mr. Ehrlich and I are confident that we will have an agreement within a matter of a few weeks.

Through the process of negotiation of such an agreement and involvement of the State agencies on aging in any cooperative efforts that result, we hope to identify areas of mutual cooperation and interest to make staff of the Legal Services Corporation aware of the particular needs of older persons for access to legal services and to minimize overlaps and reduce gaps in the availability of legal services for older persons.

Personally, I welcome the opportunity of working with the Congress in this very important area in the field of aging. I am confident that the availability of legal services for older persons will make a significant contribution to making it possible for them to look to the future with hope.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Flemming follows:]

PREPARED STATEMENT OF HON. ARTHUR S. FLEMMING

Mr. Chairman and members of the committee, I am pleased to have the opportunity to appear before you today to discuss the activities of the Administration on Aging in the area of legal services for the elderly.

Previous hearings on this subject by the Senate Special Committee on Aging and the Senate Judiciary Committee were major factors in the development of a climate supportive of increased legal services for older persons.

HISTORICAL DEVELOPMENT

I will discuss with you today the legislative history of the provision of legal services for older persons under the Older Americans Act, and the activities that the Administration on Aging is undertaking in this area.

When the Older Americans Act was enacted in 1965, legal services were not specifically mentioned in the act as one of the services to be provided or goals to be achieved.

The Older Americans Comprehensive Services Amendments of 1973 (Public Law 93-29) called for the implementation of a new approach on the part of the Federal Government to the field of aging.

These amendments called for the establishment of a network of State and area agencies on aging responsible for the development of a system of comprehensive, coordinated services for older persons.

The regulations developed for implementation of the title III program defined, as one type of "social service" that could be provided under title III, "legal services which provide legal advice and counseling to older persons in matters of importance to the individual, including serving as an advocate of older persons who have consumer problems."

As the title III program developed and State and area agency on aging staffs became more familiar with the barriers that older persons confronted and the needs they had, the importance of legal services became increasingly apparent.

Older persons were faced with mandatory retirement policies, forced retirement, and age discrimination in employment; the need to understand the provisions of and establish eligibility for social security, supplemental security income, medicare, pension benefits, and other benefit programs; in some instances, loss of ability to completely manage their own affairs without assistance; lack of protection or concern for individual rights of persons living in institutional settings; difficulty in getting drivers licenses, health insurance, life insurance, and other necessary protection because of age; increased vulnerability to deceptive consumer practices.

However, there were few places that older persons could go for assistance with these problems.

Even programs that were established specifically to provide legal services to low-income persons, including older persons, had very low participation rates by the elderly.

It was estimated in 1971, for example, that despite the high percentage of older persons who have low incomes, older persons comprised only 6 percent of the clients served by OEO legal services programs. It has been estimated that in 1975, 11.6 percent of the funds in this program were allocated to the elderly.

As recognition of the need for legal services grew, more State and area agencies on aging began to provide support for legal services for older persons.

During fiscal year 1974, 33 States provided some legal services, and a total of 4 percent of the area planning and social service funds available to State agencies on aging was spent on legal services and counseling.

This can be compared to 20 percent for transportation, 9 percent for in-home services, 13 percent for information and referral services, and 10 percent for outreach services.

When the Senate considered the 1975 Labor-HEW appropriations bill (September 1974), a $9 million increase for the title III program of funding for State and community services programs was added, and this increase was agreed to by the House of Representatives.

The Labor-HEW Appropriations Subcommittee of the Senate made clear that it intended that $1 million of this additional funding for title III shall be used for model projects to strengthen legal representation for older Americans.

Once these funds were appropriated, the Administration on Aging took steps to implement the congressional intent.

In July 1975, 11 legal services model projects were funded, at a total level of $1.2 million, to foster the improvement of legal service programs for the elderly by increasing the capability of State and area agencies on aging to increase the availability of legal services and to raise the quality of those services.

I will submit for the record a listing of these individual projects and the level of funding of each project.[1]

The overall objectives of these AoA legal services projects were:

(a) To inaugurate a process which will hopefully lead to a decision on the part of area agencies on aging to include, subject to the approval of the State agencies, a legal services component in their annual plans and budgets.

(b) To initiate a process which will help insure that such legal services activities designed to meet the needs of older persons will have available adequately trained professional and paraprofessional personnel.

Up to now the primary focus of most of the legal service grantees has been the provision of technical assistance to State and area agencies on aging.

At the same time that these legal services model projects were being implemented, further consideration was being given by the Congress to this area in connection with its consideration of the 1975 amendments to the Older Americans Act.

Legal assistance was identified as one of the four areas which are to be given priority consideration by State and area agencies.

States must spend a minimum of 20 percent of their title III allotment in these four priority areas.

To assist and encourage the States to develop legal service programs for older persons, AoA has given each State the opportunity to establish, during fiscal year 1977, a legal services model project.

States that request funds for this purpose will be expected to develop a statewide program that will support the area agencies on aging in strengthening of legal services activities on behalf of older persons at the community level.

The State agency on aging, in developing this program, obtains counsel and advice from, among others: Other components of State government, local legal services organizations, legal aid societies, State and local bar associations, voluntary organizations, community services organizations, law schools, and other educational institutions.

Total funding for these projects, which will begin on January 1, 1977, will be $1.125 million.

In order to provide the State agencies, and through them area agencies, with adequate technical assistance for this effort, the Administration on Aging will continue support of five national legal services model projects.

These model project grantees will provide assistance to State agencies on aging in developing and implementing their legal services programs in their States.

These projects are funded at a total level of $872,918.

Six other model projects designed to test innovative ways of providing legal services to older persons have also been funded totaling $425,505.

The Administration on Aging has just awarded grants under the title IV–A training program for improving the quality of training for attorneys and paraprofessionals on the problems of older persons.

Such efforts were recently authorized specifically for legal services by the 1975 amendments to the act.

Projects supporting these activities will be funded at a total level of $705,741.

The last of the activities that the Administration on Aging plans to undertake in the area of legal services is the development of an interagency working agreement with the Legal Services Corporation. Staff of the two entities has been meeting to discuss the terms of this agreement, and hope to have a draft prepared in a few weeks.

Through the process of negotiation of such an agreement and involvement of the State agencies on aging in any cooperative efforts that result, we hope

[1] See appendix 1, item 3, p. 346.

to identify areas of mutual cooperation and interest, to make staff of the Legal Services Corporation aware of the particular needs of older persons for access to legal services, and to minimize overlaps in and reduce gaps in the availability of legal services for older persons.

The Administration on Aging welcomes the opportunity of working with the Congress in this very important area in the field of aging.

I am confident that the availability of legal services for older persons will make a significant contribution to making it possible for them to look to the future with hope.

Senator KENNEDY. Thank you, commissioner.

I also am pleased to welcome Thomas Ehrlich, president of the Legal Services Corp. He has been in the job for some 9 months and now understands the difficulty we had and the frustration of several vetoes before we obtained approval on the independent Legal Services Corp. I understand one of your first communiques from OMB was a request to ask for fewer funds and one of your latest was the request to Congress from the White House for a rescission on nearly 25 percent of the funds Congress appropriated.

Before taking this position, Mr. Ehrlich was professor of law and dean of Stanford Law School, although that Western bias is eased somewhat by knowing that he is a graduate of Harvard Law School. It is a pleasure to welcome him before this committee.

STATEMENT OF THOMAS EHRLICH, PRESIDENT, LEGAL SERVICES CORPORATION, WASHINGTON, D.C.

Mr. EHRLICH. Senator, I have submitted for the record a prepared statement[1] that discusses the activities of the corporation with regard to legal services for the elderly in some detail. With your permission I would like to focus on a few key points. With me today is Mr. A. C. Wharton who directs Memphis and Shelby County legal services in Tennessee. I know he will be pleased to answer any of your questions about legal services for the elderly from his vantage point in the field.

As you know, we have a somewhat different perspective than Commissioner Flemming. The purpose of the Legal Services Corp. is to provide legal services—that is our only purpose. Our mission is to provide those services not just to the elderly but to all who are poor, regardless of age, regardless of race, regardless of geographic area. We do very much share the committee's particular concerns about the needs of the elderly for legal assistance and the extent to which those needs are unmet.

Sometimes the elderly face special needs for legal services. The pension area is one example. But our experience generally shows that the usual categories of legal issues faced by the elderly are those faced by other people who are poor. Most often they are in the areas of public benefits, housing, consumer law, family law, health law. Although the areas of concern are not usually different in legal terms, much more often they are matters of basic survival for the elderly poor.

PROBLEMS IN PROVIDING LEGAL SERVICES TO ELDERLY

Generally there are particular problems in providing legal services to the elderly, problems that create an added cost. Those problems

[1] See p. 260.

can be overcome but usually that takes added resources, particularly for outreach activities and for transportation. As you well know, Senator, for 5 hard years legal services fought a battle for survival, while costs spiraled. As a result of that burden of inadequate funding the poor generally, and the elderly poor in particular, too often suffered and suffered severely.

We now have no accurate statistics on the relative number of elderly poor that legal services programs funded by the corporation are reaching. We are now developing a project reporting system that will provide that information. In the meantime, the results of informal surveys, including one we did for this committee some months ago, suggests that the percentages vary from as little as 5 percent to as much as 15 to 20 percent. We ought not look, however, at the extent of legal services activities solely in terms of percentages of caseloads. That is very misleading.

As you know, Senator, Legal Services Corporation has been the leader in the efforts to assure legal rights through specialized litigation. It has been in areas such as food stamps, welfare, public housing, and consumer fraud, and much of that litigation has had substantial impact on the elderly. You will hear later this morning, I understand, from Paul Nathanson, director of the National Senior Citizens Law Center, a corporation-funded project that concentrates exclusively and on a national basis on the legal problems of the elderly.

Our other national litigation projects do devote a very significant amount of their time to senior citizens problems and much of their specialized work has a direct impact on the elderly. I discussed that work in some detail in my prepared statement, particularly in terms of the center for social welfare policy and law in New York, the national health law project in Los Angeles, the employment law center in New York, which has just voted to make pension law a priority for the next year, and the national housing law project in Berkeley—four concrete examples of major impact litigation centers throughout the country supported by the corporation.

I do not suggest for a minute that we are doing all we should for poor persons who are elderly. We must do a good deal more for them and for all who are poor.

"Critical Question Is Money"

As the committee pointed out in this year's "Developments in Aging" report, the critical question is money. The corporation requested $140.3 million from the Congress for fiscal year 1977 to begin a 4-year plan to strengthen and expand legal assistance for the poor. President Ford pressed for a reduction to $80 million. Despite that, the Congress has approved $125 million to begin the effort and has agreed with the corporation that the proposed rescission of the additional funding has no merit. We intend to come back to the Congress to ask for increased support in fiscal year 1978, and in the years to come, so that by the end of 1980 legal service programs funded at minimum adequate levels will be accessible to all of the poor, including the elderly poor.

Although there is no total solution without additional money, we are taking a number of steps that focus particularly on the elderly

poor. Our proposed eligibility guidelines, for example, take special account of such factors as age, physical condition, and high medical costs. In the area of training we are confident we can improve the capability of our programs to deal with the needs of the elderly. We are working with all of our support centers to design specific training programs for staff attorneys and are concentrating particularly on the training of paralegals. As you know, use of paralegals under the supervision of program attorneys is one of the most effective ways to increase access to legal services for the elderly.

We are also working with the Administration on Aging to assure that our mutual resources are utilized as effectively as possible. Some 56 legal services programs now do receive about $1.7 million through State and area aging agencies to improve their capabilities to serve the elderly. Those funds make a vitally important contribution. In some places, like the program in Camden that you heard about yesterday, these funds have made possible special units for the elderly. Other programs funded by the corporation include services to the elderly as a part of the regular activities of their offices.

Some programs have reported particular difficulties in persuading area agencies to undertake legal services activities. I expect that Mr. Wharton could elaborate on that point. But in all events, as Commissioner Flemming said, we are going to work with his organization at the national and regional levels to the end of more effective efforts for the elderly in local communities.

We are also very pleased that legal services development specialists will be provided for each State; they can be a critically important factor in these efforts. We do have some concern about the emphasis on placement of those specialists within State aging agencies and the limitations on their activities, which may reduce their potential effectiveness. In our view, if it makes sense to place those specialists within a legal services program, the States should have the flexibility to do so.

We are also convinced that the effectiveness of those specialists can be enhanced if they are sometimes involved in support activities. Commissioner Flemming has indicated that we are working with the Administration on Aging on just those issues. The corporation and the Administration are developing a joint agreement that will result in improved and strengthened cooperation and coordination.

One final word, if I may. We commend you very much for your leadership in this area and we look forward to working with the whole committee and with you, Senator Kennedy, as a member of the Committee on Labor and Public Welfare, toward providing quality legal assistance to all elderly persons who are poor and who need legal assistance that they cannot now find.

I am delighted to be here, and I will be pleased to answer your questions.

[The prepared statement of Mr. Ehrlich follows:]

PREPARED STATEMENT OF THOMAS EHRLICH

On behalf of the Legal Services Corporation, I am pleased to accept this committee's invitation to testify on delivering legal services to the elderly. The corporation brings a perspective to these hearings that may be different than

that of other witnesses. We are not an organization established to deal exclusively with elderly Americans; we cannot undertake to support legal services to all who are elderly. Rather, our concern with the problems being considered by this committee stems from our congressional mandate to insure equal access to justice for all persons who presently do not have that access, concentrating upon those who are least able to afford legal assistance.

The Legal Services Corporation is a private corporation established and funded by Congress to provide legal assistance to the poor. It began operations 1 year ago, in October 1975. There are approximately 29 million poor people in the United States, persons whose income and resources are below subsistence levels. For all but a very few of those people—whatever their age, race, or background—the predominant issue in their lives is survival.

It was once a commonly held notion that poor people had less need for lawyers than persons of means. We now know that precisely the contrary is true. Poor people are forced to rely upon law and the legal system to obtain basic necessities such as food, shelter, clothing, medical care, a job, and an education. The result has been that poor people have more encounters with the legal system than others, and the stakes involved in those encounters are much higher.

A recent study by the Bureau of Social Science Research estimates that 23 percent of the Nation's poor, or roughly 7 million persons, face legal problems each year. Legal services programs funded by the corporation are currently able to handle only about 1 million of those problems. Even that level of services is possible only by extensive use of paralegals and other mass delivery techniques, and by caseloads that range as high as 500 cases per year for an individual attorney. Despite these efforts, there remain nearly 12 million poor people who live in areas that are not served by legal services programs, and another 10.5 million who have only token access to such programs.

The inevitable conclusion from these statistics is that present resources are grossly inadequate to do the job. For 5 years, from 1970 through 1974, those resources actually diminished because appropriations for legal services were frozen despite high inflation. The outlook for the future is fortunately brighter. For fiscal year 1977, the Congress approved an appropriation of $125 million to the Legal Services Corporation—a $33 million increase over the appropriation for the current year. Of necessity, however, much of this increase will be used to restore the capabilities of existing programs that were eroded during the period when legal services appropriations were frozen. The corporation is now planning the first significant expansion of legal services coverage in more than a decade, but its resources are far short of enabling it to fulfill the congressional mandate to provide equal access to justice for all of the Nation's poor people.

It is against this background—a mandate to provide legal assistance to all poor people regardless of age, race, or background, and a history of inadequate resources to do the job—that the performance of the Legal Services Corporation and the programs it supports must be evaluated. We do not suggest that our performance in providing services to the elderly poor has been better than our performance in delivering services to all eligible poor persons. There are suggestions that it has been worse. The statistics sometimes cited are from an informal survey apparently made by the OEO Office of Legal Services in 1969, which suggested that the elderly constitute only 6 percent of legal services clients, although they account for a larger percentage of the Nation's poor.

We do not know how those figures were developed, nor whether they were correct in 1969. More important, we do not know whether those figures are accurate today. As members of this committee are well aware, the energies of the legal services community during the early and mid 1970's were focused primarily on opposing efforts to destroy the program entirely, and on ensuring its future independence from partisan politics. It simply was not possible to conduct detailed analyses of the caseloads of programs and other aspects of their work.

Now that establishment of the Legal Services Corporation has made survival certain, we are conducting such an analysis. The corporation is in the process of designing and implementing a project reporting system that will provide information on each matter handled by each project funded by the corporation. This system will tell us a good deal about our programs and the clients that they serve. We are also undertaking a study of alternative and supplemental methods of delivering legal services that should provide additional information

on how to deliver legal services more effectively and efficiently and to reach groups that we have had difficulty reaching in the past.

At this point, our best estimate is that legal services programs funded by the corporation probably do somewhat more specialized work in areas that affect the elderly than population statistics would indicate, but somewhat less general work for individual elderly clients. Within the area of specialized work, the disparity is probably due to the large number of government programs that affect the elderly. Within the area of general assistance, the disparity probably results from the reality that many elderly persons are hesitant or unable to use legal services, and programs have not had sufficient funds to engage in aggressive outreach efforts.

Beyond this general estimate, it may be helpful to the committee to have a description in some detail of the actual activities of both the general and the specialized programs relating to the elderly. I will focus first on field programs generally and then on the specialized work.

Although there has been no systematic analysis of the caseloads of all legal services programs funded by the corporation, we have estimates of caseload statistics from some programs. At the request of this committee, we recently received estimates of the number of elderly clients served from nine programs operating in the States of Nebraska, Iowa, and South Dakota. The estimates of clients over 65 ranged between 5 percent and 20 percent. In most of those programs, the percentage of elderly clients was less than the percentage of the eligible population that is elderly. The program directors believe that this is due mainly to the transportation difficulties that poor elderly people have, especially in rural areas. In addition, they stated that some elderly persons are less aware of the fact that legal services are available to them and do not understand how the programs can be helpful. The programs in those States that served a relatively high proportion of elderly clients were ones that are able to and do engage in aggressive outreach efforts, such as making presentations in senior citizens centers and nursing homes.

Every legal services program operates within a set of eligibility guidelines prepared in accordance with corporation regulations. Those regulations—still in proposed form to insure full public comment—meet a number of specific concerns often raised regarding the ability of local legal services programs to serve the elderly. It has been suggested, for example, that eligibility standards that use an "assets" test discriminate against the elderly, who frequently own their own homes or have small savings accounts. An income test, it has been argued, would take into account the circumstances of the elderly in a more realistic manner.

Under the corporation's proposed regulations, the critical factor in determining eligibility is the applicant's income, and local programs are authorized to set the upper limit as high as 125 percent of the national poverty level. Even persons who have income above that limit may be eligible for service if their income is derived from governmental programs for the poor, or if they are unable to afford legal assistance due to age or physical infirmity, high medical expenses, or substantial debts. The regulations do not penalize an applicant who owns a home. They are, we believe, flexible enough to accommodate the special needs of the elderly poor.

In addition to the assistance provided for the elderly by legal services programs generally, the corporation funds the National Senior Citizens Law Center in Los Angeles, the Council of Elders in Boston, Legal Services for the Elderly Poor in New York, and the Senior Citizens Project of California Rural Legal Assistance in San Francisco. These programs, which have a combined budget of nearly $1 million, are devoted exclusively to legal services for the elderly poor. Their activities range from providing representation and assistance in important litigation involving elderly clients—the role of the National Senior Citizens Law Center—to concentrating on providing general legal services directly to elderly clients.

Many legal services programs funded by the corporation, although not devoted solely to serving elderly persons, have units or individual specialists that concentrate upon such service. We do not know the exact number of such programs. We do know that 55 of our programs have received approximately $1.5 million in funds available under title III of the Older American Act to provide legal services to the elderly poor. Other programs have been unable to obtain title III funds, but have used funds from sources such as revenue sharing for similar purposes.

Funds used to provide legal services exclusively for elderly persons often have a multiplier affect. In some programs, for example, title III money is used to hire paralegals to perform aggressive outreach work and to provide advice and counsel to elderly clients. Because paralegals must be supervised by attorneys, and because attorneys and other paralegals will necessarily handle many of the cases produced by outreach efforts, the result is that a larger amount of the program's resources is directed toward providing service to elderly clients. Similarly, the availability of research and technical assistance from sources such as the National Senior Citizens Law Center is an incentive for programs to bring significant litigation on behalf of elderly clients.

One measure of a legal services program's performance in delivering legal services is its effect upon the client community as a whole. The fact that too few resources are available to provide assistance to all poor people makes it essential for legal services programs to set priorities and undertake projects that affect the largest number of people possible. Such "impact" work frequently provides benefits to large numbers of persons and groups regardless of whether they are actually clients of a legal services program.

Legal services programs funded by the corporation and its predecessors have done a considerable amount of work that has had an impact upon elderly people as a group. For the reasons discussed previously, it is not possible to give accurate statistics on these activities, such as major litigation, legislative advocacy, community education, and so forth. I will, however, describe for the committee various areas of the law that have received attention from legal services programs and that, in our view, address problems widely shared by the elderly poor.

PUBLIC BENEFITS

Many elderly people are unable to work and are forced to rely upon public and private benefits programs in order to survive. Legal services programs have been leaders in ensuring that those programs are administered fairly, are responsive to the needs of recipients, and that the recipients receive all to which they are entitled.

Virtually all of the work that has been done regarding the supplemental security income program (SSI)—a national program begun in 1974 that includes the elderly as one of its primary beneficiaries—has been done by legal services lawyers. The Center on Social Welfare Policy and Law, a national support center funded by the corporation that specializes in public benefit law, reports that a substantial number of programs are bringing administrative and judicial proceedings regarding various aspects of the SSI program. According to the center, a major portion of its practice is now devoted to SSI. It has, among other things, published an SSI *Advocates Handbook* for use in administrative proceedings. The National Senior Citizens Law Center, which is also active in the SSI area, has published a similar manual for attorneys. Both of these support centers, as well as legal services programs generally, have done substantial work regarding social security benefits and procedures.

In addition to work in areas of unique concern to the elderly and a few other groups, legal services programs have become specialists regarding general benefit programs in which the elderly participate. Issues related to the medicaid program, for example, are of considerable concern to the Center on Social Welfare Policy and Law and the programs that it helps. Until a few years ago—its Food Research Center became an independent operation—the Social Welfare Center was also involved in a substantial amount of food stamp litigation, and that program still provides some of its caseload.

A third example of a benefit program that affects elderly people is the local general assistance programs. For a person under 65 who has no dependent children and is not disabled, such programs may provide the only available source of income. The Social Welfare Center and many other legal services programs have devoted a substantial amount of their efforts in the public benefits area to rationalizing those programs.

Finally, legal services programs have done impact work in some areas of public benefits law that, although not directly affecting elderly people, have affected the administration of programs in which they participate. The aid to families with dependent children program, for example, rarely provides direct benefits to elderly persons, but litigation concerning that program has resulted in procedures for notice and hearing prior to termination of benefits being

instituted in medicaid, social security, and SSI. In a very real sense, elderly people were served by the legal services programs bringing those actions.

More generally, the use of trained paraprofessionals to provide counsel and representation in administrative proceedings has greatly expanded the delivery of legal services in the area of public benefits. Legal services programs have pioneered this development. In addition to recruiting and training paraprofessionals on the local level, the National Paralegal Institute—until recently a support center funded by the corporation and its predecessors—provided training and materials for paralegals, much of which concerned SSI and other public benefit programs. The corporation is now making plans to train considerably more paralegals for this type of work through its office of program support.

HEALTH

Elderly people have a disproportionate number of medical problems and must rely upon health benefit programs to a greater extent than other poor people. Legal services programs have been leaders in developing the law relating to such programs, particularly in pioneering the view that they create judicially enforceable entitlements to health care and in policing benefit programs to ensure that they are administered fairly.

In addition to the work done in this area by local programs, the corporation funds the National Health Law Project in Los Angeles to provide specialized help to legal services programs on health law issues. The center devotes a substantial portion of its practise to programs specifically designed to aid the elderly, such as the medicare and home health care programs. The project represents several groups of elderly people, and estimates that approximately 20 percent of its litigation time involves elderly clients directly.

In addition, the project engages in a substantial amount of work regarding general health care programs that have a substantial impact upon elderly people. In this category are the Hill-Burton program, which requires that federally funded hospitals provide a minimum amount of free health care, the medicaid program, and prepaid health plans. Other legal services programs funded by the corporation, most notably the National Senior Citizens Law Center, have concentrated upon issues relating to nursing homes, guardianship, and custodial care.

HOUSING

Elderly people living on fixed incomes often cannot afford to pay the rents prevailing in the private housing market, and therefore must live in public housing projects or other types of subsidized housing. Those elderly persons who own their own homes are often unable to keep them in good repair or even to pay the taxes and utilities.

Programs funded by the Legal Services Corporation have undertaken impact work in all of these areas. The National Housing Law Project in Berkeley, Calif., devotes a substantial portion of its practise to public housing issues, and helped to pioneer the concept that there is an entitlement to public housing. This work is especially significant for elderly persons; one recent estimate is that two-thirds of all new construction in public housing is for the elderly. The housing law project also devotes a great deal of time to ensuring that the relocation provisions of urban renewal laws are observed and administered fairly. Again, this is an effort that particularly affects older persons, whose lack of mobility and resources often makes them unable to find decent housing outside of decaying urban neighborhoods.

The housing law project does a considerable amount of work regarding problems of home ownership—problems that affect the elderly more than any other identifiable group of poor people. Specifically, the project devotes a large amount of its practice to the areas of mortgage foreclosure and construction programs such as those administered by the Farmers Home Administration. It has also done work in the area of foreclosure for nonpayment of taxes, and ensuring that provisions for waiving property taxes in federally subsidized housing are followed.

Other legal services programs have addressed themselves to different housing problems that affect the elderly. The National Consumer Law Center in Boston, for example, has done a substantial amount of work regarding home improvement frauds, a problem frequently encountered by elderly persons desiring to keep their houses in good repair. The consumer center has also undertaken activities in the utilities area, attempting to hold rates down and prevent erroneous termination of service.

EMPLOYMENT

Elderly persons who are still able to work frequently find their ability to do so impeded by non-job-related age requirements. With the exception of the National Senior Citizens Law Center, few legal services programs have concentrated on the area of age discrimination directly. A great deal of the work they have done regarding race and sex discrimination, however, has had a substantial impact in age discrimination litigation. The standard of proof in such cases is perhaps the most obvious example. Legal services programs, particularly the National Employment Law Center in New York, have been leaders in establishing the requirement that an employer justify statistical disparities in the numbers of women and minorities employed. That standard is also applied by courts dealing with charges of age discrimination in hiring and promotion.

A second cluster of employment-related issues that concern the elderly relate to pensions. The fact that many employers' promises of financial security following retirement are often illusory has been well documented. Very little work, in legal services or elsewhere, has been done regarding pension law. The Senior Citizens Law Center, however, is recognized by the Labor Department and others as the expert in that area, and the board of directors of the Employment Law Center has recently made pension issues a priority for that program in the coming year.

This summary does not exhaust the specialized activities undertaken by legal services programs that have an effect upon the elderly poor. The Consumer Law Center, for example, has been participating in the development of proposed Federal Trade Commission regulations regarding funeral homes and hearing aids, and plans to become active in those areas when the regulations go into effect. More generally, elderly consumers benefit when a legal services program wins a major truth-in-lending case, and elderly tenants benefit when the courts require landlords to adhere to a warranty of habitability. The point is clear: A great deal of work done by programs funded by the Legal Services Corporation has a direct and substantial impact upon elderly persons, regardless of whether they also receive service as individual clients. For this reason no statistics can reflect accurately the extent to which legal services programs serve the elderly.

Nonetheless, we do not suggest that we are presently meeting the needs of the elderly poor for legal services. There are too few resources devoted to ensuring equal access to justice for the elderly, just as there are for poor people in general. With respect to the elderly, however, the problems of too few programs are compounded by lack of physical access to legal services. Many elderly people are less mobile than other members of the population and may be less well informed regarding the availability of free legal services and the ways that such services can help them. Access may be particularly difficult for persons who became poor late in life and live many miles from the ghetto areas in which legal services offices are typically located.

What can be done to overcome these problems? At this point, the corporation plans two steps and we hope the Congress will adopt this committee's recommendation concerning a third. Other proposals will almost certainly emerge after the project reporting system is implemented and the delivery study is completed.

First, the corporation will work to coordinate the expertise of legal services programs in delivering legal services to poor people with that of organizations and agencies that have experience regarding the particular problems of the elderly. The most obvious example is the Administration on Aging, which has made the provision of legal services a priority for its programs. The corporation and AoA should not duplicate activities such as training attorneys and paralegals in areas of the law that affect the elderly. The development of outreach programs and sensitizing service providers to the problems of working with elderly people on a personal basis are other areas that lend themselves to cooperation between the two organizations. Ways should be found to ensure that title III grants to fund elderly specialists will continue to legal services programs that currently receive them, and be available to those programs that have been unable to obtain them.

Several measures have already been begun to achieve that cooperation. Persons from the corporation's office of program support and the AoA staff are meeting to discuss training needs and explore the possibility of coordinated training programs. The corporation and AoA have exchanged proposals for an

agreement that would ensure cooperation in several specific respects on the national, regional, State and local levels. We intend to continue these activities in the future, and to identify other agencies and organizations that can help us deliver legal services to the elderly.

The second step is more training of service providers, particularly paralegals, in areas that concern the elderly. Our office of program support is currently making plans to train more attorneys and paralegals for legal services work—including many areas that affect the elderly—than has ever been done before on a national level. The need for lawyer training is obvious. But paralegals have also been of immeasurable value in expanding the ability of our programs to deliver legal services efficiently and effectively, though they are not the answer to all delivery problems. Each paralegal must work under the supervision of an attorney in order to ensure the quality of work and avoid the unauthorized practice of law. A legal services program can utilize paralegals only to the extent that it has the resources to maintain proper supervision.

Finally, we urge the Congress as a whole to adopt this committee's recommendation that increased funding for the Legal Services Corporation is essential. The specialized outreach and educational programs necessary to give the elderly access to legal services are costly, and the cost of providing individual service to such persons is therefore higher. Although legal services programs are sensitive to the necessity for such efforts, the financial realities of the last 6 years have precluded needed special efforts. Operating on frozen budgets during a period of high inflation, legal services programs could undertake extensive outreach only at the expense of other clients.

The increases in the Legal Services Corporation's appropriation for fiscal year 1977 will help but not solve the problem. We will not be able to restore the programs to their pre-1970 capabilities, much less enable them to implement the types of projects necessary to reach more of the elderly poor. It is only by substantially increasing the Legal Services Corporation's budget that our present programs will have the resources to make those efforts and that we will be able to establish new programs to serve areas that presently have no access to legal services at all.

We do not recommend that funds be earmarked to provide specialized services to the elderly. The corporation's mandate is to provide service to all of the poor, concentrating only upon those least able to afford such service. Earmarking funds for any group would inevitably mean less efficiency in working toward that goal. It would mean that other clients or groups would be denied access to the legal system altogether. Such trade-offs should not be necessary when the sound solution is to provide the corporation with sufficient resources to perform the job for which Congress established it.

In sum, the Legal Services Corporation is concerned with the problem of delivering legal services to the elderly poor, just as we are with all groups of poor people. We believe we have made progress in that direction. But we are aware of the problems in reaching the elderly poor, and agree that more must be done in the future. Given adequate resources, we can do the job.

Senator KENNEDY. Thank you very much.

Mr. Wharton, would you like to make a comment?

STATEMENT OF A. C. WHARTON, MEMPHIS AND SHELBY COUNTY LEGAL SERVICES, MEMPHIS, TENN.

Mr. WHARTON. The only comment I would have would be to emphasize President Ehrlich's comment about the lack of data base as to how many senior citizens are presently being served in legal service programs. In my own program, however, we do have figures based on 6 months of service.

Now based on that 6 months experience we were able to determine that at least 79 percent of those senior citizens who were served were persons who were faced with problems which, had it not been for the special outreach components and these legal services programs, would simply have suffered with those problems and allowed them to bother them for a longer period of time.

House Calls for the Elderly

One other interesting statistic is the fact that 59 percent of those served were served at locations other than central offices. We have a program pursuant to which the attorneys actually made house calls, if necessary, and during our first 6 months of operation, approximately 60 percent of the clients were served in their homes at places other than the downtown locations, not simply by choice but by necessity because of handicap or other inabilities to obtain transportation.

Senator Kennedy. I think both Mr. Ehrlich and Mr. Wharton anticipated the first question—that is the degree of commitment of the corporation to providing services for the elderly. It seems to me that most governmental programs do not sufficiently involve the elderly.

I think this is true, in general, of health and manpower training programs. The elderly end up participating minimally in these kind of programs.

Use of Increased Funds

I would like to know what plans there are for the money that was threatened with rescission this year.

Also, what programs do you have that are geared to serving the legal needs of the elderly? How are we going to be able to measure their effectiveness?

Mr. Ehrlich. Those funds are to be used, Senator, in two major ways. One is to increase the capabilities of existing programs, which have had, as you know—including the ones in Boston and others in Massachusetts—frozen budgets for 5 hard years. Those programs will be able to strengthen their capability to serve the poor, to begin particularly the kinds of outreach efforts that you are interested in that can deal with the needs of the elderly in ways that particularly are important for them.

The second major area is to provide service in at least some parts of the country where there now is no access to justice at all, where the elderly and nonelderly poor are totally outside the legal system.

Senator Kennedy. Is this rural as well as inner-city?

Mr. Ehrlich. Sadly, it is both urban and rural in much of the country—the South and the Southwest particularly—where there are no legal services programs at all. This coming year, because the Congress has appropriated $125 million, and in the next 3 years, if we are successful in reaching our goal, we will provide service throughout the country. We are not now doing that and at the end of this year there will still be some areas of the country, including some where a good many elderly people live, who have no service.

Responding to Needs of Elderly

Senator Kennedy. Can you give us an idea as to how you are going to assure that there will be adequate commitments to the needs of the elderly?

You stated earlier that percentages of individuals using legal services was not an appropriate measurement. How will the elderly be able to judge that there is a strong commitment to their legal

needs? How are we going to know then that you are measuring up to those standards?

Mr. EHRLICH. Our commitment is clear and the test, of course, will be the performance on that commitment. In our view, training is probably the singlemost important factor involved—training of lawyers and training of paralegals. We must be sure that both in the substantive law, particularly related to the elderly, and in other areas where the legal problems of the elderly poor are the same as those of others who are poor, legal services staffs are well trained.

WHAT ARE LAW SCHOOLS DOING?

Senator KENNEDY. What are the law schools doing? What is Stanford doing?

Mr. EHRLICH. The short answer is: Not enough. Stanford does, as it happens, have a seminar that deals on a clinical basis with legal problems of the elderly, in conjunction with a program there that the Administration on Aging supports. But in most law schools, including my own, that field has been too often neglected.

The corporation has its own training programs, designed especially for legal services lawyers, to provide training in areas that relate particularly to the elderly and other areas, such as administrative benefits. Our training programs also try to give some sense of the special problems that those who are elderly face when they come up against the law.

The second area of training deals with paralegals. We can do more than we have done in terms of training paralegals. Very often paralegals come from the very community where they will be working. If they are elderly as well, that is an additional advantage in working with the elderly.

Senator KENNEDY. Would it be useful if we had a letter from you and Dr. Flemming to the bar association urging them to urge the law schools to develop these kinds of programs? Perhaps we could ask the bar examiners to include questions on these areas of the law. Would you work with us on this?

Mr. EHRLICH. We would be delighted to work with you and your staff in encouraging the bar to help provide legal services to the elderly poor. We might think in terms of prodding the law schools as well.

Senator KENNEDY. I hope that next year we will be able to find out what is being allocated and what is being committed to legal services for the elderly so that we can more accurately assess their impact.

This is important as there is a very strong impression that legal services for the elderly has not been as strong as other areas. We want to be fair, both to you in terms of judging performance and to the elderly, in assuring them that their needs are being responded to.

I think they are entitled to have a clear understanding of what resources are being devoted to their needs.

I ask that we try to work that out with the staff.

I have some other questions which I will submit to the witnesses. I would like to know what is being done in rural areas to extend the outreach programs.

Model Legal Services Programs

Dr. Flemming, the section 308 model legal services programs have finished their first year of operation. How successful have they been? What is your evaluation of them and what can be done to assure their success?

Dr. Flemming. May I say, first of all, that as far as the grants that were made to the organizations that in turn have been rendering technical assistance to State and area agencies, I feel that the organizations have done a good job. This is why we have renewed most of those grants.

When it comes to some of the more specialized model projects, I have taken note, for example, of the work done by the Legal Services for the Elderly Poor in New York City. They have been able to obtain statewide injunctions in New York and New Jersey to prevent massive transfers of residents out of nursing homes pursuant to utilization reviews under medicare. Under these injunctions, residents may be transferred only after they have been given the opportunity to exercise their rights to a hearing. This injunction has prevented the transfer of about a thousand residents and thereby significantly reduced the negative aspects of transfer trauma.

The legal research services for the elderly here in Washington has developed a law and aging manual to assist the area agencies in developing resources for the elderly and this manual has been widely distributed. Likewise, it has assisted the State agency on aging for West Virginia in obtaining a grant under title XX to establish a paralegal services program consisting of 30 trained paralegals who are senior citizens to visit sites where elderly are congregated in an effort to identify and resolve their legal problems or to refer them to an appropriate legal service. The first job that has been done is one consistent with our desire to build up the capacity and capability of State and area agencies.

Paul Nathanson, in connection with his work growing out of the center in southern California, has performed a similar service for the States in the West and also some in the Middle West.

So I would say, just looking back at just 1 year's operation, that the grants that we have made have helped to move us forward.

Now as I indicated in my opening statement, we are going to try to build on that by institutionalizing this operation at the State level.

Senator Kennedy, one of the things I have tried to keep in mind in connection with the legal services operation is to do everything possible to make it a meaningful and integral part of the operation of the national network on aging.

You were responsible for providing very effective leadership in making it possible for us over the period of the last 2½ years to put this national network into place. It is in place and it is working. I feel it is very important for us to relate legal services to that network. We are very anxious to develop a capacity and capability at the State level which will provide leadership at the area level and the community level and move us forward in this area.

One of the things that we are going to do in order to get a fix on this is to find out within the next 30 to 60 days how many older persons are or have been served through legal services programs in

a given geographical area. Then we are going to ask for an estimate as to the number that will be served by the end of this fiscal year. Then we will be doing the same thing as far as 1978 is concerned.

It is interesting to note that even though the network is new, and we are just getting underway, that at the present time there are about 100 local legal service projects for older persons which are financed in whole or in part by area agencies. They are using somewhere between $2 and $2.5 million of their money for that particular purpose. That is in addition, of course, to the money that we have allocated at the national level.

Special Legal Services Training Title

Senator Kennedy. Would it be useful to have a special title in the Older Americans Act for legal services training?

Dr. Flemming. As far as the Older Americans Act is concerned you have given us a clear legislative history on it in terms of using some of our IV–A training funds for this particular purpose. I have indicated we are in the process of doing that. This is the second time this has been done. Personally, I rather like that approach as contrasted with putting in a separate title. If we begin to put in special titles for specific areas we could be opening up a Pandora's box. But we are delighted to have the Congress give us a clear indication of intent and then delighted to move in and implement that intent.

Mr. Ehrlich. The Legal Services Corporation does want to see as much focus on legal services as is possible. In this area, we care less on the particular mechanism, whether it is a separate title or the clear mandate to do the kinds of things we have been talking about today under the Administration on Aging, and the necessary funding. If it can be done best through a separate title, that would be fine—that would be the very clear indication of the importance of legal services to the elderly. In all events, we do hope to have that indication.

Senator Kennedy. Thank you very much.

Mr. Ehrlich. Thank you, sir.

Dr. Flemming. Thank you.

Senator Kennedy. We will be looking forward to seeing you sometime next year.

Mr. Ehrlich. We look forward to working with you.

Dr. Flemming. Very much.

Senator Kennedy. Mr. F. William McCalpin, assistant secretary of the American Bar Association, formerly served as chairperson of the special committee on prepaid legal services and the standing committee on legal aid and indigent defendants. He is also a practicing attorney in St. Louis with Lewis, Tucker, Rice, Allen, & Chubb.

Mr. McCalpin, we are going to have a short recess and then my colleague, Senator Randolph, is going to be here to continue with the hearing.

We will recess.

Mr. McCalpin. Thank you, Senator.

[Whereupon, a short recess was taken.]

AFTER RECESS

Senator RANDOLPH [presiding]. The committee is privileged to hear William McCalpin, who is the assistant secretary of the American Bar Association.

Mr. McCalpin formerly served as—I will just say chairman, not chairperson—of the special committee on prepaid legal services and the standing committee on legal aid and indigent defendants. He is also a practicing attorney in St. Louis with Lewis, Tucker, Rice, Allen, & Chubb.

We welcome you, Mr. McCalpin, as we welcome, of course, all witnesses. We regret the delay, the situations that are now complicating hearings such as this.

Would you proceed, please?

STATEMENT OF F. WILLIAM McCALPIN, ST. LOUIS, MO., ASSISTANT SECRETARY, AMERICAN BAR ASSOCIATION

Mr. MCCALPIN. Thank you very much, Senator. It is a distinct pleasure for me to be here this morning in response to the committee's invitation. Justin A. Stanley, president of the American Bar Association, is today in London for the opening of the fall term of the courts of Great Britain.

I am joined here this morning by Mr. Daniel J. Piliero of the District of Columbia, who is the chairman of the young lawyers section of the American Bar Association, and Mr. William S. Greenberg of Trenton, N.J., chairman of the committee on delivery of legal services to the elderly of the young lawyers section, about whose activities I shall have more to say in just a moment.

Senator RANDOLPH. We welcome your colleagues to the witness table.

Mr. MCCALPIN. Thank you, sir.

I have submitted a prepared statement. In the interest of conserving the time of the committee—I know you have a couple of other witnesses who are here—I shall not read that statement but merely ask that it be included in the record and I should like, if I may, simply to supplement a few of the points which are made in the prepared statement with some additional remarks.

Senator RANDOLPH. The statement in full will be included in the record.

Mr. MCCALPIN. Thank you.

[The prepared statement of Mr. McCalpin follows:]

PREPARED STATEMENT OF F. WILLIAM MCCALPIN

Mr. Chairman and members of the committee, My name is F. William McCalpin, a practicing attorney from St. Louis, Mo., and assistant secretary of the American Bar Association. I appear here today on behalf of the American Bar Association at the request of our president, Justin E. Stanley. It may be useful for you to know, in view of your consideration today of the legal problems of the elderly, that I am the immediate past chairman of the association's standing committee on legal aid and indigent defendants and have also previously served as chairman of ABA's special committee on prepaid legal services and the special committee on availability of legal services.

In preparing for my appearance here today, I was reminded that the first hearing held by your committee on the subject of the legal problems of the elderly was held in my hometown of St. Louis in conjunction with the American Bar Association's annual meeting in 1970. So it is a particular pleasure to renew the dialog between your committee and the ABA on this important issue.

Our association has had a long history of interest and concern with making legal services available to those who do not have traditional means of access to these services. Historically, our major efforts in this regard have been focused upon the indigent. Lawyers in New York established the first legal aid program exactly 100 years ago. Continuing efforts by the organized bar and other groups to try to make such services universally available have led to the establishment of significant Federal initiatives in this area, most notably the Legal Services Corporation.

With respect to the nonindigent members of society, our early efforts focused on the concept of lawyer referral programs by which members of the public could receive from a State or local bar association the names of qualified attorneys in the client's locale. Generally, through an agreement between the participating attorneys and the bar association, the client would be charged only a nominal fee for an initial consultation. There are now 261 such referral programs serving well over half a million people annually.

In recent years, however, the ABA has become heavily involved in a variety of efforts oriented toward improving the delivery of legal services: prepaid legal service plans, paralegals, specialization, advertising, surveying the legal needs and problems of middle-income citizens, legal clinics, pro bono activities, and the like. There are seven committees of the association that are involved so intensively and directly in this area that we have created a coordinating committee, the consortium on legal services and the public, to focus these efforts.

I have briefly mentioned these efforts to indicate that the association has recently undertaken a number of programs which, while not directed exclusively at the legal problems of the elderly, will have positive impacts on the delivery of legal services to this group. Our involvement to date with the specific needs of the elderly has been limited to the work of three constituent groups within the association.

The Young Lawyers Section

A committee on legal services to the elderly of the young lawyers section is engaged in seeking to have State and local bar associations establish programs to provide legal services to the elderly. Your chief counsel, David Affeldt, met with this group at a conference held in June. The committee has put together a package of materials for use by State and local bars and is seeking to have programs for the elderly implemented by these groups.

At least one project has already been started as a result of the committee's efforts. The New Jersey State Bar Association has begun a lawyer referral program for the elderly as an extension of its existing referral service. When elderly persons seek legal counsel through the bar association, their names are referred to a panel of lawyers, currently 38 in number, who have an interest and expertise in this area. The lawyers perform the work for the clients at reduced cost or, in some instances, at no cost to the client. The program is just getting underway but has good support among the attorney participants.

The Family Law Section

The association's house of delegates, the policymaking body of the association, adopted in August 1975 at the request of the family law section, the following resolution:

"Resolved, that the American Bar Association approve the support of a program to establish, in cooperation with local and State bar associations, panels of retired attorneys to provide legal assistance on a *pro bono* basis to elderly persons financially unable to obtain counsel in their communities."

The section has initiated efforts to establish such programs, but the movement is really in its infant stages at this point. The Older Americans Legal Action Center in Dallas, Tex., is one of the first such programs. This effort combines a core of four staff attorneys, whose salaries are paid from Older Americans Act funds, and a panel of over 60 retired attorneys who provide volunteer services in perhaps three to eight cases each per year. One interesting feature of this program is the use of a van as a "mobile office" by which an

attorney and a paralegal travel to senior citizens centers to talk to elderly people about their legal problems. Both the State Bar of Texas and the Dallas Bar Association are participating in this effort.

Real Property, Probate, and Trust Section

The real property, probate, and trust section's committee on the legal problems of the aged has taken a two-pronged approach in this area. In 1974, it conducted a survey to determine which States had fulfilled the mandate of the 1971 White House Conference on Aging by establishing State agencies to coordinate and monitor State services for the elderly and to promote such services. The survey results were published in the section's journal, thereby providing the 21,000 members of the section an awareness of and guide to the programs and services available in their States.

The other activity of the committee has been an attempt to increase the expertise of probate and trust lawyers to deal with problems of the elderly. Various articles have been written by members of the committee on specific topics relating to the legal needs of the elderly and published in the section's journal. Currently, the committee is preparing such an article on the use of powers of attorney in these cases.

A number of State and local bars have also instituted similar programs.

The Nevada State Bar, in conjunction with the Clark County legal services program and the State supreme court, has instituted a project by which a panel of lawyers volunteers to handle overflow cases from the legal services program on a *pro bono* basis. While the project provides free legal services to a wide variety of clients and not just the elderly, it has resulted in more than 175 hours of free legal services being provided annually by the private bar to the elderly.

In Louisiana, the State Bar Association and at least three local bar associations have worked with public and private agencies to establish a lawyer referral service for the elderly which combines training of the participating attorneys in the legal problems of the elderly, publicity about the program through newspapers and through organizations of the elderly, and low cost legal services to the elderly.

Virginia's two statewide bar associations combined efforts last year to conduct a 2-day seminar on the legal problems of the aged. One hundred twenty-five Virginia lawyers attended the seminar, and their registration fees paid for the cost of the seminar and for the publication of a resource manual in this area.

These are examples of the sort of activity now going on in the organized bar. More, of course, needs to be done to extend such programs into areas not now served. The president of the ABA and I have discussed the possibility of our establishing an association committee or task force to work in this area and foster the spread of similar programs. Exploratory conversations have been had with at least one foundation on the subject of financing such efforts. While no decision has been made on this score, I know that President Stanley is most interested in the subject.

What could such a task force accomplish? What sorts of initiatives could it encourage? As an initial agenda, the task force might explore any or all of the following ideas:

(1) Encouraging lawyer referral programs, now operated by virtually every State and major local bar association, to establish distinct panels of lawyers who have expertise in this area.

(2) Compiling existing materials on the legal problems of the elderly, developing new materials as necessary, and "packaging" these materials for use by State and local bars in connection with programs they may operate for the elderly.

(3) Conducting continuing legal education programs on this subject.

(4) Establishing panels of volunteer lawyers to provide legal services to the elderly who are unable to afford private counsel.

(5) Developing prepaid legal service plans specifically for the elderly. One common problem with respect to improving the expertise of the private bar in a particular area of the law is the lack of a sufficient volume of cases in that area to permit the practitioner to devote himself intensively to it. Prepaid programs, apart from their many other merits, would help to stimulate the necessary volume of cases.

(6) Working to obtain simplification of legal processes, particularly administrative agency procedures. Many problems of the elderly could be resolved by the elderly person himself, or with minimal assistance of counsel, if the legal processes were less complex and intimidating. Particularly with respect to administrative agency proceedings, I have the impression that it is the citizen, and not his administrative remedies, which generally becomes exhausted first. Bar associations are making efforts to simplify many legal procedures in sound and responsible ways, and such efforts should be encouraged with respect to areas of the law in which the elderly citizens are commonly involved.

(7) Encouraging each of the ABA's sections to establish a committee on the legal problems of the elderly. Our organization has 25 "mini-bar associations," called sections, composed of lawyers with interests in a particular field of law, such as tax law, family law, and administrative law. A committee of such a section could substantially increase both the sensitivity of its members about the legal problems of the elderly and their expertise in this field.

(8) Working to encourage government agencies to be more willing to allow citizens, including the elderly, to be represented by counsel in administrative proceedings. Historically, certain agencies have prohibited attorney participation or made it difficult for individuals to be represented by attorneys. The Veterans' Administration, for example, still prohibits attorneys from being paid more than $10 for representing a client in a VA proceeding. Such arbitrary and unreasonable limitations seriously impair the ability of a citizen to protect his rights and should be eliminated.

I think these and other measures are ones which can and should be taken by the organized bar. The percentage of our total population which is over 65 years of age now exceeds 10 percent, and that figure is growing each year. There are special and definable legal problems experienced by many members of this group. The bar has begun to address itself to those unique legal problems and needs, and these efforts should be strengthened and expanded.

Thank you for this opportunity to appear before you and present my views and those of the American Bar Association.

Mr. McCALPIN. As the prepared statement indicates, the American Bar Association has long maintained an interest in the delivery of legal services to diverse groups of American citizens. Historically, and going back exactly 100 years, our interest has focused upon the indigent. More recently, and particularly within the last 10 years, that interest has broadened out to include numerous other groups of American citizens.

In addition to the activities which are recited in my prepared statement, the standing committee on legal aid and indigent defendants in the last few years has taken particular pains to identify constituencies of indigent persons, subgroups within that categorization, if you will, who are particularly to be considered in the provision of legal services.

Those constituencies include juveniles, native Americans, prisoners, the elderly, ethnic minorities, and the like.

LEGAL SERVICES FOR THE HANDICAPPED

Senator RANDOLPH. I wish you would add the handicapped also.

Mr. McCALPIN. Yes, sir, we have. As a matter of fact, just at the annual meeting in Atlanta, the house of delegates passed a resolution respecting the handicapped citizens of the United States.

Senator RANDOLPH. There is a very substantial number of handicapped persons in our population, but they are also individuals who can be in the mainstream of American life and be very productive in our society.

Mr. McCALPIN. There is not any question about that, Senator. They

are particularly deserving of the really minimal assistance which we can give them to bring them into, as you say, the mainstream and to cause them to bring their undoubted talents into the productive life of the United States.

The family law section of the American Bar Association was really responsible for the 1970 hearing which Senator Williams referred to in his opening remarks yesterday. Mr. Norman Kalcheim, of Philadelphia, the chairman of the committee within that section, caused a hearing of this committee to be held in St. Louis 6 years ago.

As the remarks indicate, the real property, probate, and trust sections dealing as they do with matters of estates, and trusts, and real property, has taken a particular lead in exploring how legal services might be brought to elderly citizens in manners which I have described in the prepared remarks.

Senator RANDOLPH. The Committee on Aging held the hearing in St. Louis.

Mr. MCCALPIN. I believe you attended.

Senator RANDOLPH. I did attend. I can't pinpoint the date, but I believe it was in 1970.

Mr. MCCALPIN. August 1970, in conjunction with the annual meeting of the American Bar Association in our city at that time.

Senator RANDOLPH. I think this is further proof of what you said earlier. Is it correct that the American Bar Association has a continuing desire to address itself to this very important problem?

Mr. MCCALPIN. Yes, sir. That is exactly correct, and the family law section has taken up the endeavor in the interim as well as the real property section. They have engaged in the activities described in the prepared remarks.

YOUNG LAWYERS INTERESTED IN ELDERLYS' LEGAL PROBLEMS

Of more immediate interest, I think, is the activity of the young lawyers section and the two representatives who have joined me here today. I think it is a matter of interest that it is the young lawyers who are particularly interested in the problems of legal services for the older citizens of the United States and they seem to have bridged that gap that we hear about so much. It is not the lawyers in between, but the young lawyers who are so interested.

Senator RANDOLPH. On the Salem College campus at Salem, W. Va., which is my alma mater, we have the agent there on the campus. They have an innovative program, which I do not have time to discuss in detail now. There was a belief by many people that the students would resent this group of persons who would possibly mingle with them, at times eat with them, and would be a part of the campus life. Instead, they are prompted by them and helped. I receive letters from the board of trustees and the officials of the college, saying "This has helped the students. It has given them help which they didn't realize. Thank you very much."

Mr. MCCALPIN. I think that experience is mirrored and reflected in the bar as well, Senator. In June of this year, the young lawyers section brought together representatives of a number of members of the bar from eight or nine States to a meeting here. Those repre-

sentatives had expressed a particular interest in creating legal services programs for the elderly.

The staff counsel of this committee, Mr. Affeldt, was in attendance at that time. The section is continuing that activity. In a series of five meetings to be held around the country this year, beginning next week in Chicago, representatives of the young bar in all 50 States will be offered five or six programs to be implemented by young lawyers in all 50 States and in communities across the country.

One of these programs will include the development of legal service programs for the elderly. At the meeting in Chicago next week, 68 lawyers have already indicated an interest and an expectation of attendance. They will come from 12 or 14 States. At that time, material such as I have in my hand and were used at the meeting here in June will be offered to those in attendance so that they may return to their States and their local communities and build upon the kinds of ideas which Commissioner Flemming and Tom Ehrlich described here this morning.

Coming from those directions, they can put together programs to provide legal services to the elderly in their States.

As I have said, that meeting at which representatives of 12 or 14 States will be in attendance will be repeated four times throughout the course of this year so that all 50 States will be represented and given an opportunity to participate to inaugurate programs to provide legal services for the elderly.

As is indicated in the prepared statement, building upon these efforts and those of others in the field, the American Bar Association is exploring the possibility of bringing these efforts together under a committee or a task force which might have the charter which is outlined in the prepared statement.

Use of Paralegals To Help Elderly

I would conclude, I think, with offering just a few additional thoughts for the consideration of the committee. As Tom Ehrlich said a little bit earlier, it seems to us that this area of legal services for the elderly is one which is particularly appropriate for the activities of paraprofessionals, paralegals. It is in large measure an area of problems with administrative agencies where paralegals can much more easily find access to the system than in the courtrooms where the court has the tendency to require a license to practice law as the price of admission.

In addition, the use of paraprofessionals admits of the possibility of using those persons most familiar and concerned with the problems, to wit, the elderly themselves, in a helping way usually with some advice and consultation with lawyers but it seems to us that the use of paralegals, paraprofessionals, is particularly appropriate in this area of the provision of legal services and, indeed, the paralegals help the professionals to expand their opportunity, to expand their area of service.

Agency Restrictions on Legal Services

One problem area that I would draw to the attention of the committee is the area of restrictions really on the provision of legal

services to the elderly, among others, by the practices of certain of the agencies involved.

It is interesting that Senator Randolph is here. I remember about 10 or 11 years ago at a meeting of the West Virginia bar in Charleston, there were representatives there of the Social Security Administration. At that time, that agency had particular restrictions on the compensation of lawyers in the representation of persons with problems before the Social Security Administration. Largely, I must say, because of its own feelings, that agency changed its approach with modest prodding from the bar. It is now possible for attorneys to participate in the solution of problems within the framework of that agency on a modest basis and as a result we have seen a very dramatic increase in the representation of persons with problems before the Social Security Administration. A dramatic increase in the use of lawyers.

Just this past year, there was presented to the house of delegates of the American Bar Association a report and recommendation from the special committee on Federal limitations on attorneys fees. That report drew particular attention to the practice of the Veterans' Administration which has, among other things, a limitation of $10 on fees which may be paid to an attorney for representing a person with a problem before that agency.

While I am sure that rule was conceived in the hope and the thought that it was in the interest of the veteran that he not have to pay an inordinant fee to have his problem solved, in truth and practice I think that regulation works to the disadvantage of the veteran because, as a practical matter, it means that he cannot get legal representation in the solution of his problem.

I have pulled from the bound book of reports the report and recommendation of that committee which was, as I say, adopted by our house of delegates in Philadelphia in February of this year and I would ask that, together with the very useful appendix which is a compilation of limitations on attorneys fees, be added to the record of this proceeding.

It is my understanding that a few copies of that were handed in to the staff this morning without, I am sorry to say, that compilation at the end of the report which will be submitted to the staff before the day is over.

Mr. AFFELDT [presiding]. We shall make that part of the record.[1]

Mr. MCCALPIN. Thank you.

PUBLIC INTEREST LEGAL SERVICES

Finally, I would draw the attention of the committee to the resolution of the public interest practices committee, which was adopted by our house of delegates some time ago and it calls upon each lawyer in the United States, as a matter of his basic professional responsibility, to provide public interest legal services. The generic words of that resolution certainly admit of the provision of those legal services to the elderly. That committee is busy at work now drafting specifications for the implementation of that generic resolution and I have no doubt that when completed it will clearly call for the provision of

[1]See appendix 1, item 9, p. 361.

legal services to the elderly, among others, as a basic element in the discharge of the professional responsibility of each lawyer under canon 2, to make legal services more readily available.

I would simply finish by saying that the American Bar Association and all State and local bar associations, I think, have become increasingly aware of the obligation to provide legal services to all segments of the community and we welcome the activity of this committee in a particular area among a particularly deserving group of American citizens and we will lead in the field but we will also respond to your lead as we see it developing in the months and years ahead.

We look forward to cooperating not only with this committee, but with the Legal Services Corporation, Commissioner Flemming, and others interested in this vital field.

I thank you. We would be glad to answer any questions on any of our activities.

Mr. AFFELDT. Thank you very much, Mr. McCalpin, for an excellent presentation.

I shall raise a couple of questions and then ask some of the staff members if they would like to pose any questions to you or to the panelists.

First, the American Bar Association adopted a resolution in 1975 which said, and I quote: "It is the basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services." What steps has the ABA taken to increase the involvement by private attorneys in providing legal services for the poor, and particularly the elderly poor?

Mr. MCCALPIN. Well you, of course, have just quoted from the public interest recommendation of the special committee on public interest practice to which I referred a moment ago. I think I can say several things about what we are doing to implement that.

First, as I have said, the committee that fathered that recommendation is now at work designing the specifications by which the generic resolution will be implemented, and I think you will recognize that the passage of that generic resolution represented something of a milestone because it did advance the concept of basic professional responsibility a good deal.

Second, the gentlemen at my left and my right in the young lawyers section are, as I have said, busy at work energizing the State and local bars all over the United States—particularly the younger members of those bars—to create programs which may participate in the legislation which this committee has sponsored.

Mr. AFFELDT. I believe Mr. Greenberg has undertaken some efforts in New Jersey, and I would appreciate it if he could provide some comments about his activities for the record.

STATEMENT OF WILLIAM S. GREENBERG, TRENTON, N.J., CHAIRMAN, COMMITTEE ON LEGAL SERVICES TO THE ELDERLY, YOUNG LAWYERS SECTION, AMERICAN BAR ASSOCIATION

Mr. GREENBERG. Thank you, Mr. Affeldt.

The importance of the New Jersey project is that it is one example of what can be done in delivering legal services. That is what this program is all about, getting the services to the people who need them.

In New Jersey, particularly, we have a panel of some 38 volunteer lawyers and we have approached it as an extension of a more traditional lawyer referral service with the emphasis on the substance of the problems of senior citizens, the elderly.

Thus, when a senior citizen or a person who is elderly knows to call the New Jersey State Bar Association—at an 800 number, I might add, a toll free number—seeking legal services, that is automatically plugged into or assigned to one of these 38 volunteer lawyers on a regional basis, trying to match up the lawyer with the potential client. It is done on a very low cost or no cost basis to the individual.

I might note that one of the things that the American Bar Association has to be concerned with, and that we in New Jersey have been concerned with, is what do you do about the problem of the elderly when a senior citizen, who is not necessarily poor but needs legal services, is not necessarily indigent but does not know where to go for a lawyer or how to seek legal services, and the question of the fee, and the question of the participation of lawyers?

We in New Jersey have tended to indicate that regardless of economic means it is the problems of the elderly that we are addressing and that will then be followed through on an individual lawyer-client basis. Those who are able to pay, pay; those who aren't will receive the services free.

It is very interesting, and I think you know that very many senior citizens do not want charity, do not want a handout. It is simply a problem of getting together a person in need with a person who has got the wherewithal to supply the need. A very important concept that I have stressed around the country at these regional meetings of the young lawyers section is that this is not necessarily a program of freeing legal services in the sense that only indigent people should be considered. It is a program of delivery of legal services in all of its ramifications and I think that is a very important concept, particularly to our elderly—a refusal to become a part of the program that is merely one more indigent and merely a charitable one.

Role of Law Schools

Mr. Affeldt. I would like to pose this question for all three panelists. This relates to the role of the law schools in training attorneys to be responsive to the legal problems of the elderly. I know from my own personal case when I attended the University of Texas Law School, which I consider to be a top flight law school, that I had very little training at all for the type of work I am doing now. Much of the training was for the traditional attorney-client relationships, business associations, personal injury cases, and so forth.

What, in your judgment, should the law schools do in order to sensitize and prepare the attorneys of tomorrow for the legal issues affecting the elderly?

Mr. McCalpin. Well, I think that in a little different context and from a little different direction the law schools are moving in directions which will be productive in the terms that you have described. The thrust really has come from the poverty law area and the involvement of law students and clinical programs in cooperation with

local or legal service agencies funded by first OEO and now the Legal Services Corp.

As a result of that, law schools are beginning to pay a lot more attention to consumer law, landlord and tenant law from the tenant's point of view rather than the landlord's point of view, and problems of that sort.

Now this inevitably will have some fallout in substantive problem areas which are of concern to the elderly.

The sensitizing which is going on in that is, I suppose, largely directed at sensitizing law students to the problems of the poor. I suspect we need to add a dimension to that, sensitizing them to the problems of the elderly. All this, of course, is laid on the traditional disciplines and administrative law and procedural law which has gone on, and I think it has added new dimensions to it.

I do believe that maybe what we need to do is to wed more combined sociology courses with legal courses, and there are some efforts in those directions around the country.

Mr. AFFELDT. Very good.

Mr. Piliero, would you like to comment on that for the purpose of our hearing record?

STATEMENT OF DANIEL J. PILIERO II, CHAIRMAN, YOUNG LAWYERS SECTION, AMERICAN BAR ASSOCIATION

Mr. PILIERO. Thank you, Mr. Affeldt.

I would agree with Mr. McCalpin's comments. I think the number of issues which are before the bar, and indeed before the profession, will tend to converge on the solutions to the problems of the elderly in the legal area. We are at the moment, it seems to me, struggling with the concepts of making known the availability of services to people through a reconsideration, I suppose, as an association and as a government, of the respective positions which we might have with respect to advertising availability of services. We are struggling, it seems to me, with the concepts of how legal services may best be delivered and whether we should, as Mr. McCalpin said, spend a number of years exploring through prepaid plans and other varieties and types of programs.

The concept of providing information about the availability of legal services and providing information and accessibility to legal services will have, it seems to me, a very significant impact on the elderly as it will on other generic groups of people as we begin to open those discussions and resolve certain issues.

PINCUS LEGAL EDUCATION PROGRAM

More particularly to the point of whether it would be appropriate in a law school setting to design a specific program or to include in each of the more than 150 law schools programs on legal services training for the elderly, I would suggest to you the Pincus program for clinical legal education.

Bill Pincus has for more than 6 or 7 years supported 120 active clinical programs. He has indeed funded clinical programs of a great variety. I receive his materials and I would be pleased to sup-

ply, at a later time, information on whether there are specifically funded clinical legal programs designed to assist the elderly as a group, and if there are not, I think perhaps that organization might be interested in considering the subject.

Within the context of clinical programs generally, there being more than 100 funded projects across the law school community, my impression is that you would benefit from having law schools include some clinical training with special attention to the elderly.

I did not take from your comment the suggestion that there be a substantive law course on the subject of legal problems of the elderly as much as, perhaps, a combined substantive law and clinical program. To that extent, it would seem to me that it would certainly be useful to consider the existing mechanisms, such as the Ford Foundation grant called CLEPR—Clinical Legal Education for Professional Responsibility—which Bill Pincus administers, and other existing programs that you and I have had occasion to work with and which the private sector might well energize in a law school, or two more programs which would be models.

My belief is that Mr. McCalpin is probably correct. It is the young members of the bar doing the kinds of things which we are now doing which will be more valuable in the long run to ultimately delivering the services to the elderly—to have lawyers in the field already established and working who we know are not merely thinking about going out to practice law and who ultimately go to do something else, but lawyers who are there physically in the field practicing, who have their own firms or belong to firms, either volunteering their services or developing a side of their practice in a profit setting, if that be the case, but developing a side of their practice with a particular view toward the fact that there is a special area here of attention which is necessary, and attention which they should be involved in.

Mr. AFFELDT. Mr. Greenberg.

CLINICAL CONCEPT

Mr. GREENBERG. My view, quite frankly, is that I adhere to the concept that in the law school setting an emphasis on the clinical programs is wise and the substantive area of the law should be handled the way they have traditionally been handled in law schools, which is smaller seminars on these particular programs and a particular substantive, such as social security and veterans statutes, and so forth.

Mr. AFFELDT. Where did you attend law school?

Mr. GREENBERG. Rutgers, the State University of New Jersey.

Mr. AFFELDT. Did you have any courses on social security or medicare?

Mr. GREENBERG. No, they were traditional. This is the emphasis I think we should have in the future. They were all subsumed in administrative law courses and you were lucky to touch upon a particular case.

As you know, the traditional method of law teaching is the case method. There are very few cases that get to the courts dealing with the substantive problems of the elderly as elderly. I think a greater

emphasis should be made to include substantive law but I wish to make the following point, and that is, agreeing with what Mr. McCalpin and Mr. Piliero have said, I would put the two together, and that is conducting legal education programs for practicing lawyers should deal with the substantive areas of the law of concern to the elderly.

In the State of Virginia, the Virginia Bar Association had a program, I believe, last fall, in which practicing lawyers would come together, traditionally Saturday morning or 1 or 2-day sessions, and deal with particular substantive areas whether it be social security, whether it be supplemental security income, veterans statutes, or private retirement.

As you know, we have a brandnew Private Pension Reform Act of last year which, I believe, Senator Williams is one of the principal sponsors of. These are the kinds of things that should be emphasized, in my view. The practicing attorney should be encouraged to get the information in terms of the substantive areas of law. That is the emphasis I would make, not necessarily in law school but once the lawyer is admitted and is practicing. That is where he should get the knowledge of the substantive area in the law.

Continuing Legal Education

Mr. McCalpin. There is a development which is emerging around the country which I think is apt to tie in rather closely to what Mr. Greenberg has suggested, and that is the increasing emphasis on the requirement of continuing legal education as a condition of maintaining your license in effect. At least two States have now adopted rules of court which require lawyers to spend a specific number of hours in upgrading their skills continuing their education.

Mr. Affeldt. Are those States Iowa and Minnesota?

Mr. McCalpin. Exactly, and I think it is 45 hours in a 3-year period of accredited instruction as a condition of maintaining the license. It is courses of that kind which can easily accommodate the concept which Mr. Greenberg has suggested.

Mr. Affeldt. Mr. Schneider.

Mr. Schneider. On behalf of Senator Kennedy, let me raise a few questions.

Paralegals

You mentioned favorably the paralegals here dealing with the problems of the elderly. Yesterday, there was testimony which indicated that some State bar associations apparently have passed regulations which tend to forbid nonlawyers from handling administrative law cases for elderly clients. I am wondering if you could comment.

Mr. McCalpin. Well, I think that generally speaking, the use of paralegals is considered to be entirely appropriate within the framework of their working in a general way with guidance from professionals. Now so far as I know, the only areas where there are flat prohibitions. if I remember, in Michigan a few years ago there was a proposal that nonlawyers represent persons before the Workmens Compensation Commission and I believe the Michigan bar opposed that.

In other words, it was completely independent, outside of the rules, outside of the training and the code of professional responsibility of the profession.

I think that so long as paralegals work within the general structure of the profession subject to the rules as to confidentiality, conflicts of interest, and the general supervision of professionals, I don't think that there is any organized opposition by the bar.

Mr. SCHNEIDER. Let me turn it around a little bit. What is the bar doing to encourage these paralegals?

Mr. MCCALPIN. Well, the bar is doing all kinds of things. The availability committee, which I was privileged to chair for 5 years, spun off the idea of paraprofessionals. There was created a special committee of the American Bar Association, under the chairmanship of Lee Turner of Kansas, about 6 or 7 or 8 years ago. That committee has sparked and energized the creation of numerous paralegal training programs around the country within recognized institutions of education, frequently at the community college level, sometimes in the general public educational system.

That committee has dealt with not only the training but the utilization of paralegals in the profession and I think as a result of the activities of the organized bar we have seen an enormous increase in the use of paralegals.

The OEO funded programs took it up. The OEO provided money for the utilization and training of paralegals. That mantle has now passed to the Legal Services Corp. I have had some conversations and correspondence with Mr. Ehrlich in that connection over the past year or so. I think the bar has done very much to increase the recognition, the training and utilization of paralegals in the last 6 or 7 years.

PRO BONO REPRESENTATION

Mr. SCHNEIDER. One final question. One of our later witnesses in prepared testimony quotes from a speech by Justice Brennan at Harvard on the possibilities of the legal profession urging that each member of the bar be required to spend 5 hours per week in pro bono representation. No bar association, according to him, has yet imposed such an obligation upon its members.

Do you think that that is a reasonable standard and do you think that the bar association might consider that?

Mr. MCCALPIN. Mr. Affeldt and I were discussing earlier the resolution which was adopted by the house of delegates of the American Bar Association a year or so ago at the instance of the special committee on public interest practice. That resolution, which is now the policy of the American Bar Association, says that it is a basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services.

Now what you are doing, of course, is quantifying that obligation in terms of 5 hours a week. As a lawyer engaged in the private practice of law myself I would say to you that I think 5 hours a week is pretty stiff. I do think that there is an obligation. I think that we are at work now trying to translate that obligation into specifics.

I am not sure that each lawyer is constitutionally made up so as to provide the service himself. It may be that you will do it in a

surrogate way. I point to you the sample of Hogan and Hartson here in Washington which has supported a public interest section in the firm which has a lawyer in charge and two or three other lawyers.

John Ferren, who is the head of that section, is a very devoted and able lawyer and he is completely supported by the firm along with his section. I think that this is the way that it may be, that the quantum of the obligation may be translated in different ways across the country.

Indeed it may be that some will merely support it financially, but I think that the bar has accepted Mr. Justice Brennan's principle and it is now trying to translate that into active reality.

Mr. AFFELDT. Mrs. Fayé.

Mrs. FAYÉ. No questions.

Mr. AFFELDT. I think one of the impediments for private attorneys to provide legal counsel for the elderly is, as you pointed out, the $10 limitation for VA benefits. In a prior working paper for the committee—prepared by Legal Research and Services for the Elderly—one of the contributing attorneys pointed out that in so many cases the issues affecting the elderly are the type that are very complicated and do not offer much of a return for the expenditure of time for the private attorney.

PROPOSALS TO IMPROVE FEE SYSTEM

What, in your judgment, can be done to improve the fee system so that it will be more financially attractive for the attorney to represent the elderly client and yet not result in a great dilution of benefits—to the point that it would not be advantageous for the elderly client to be pursuing his legal rights?

Mr. MCCALPIN. I think there are a couple of things that can be and are being done in that respect. First of all, the use of paraprofessionals is a less expensive way of going about solving the problem than to utilize a fully trained and higher priced professional.

Second, the concept of prepaid legal services which has been espoused by the bar is one which offers a solution. I happen to sit on the board of Prepaid Legal Services, Inc., in St. Louis. A senior citizens group has come to us with a view to creating a prepaid legal services program for that senior citizens group of the typical open panel variety where they pay what amounts to a premium. It is a spread the risk sort of thing which makes it possible for them to get the services.

There is, of course, no reason why a group of senior citizens could not do as many labor unions have done across the country and that is to create a closed panel legal services program where counsel is on a salary rather than paid a fee for service, and this again has the effect of minimizing the cost so far as the individual recipient of the service is concerned.

I think that these are at least a couple of ways that that problem can be addressed very quickly within a nonradical solution.

Mr. AFFELDT. Do the other panelists wish to make any contributions?

Mr. PILIERO. Mr. Affeldt, I think we will have to recognize that, aside from the possibility of there being a fee, there will be those

who are simply not able to pay a fee at any level, and the system will not be a fee-generating one. To that extent the work of the volunteer lawyer which we are energizing and the work of the Legal Services Corp. upon which you received testimony this morning, and as I understand it, a reporting system of some sort which Senator Kennedy requested be established, will probably be the best aid.

For the private bars' part, I would suggest that the young lawyers will be addressing some 275 affiliates in the coming year. We would expect that in excess of 500 or 600 presidents of the young lawyers groups throughout the country will be attending with officers and committee chairpeople and we would hope to energize committees of practicing lawyers in a volunteer setting.

As Mr. Greenberg suggested, in some instances these volunteers function on a fee basis where it appears that the problem and client warrant a fee. In most instances, however, it is just volunteer time which comes back to the question of what is the bar doing with the volunteer services. We don't keep track of the hours. I can only tell you that in a disaster assistance project I know we answered 5,000 claims over a 2-year period.

In the past year we have had volunteers present in an Indochinese refugee assistance program made at the request of the Department of State last year. I know that we have established an assistance program and answered more than 1,500 calls on this program. Similar programs will be the subject of our five regional meetings which Mr. McCalpin suggested. So I think that although we are unable to quantify and send in tables of hours devoted to these projects, the private bar does pull a good share of its weight, and without a fee. I don't think the fee question has stopped us from providing the service. Indeed, we accept no fees on any of the problems which I discussed.

Mr. McCALPIN. In addition, of course, to paralegal and prepaid legal, we do have the discharge of the public interest obligation which we have discussed earlier as well. Of course, the services of the Legal Services Corp., which has been greatly supported by the bar, are approaches to solving the fee problem for legal services for the elderly as well.

Mr. AFFELDT. Any more questions?

Thank you very much.

Mr. McCALPIN. Thank you.

Mr. GREENBERG. Thank you.

Mr. PILIERO. We appreciate the opportunity to testify.

Mr. AFFELDT. Now we shall hear from Mr. Paul Nathanson who is the executive director of the National Senior Citizens Law Center. His testimony at the committee's Los Angeles hearing in 1974 provided a spark for the Tunney amendment to the fiscal 1975 Labor-HEW Appropriations Act. It provided a $1.2 million special funding level which led to the creation of 11 model projects throughout the country.

The National Senior Citizens Law Center also provides technical assistance on a wide range of issues to State and local offices of aging, serving 29 States west of the Mississippi.

We welcome you, Mr. Nathanson.

STATEMENT OF PAUL S. NATHANSON, EXECUTIVE DIRECTOR, NATIONAL SENIOR CITIZENS LAW CENTER, LOS ANGELES, CALIF.

Mr. NATHANSON. Thank you. It is a pleasure to be here.

I am here actually in a dual capacity; as executive director of the National Senior Citizens Law Center, and as a member of the executive committee of the newly formed legal services section of the largest State bar association, the State Bar Association of California. I have submitted a statement [1] for the record on behalf of the legal services section.

I also have a prepared statement [2] which I hope will be included in the record.

We have heard today and yesterday, and we will continue to hear, about the efforts that the private bar has been making with respect to providing legal services for the elderly.

However, I am not convinced that aggressive advocacy—major litigation and legislative and administrative advocacy—will go on if the sole representative of the legal rights of the elderly poor is the private bar.

I think that the staffed legal services programs funded now by the Legal Services Corp. and by the Administration on Aging through its title III program have been a major source of improvement in the daily lives of older people through their advocacy efforts.

It is this expertise in dealing on a daily basis with social security, food stamps, title VII, SSI and the major Federal benefit programs which I think is critical. I do not see that expertise arising—except perhaps in the long, long range—out of the private bar and judicial-type programs.

ACTIONS TO DEVELOP EXPERTISE FOR ATTORNEYS

Mr. AFFELDT. What steps do you think would be necessary in order to develop this expertise for these various programs?

Mr. NATHANSON. For private attorneys?

Mr. AFFELDT. For private attorneys and perhaps legal services attorneys because I think many of them are not that well informed about programs.

Mr. NATHANSON. There are several things that can be done. Publicly-funded legal services attorneys have the various backup support centers mentioned by President Ehrlich. They have training programs. There are manuals which are prepared to at least begin to give out some of the expertise. These resources are generally not available to the private practitioner.

For example, I spoke recently with a private attorney in Chillicothe, Mo., who would very much like to take an occasional social security case but cannot spend the 2 days required to go down to Kansas City, read the Federal Register and then go back home and do the research.

If that attorney had available the services of a support center such as ours—or the Welfare Law Center in New York, or another one,

[1] See appendix 1, item 10, p. 369.
[2] See p. 292.

depending on what the question was—where he immediately could be told, "Look, that is a case that is worth pursuing," or "We are doing something in Florida with respect to that," and so forth, I think you would see him taking social security cases because he would be able to afford it. And in the long run you would see the private citizen being able to afford having that attorney in Chillicothe take the case at a reasonable fee.

Legal Services Assistance for Elderly

I would like to give a few examples of the ways in which legal services attorneys have assisted elderly clients. In *Kennedy* v. *Matthews*, brought by the Food Research and Action Center, a court order was obtained requiring the release of $37.5 million in funds impounded under title VII of the Older Americans Act. As a result, the nutrition services for the elderly were expanded to reach an additional 63,000 persons as a direct result of that case brought by Ron Pollock and his associates.

In the case of *Cardinale* v. *Weinberger*, legal services attorneys were successful in negotiating the right to a hearing before reduction, suspension, or termination of SSI benefits.

The case of *Abascal* v. *Weinberger* ultimately resulted in the Social Security Administration handing out over 1,000 copies of the SSI claims manual to legal services attorneys and other advocates. Initially, the Social Security Administration had indicated that it did not want to hand out that manual which is, as you know, the basic law of the SSI program. It did not want advocates in the field to have it. A lawsuit was brought by Ralph Abascal. Our office went to Baltimore and negotiated with SSA and, as a direct result of those negotiations, it sent out the manual to legal services attorneys.

Even in the face of such major decisions nothing is perhaps as moving as the self-explanatory letter recently received from the National Senior Citizens Law Center with respect to a case involving the eligibility of a plaintiff for a civil service retirement annuity.

I would like to quote just for a moment.

> So let me thank you most sincerely for whatever you did for me. I have tried for over 17 years to negotiate the return to me of my right to a pension for nearly 30 years of Government service, mostly abroad. Now it is all over, thanks to you, Mr. Harden, and others of your service. It gives me great satisfaction to tell you that last Friday, September 3, I received two U.S. Treasury checks, one for $28,654 and another for $1,200.
>
> Also, I was informed I would received $200 monthly from now on. I am deeply grateful for everything, now that you and your service have accomplished what I tried to do alone for so long.

Substantive Expertise Can Make Litigation Unnecessary

Obviously, benefits to clients derive not only from actual litigation but from the general substantive expertise of legal services attorneys and from the enhanced credibility given the negotiations of such attorneys by the mere threat of potentially successful litigation.

Thus, at the simplest level, merely being able to decipher and understand complex pension reports and their significance recently resulted in the discovery of pension credits previously overlooked and

the ultimate issuance of a check for $14,000 to a client for retroactive benefits. In addition, the retiree and his spouse, if he predeceases her, will now receive a monthly annuity of $357.

Now, these are concrete individual cases. My point is that the expertise that legal services attorneys are able to acquire often results in helping people on an individual basis without the need for litigation.

I think it is critical that the expertise which the legal services attorneys have now acquired be available for legislative and other public hearings. It seems to me it would be an excellent idea if there were a way of allowing that expertise to be used in public hearings.

I note with pleasure that Senator Kennedy and others have introduced or sponsored legislation, such as S. 2715, which would provide attorneys fees for aiding individuals and for participating in public hearings. That kind of an approach, I think, is critical if we are really going to tap into the expertise that now exists in the field.

The Federal Trade Commission has been involved in providing attorneys fees or hiring attorneys to represent the consumer interests in its own hearings. That is the kind of thing I think we would like to see more of.

Unfortunately, the other side of the coin is shown by the Social Security Administration. The SSI study group specifically mandated SSA to have legal services attorneys on an advisory panel to talk about the problems in the SSI program. After having had a couple of meetings, SSA is now indicating that it is not even willing to come up with the travel costs of these already financially strapped legal services attorneys to come to Baltimore for task force meetings. It seems to me that that is an area where, if it is anyway possible, there ought to be some legislative mandate to the Social Security Administration.

Mr. SCHNEIDER. Excuse me just 1 second. This is an administrative decision taken by the Social Security Administration. Previously travel vouchers?

Mr. NATHANSON. They provided travel for two meetings.

We have a letter in our office indicating that it looks as though SSA is not going to pay the travel for a few legal services lawyers from around the country to come to Baltimore to work with SSA on improving the SSI program.

I would like to highlight just a few special problems that have come up with respect to legal services for the elderly. One is the funding structure of the Older Americans Act and other Federal programs—the idea of "seed money" and maintenance of effort. We have heard from directors of several projects now serving the elderly who have encountered tremendous problems in the face of these unrealistic kinds of requirements. This is especially true, given the fact that local money is, first of all, generally very limited and a truly effective legal services program—that may be involved with challenges to some of the practices of local municipal agencies—may have an even harder time getting some of these limited funds from the local agency.

Paralegals Essential for Expansion of Legal Services

I think that State and local bar associations have to be educated to the fact that paralegals are critical to the development and expansion of legal services for the elderly. Spokesmen for the bar ought to voice that support, not just in public meetings, but should also go back to Michigan and to other places where paralegals are encountering problems from the organized bar.

Mr. Schneider. Excuse me. At that point could you provide any information you have of situations in various States where those problems do exist so that we can go back to the bars?

Mr. Nathanson. Yes.

I think that the private attorneys, especially in rural areas around the country, have to be educated to the fact that the setting up special elderly law units, whether they be funded through the Legal Services Corp. or through the Older Americans Act, is not going to take away business from local lawyers. Such offices are probably going to really generate more business by increased referrals and utilization of the legal process in general.

Fee Schedules Must Be Improved

As has been pointed out, if the private bar is going to get involved in dealing with the major legal problems of the elderly, the fee schedules under social security, SSI, and especially the situation under the Veterans Administration, must be improved.

I understand Senator Hart of Colorado has introduced legislation to do away with the $10 limitation on attorneys fees with respect to veterans cases; and in the House, Congressman Cohen has introduced similar legislation.

As I also understand——

Mr. Affeldt. I want to mention some points raised by the Veterans Administration. The Veterans Administration's $10 limitation is designed for a couple of purposes. First, to prevent a reduction in benefits for the veteran and his family. Second, the Veterans Administration maintains that this is not an adversary proceeding. The VA personnel actually work for the veterans in terms of receiving their benefits.

What would you say to those arguments?

Mr. Nathanson. Well, taking the latter question first, I think it is probably correct that in a vast majority of situations the counselors that the VA uses are very helpful and give out good information.

I think, however, that in any kind of a situation which challenges the basic system and therefore needs advocacy against the system—such as the kinds of cases we have seen coming out of legal services programs in general with respect to social security, SSI, food stamps—the various VA groups that get funded by the VA itself will not be in the forefront.

In addition, I am a little leery of saying it is not an adversary proceeding. We have heard that for years with respect to guardianship and involuntary commitment and I certainly believe individual representation is needed there.

I think there are various interests at stake in any of those hearings and a person has a right to independent counsel.

Could you repeat the first question that you asked? Your question had two parts and I often have trouble remembering both parts of two-part questions.

Mr. AFFELDT. I was asking you what your rebuttal would be to the Veterans Administration's arguments for limiting the fee to $10.

One, dilution of benefits. Second, this is essentially a nonadversary proceeding to help the veteran.

Mr. NATHANSON. I agree with the position that would not have these fees come out of benefits due. I would like to see that happen with respect to the social security fees. I think Congressman Cohen, in his legislation in the House, sets up a special fund for providing fees for attorneys who work in the VA area and I think that is the approach that we ought to be looking at instead of taking the fee out of the benefit.

Mr. AFFELDT. I shall ask Mr. Schneider if he has any questions.

MAKING EXPERTISE MORE READILY AVAILABLE

Mr. SCHNEIDER. One of the points that you made was the necessity of bringing the expertise available to the services from the program, make it available to private attorneys. What are you doing to make that expertise available to other practitioners in the area to be eligible to social workers and counsel, et cetera?

Mr. NATHANSON. Well, as you are aware, we have two grants. One is from the Administration on Aging to provide technical assistance to State and area agencies on aging in setting up legal programs for the elderly.

Above and beyond giving that kind of technical assistance, we are also involved in really answering substantive questions for the area agencies, for the State offices, and for anyone else in the aging network.

The legislative and administrative newsletter, which is put out by our Washington office on a weekly basis, goes to all area agencies, all aging groups, and anyone else that is interested. We are trying to build that network now.

One of the main things we have been involved in, in the last couple of years, is trying to bridge that gap between the legal services community on the one hand and the professionals in aging on the other, so they start to see the obvious interrelation. I guess if I were to use the word interface in this connection, you would know I am talking to aging professionals on a daily basis.

RECOMMENDATIONS

Mr. SCHNEIDER. Do you have any recommendations for steps that the Legal Services Corporation could take or should take to more adequately serve the elderly?

Mr. NATHANSON. Well, I think that one thing they ought to be doing is definitely focusing in some way or another on those people that can't come in to a legal services office. I don't have any doubt that legal services offices will serve anybody that will and can come into the office and can wait as long as clients often have to wait.

Saying "We will serve anybody that comes in," is not sufficient with respect to isolated individuals—especially the elderly—who have no means of transportation. The effort ought to perhaps aim not specifically at the elderly only, but rather at increased outreach efforts to get services to people who are not now coming into legal services offices. This would include rural segments of the population and I imagine in the long run would hit the elderly heavily anyway.

I am not sure exactly how I feel about specifically earmarking some dollars out of the corporation for the elderly. I would rather go the other way.

Mr. SCHNEIDER. What about requiring that in each legal service office that one or more of the individuals be specially trained to deal with the problems?

Mr. NATHANSON. Generally, I agree with something like that. However, you have to be careful when you create an elderly law specialist that the SSI specialist, the food stamp specialist, and all the other specialists don't start dumping their work on the elderly law specialist.

I think it is important that you have somebody in the office who has the big picture with respect to this client group, who works with aging organizations and who works with the bar associations. I think it is important to focus on these client groups because the elderly have a lot of friends and strengths which can be parlayed by a lawyer who is a part of the "aging network."

In addition, it is really important that the elderly law specialist sensitize other staff members of the legal services project to the special needs of the elderly.

EDUCATING PRACTITIONERS ABOUT USEFULNESS OF ATTORNEYS

Mr. AFFELDT. One point you made in prior hearings is that many practitioners don't know how to use legal services attorneys to benefit their programs or clientele. What tools do you think would be most effective in educating practitioners about the usefulness of legal services attorneys? How can they be sensitized?

Mr. NATHANSON. I think since that time in 1974, a lot has fortunately happened, such as the changes in the Older Americans Act and the existence of the legal services model projects. I think we are at a point now of having at least a basic level of sensitivity.

The next step is going to be some sort of real training at the local level, both with respect to the roles of lawyers, paralegals, social workers and others, and as to the substantial legal issues of importance.

I think it is important that social workers and lawyers be educated to see what their appropriate roles in the entire network are. Everybody ought to be doing what they are best at, as opposed to trying to do somebody else's job and spending time with professional jealousies—at the ultimate expense of needy older people. A perfect example is the area of protective services. This is an area where there ought to be a lawyer, a social worker, and a psychiatrist or a psychologist, working together.

Mr. AFFELDT. I thank you very much.

First, let me ask if Mrs. Fayé has any questions.

Mrs. FAYÉ. I would like to know what your relationship would be, that of the National Senior Citizens Law Center, with the new program that AoA is putting in, with a person in a State agency to handle legal advocacy.

Mr. NATHANSON. Well, our grant now from AoA is to provide technical assistance to State and area agencies on aging. I think it is up to the 29 States as to how to be involved in that program. Once the developers are in place, our job will be to provide them with technical assistance on how to set up legal services offices and also give them substantive backup or support if that is what they need. We now plan on having a training conference in January in Los Angeles for the developers from all 29 States.

Mrs. FAYÉ. My thought is you are already providing technical assistance to the State agencies and the area agencies. How does that relate to the person coming into the State agency?

Mr. NATHANSON. Well, last year we had a grant to give technical assistance to several States. Now the developer will be on the local scene, on a daily basis, able to talk to law schools, bar associations, and so forth, and we will be able to deal with the developer in each State who will be focusing all of his or her attention on developing legal services within the State.

Mrs. FAYÉ. Basically, are you going to be giving technical assistance to the developer?

Mr. NATHANSON. Yes. That is right.

Mrs. FAYÉ. But he would already be a lawyer as well?

Mr. NATHANSON. He may be a lawyer but that is not necessarily the same as being sensitive to legal problems of the elderly or being aware of what can be done in the State. The lawyer-developer will need special technical assistance.

Mrs. FAYÉ. These people are going to have to be trained then?

Mr. NATHANSON. I don't know. It depends.

Mrs. FAYÉ. Trained in the elderly problems area when they come in?

Mr. NATHANSON. The hope, of course, is that you can get somebody who has already been in the legal services program and is aware of the special legal problems of the elderly. That would be ideal, but in lots of situations you won't or you may have someone from a legal services program who is not aware of the intricacies of filing fee legislation or title XX as funding sources for an older Americans legal project, for example.

There are various pieces to the full education of one of these developers that we would hope to be able to provide.

Mr. AFFELDT. Thank you again for an excellent presentation.

[Testimony resumes on page 332.]

[The prepared statement of Mr. Nathanson follows:]

PREPARED STATEMENT OF PAUL S. NATHANSON

My name is Paul Nathanson. I am the executive director of the National Senior Citizens Law Center. The center is currently funded under two grants: the first grant, from the Legal Services Corporation, has allowed us to give substantive assistance to Legal Services Corporation attorneys so that they

could better serve the elderly poor. Thus, upon request from a legal services program, the National Senior Citizens Law Center (NSCLC) will draft pleadings, write memoranda and briefs, assist with litigation, act as cocounsel, otherwise participate in cases affecting the elderly, and provide legislative and administrative advocacy on behalf of clients of legal services programs. In the past our functions also included sensitizing legal services projects to the need for servicing the elderly poor and training legal services attorneys in the special substantive areas that affect the elderly. NSCLC's main office is in Los Angeles, Calif., but it maintains an office with three staff attorneys in Washington, D.C.

We are also funded under an Administration on Aging model projects grant to assist State and area agencies in 29 States to develop and expand legal services delivery systems specifically designed to aid the Nation's elderly.

STATEMENT OF THE PROBLEM

The Need

Perhaps more than any other group, the elderly rely upon complex public and private institutions for their daily subsistence. Therefore, their legal problems frequently relate to the policies and actions of governmental agencies and private corporations, both of which often present undecipherable bureaucratic mazes which even younger persons find difficult to manage. Many of these elderly people now classified as "poor" were, at one time, a part of the mainstream of middle America, and became poor only when forced to live on fixed incomes at age 65. Worse, the income of these newly poor elderly people is constantly reduced by inflation.

Superimposed upon the lives of the low-income elderly is a vast array of complex statutory, regulatory, and decisional law. Their shelter may be provided or secured under Federal and State public and subsidized housing laws, relocation laws, environmental protection laws, and zoning laws. Their health is often dependent upon medicare, medicaid, laws regulating nursing homes, and laws relating to the advertisement of prescription drugs. Their nutrition is often secured by the food stamp program and nutrition programs established by other Federal laws. The source of their income may be social security, supplemental security income under title XVI of the Social Security Act, or private pensions. The dignity of personal freedom and control of property is subject to the vagaries of the law of guardianship, conservatorship, and involuntary commitment.

Thus, the elderly are, on the one hand, confronted with a vast complex of crucial legal issues, bureaucracies, and forms with which to deal; and on the other hand, they have no real place to turn for adequate and effective assistance. Unlike younger people, who have been forced from birth to live under governmental programs and large bureaucracies, today's elderly have not learned to "work the system." Because the elderly have no place to turn for assistance, and because they are not adept at working the system, the elderly as a distinct group in our population, are the least able to deal with issues of a legal nature.

Before examining the available legal services resources and methods which may serve to increase these resources, I would like to take a moment to discuss some of the significant legal issues presently surfacing through the work of legal services attorneys serving the elderly. (I include in this category, attorneys funded by the Legal Services Corporation and other sources such as the Older Americans Act.) I think that, although the focus of these hearings is on the *expansion* of legal services, such a discussion may serve to crystalize and underscore the need for such services.

Over the past 10 or so years, legal services attorneys have won numerous victories which have had a significant impact upon the daily lives of elderly poor people in America. These run the gamut from results in individual cases to nationwide class action suits. I hope it will be informative to mention just a few—the listing is designed to provide an overview and is by no means intended to be exhaustive. The following major victories have been won in the last few years:

Income Maintenance Cases

Buffington and Elliott v. *Weinberger*, Civil No. 734–73C2 (W.D. Wash. 1974); 371 F. Supp. 960 (D. Hawaii 1974); No. 74–1611, 74–3118 (9th Cir. 1975)

These suits, consolidated before the Ninth Circuit Court of Appeals, assure all social security recipients facing recoupment of alleged prior overpayments

from their future benefits the same rights to advance notice and an opportunity for a hearing guaranteed to welfare recipients by *Goldberg* v. *Kelly*, 397 U.S. 254 (1970). *Elliott* was brought on behalf of a class consisting only of social security recipients residing in Hawaii, but since *Buffington* was brought on behalf of a nationwide class, the favorable district court order required the Social Security Administration to alter its notice and hearing procedures in all overpayment cases in order to comply. Although the Ninth Circuit's affirmance of both cases has been vacated by the Supreme Court for rehearing in light of *Mathews* v. *Eldridge*, 96 S. Ct. 893, the district court opinions in each case were thereby reinstated and the Social Security Administration has continued to abide by the revised procedures required by these orders. Under these procedures, before any overpayment can be recovered out of future benefits the affected recipient is entitled to an oral hearing on the question whether such recovery must be waived because the recipient was not at fault in causing the overpayment and because recovery would deny him the funds necessary to purchase adequate food, clothing and shelter.

Cardinale v. *Weinberger*, 399 F. Supp. 1168 (D. D.C. 1975)

This suit is also a notice and hearing case, this time involving the SSI program. Though SSI is unquestionably a welfare program whose recipients endure the same "brutal need" found by the Supreme Court to be dispositive in *Goldberg* v. *Kelly*, the Social Security Administration has sought to carve out a number of exceptions to the general requirement that SSI benefits could for no reason be reduced, suspended or terminated without advance notice and an opportunity for an oral hearing being provided to the affected recipient. These exceptions, ostensibly designed for such purposes as the correction of clerical error and the implementation of changes flowing from information provided by the recipient himself, were so broad as to swallow up the general rule. The *Cardinale* case successfully sought an injunction against use of the exceptions and a reaffirmation of the requirement of *Goldberg* that advance notice and an opportunity for a hearing be provided in all cases of potential reduction, suspension or termination of SSI benefits.

O'Connor v. *Weinberger*, Civ. No. 74-591 (D. D.C. 1975)

O'Connor was brought to correct the Social Security Administrations failure to provide SSI recipients whose benefits were at risk adequate notice of their rights to appeal. The original notice used by SSA in cases of reduction, suspension or termination of benefits did not, for example, inform the affected recipient of his right to an oral, adversary hearing before the adverse action would be commenced. After the entry of a temporary restraining order on behalf of a nationwide class of SSI recipients enjoining the use of the defective notice, the Social Security Administration stipulated to the substitution of a constitutionally adequate notice which is still in use.

Abascal v. *Weinberger*, No. C-73-2353 (N.D. Cal. 1974)

Abascal was another case which was successfully settled. Originally brought to force publication in the *Federal Register* of those portions of the Social Security Administration claims manual which address the SSI program, this suit was settled when the Social Security Administration agreed to provide these portions of the manual to legal services attorneys, paralegals and other advocate groups. It is the claims manual, rather than the statutes and regulations, which is actually used by Social Security claims representatives working in district offices to determine a recipient's entitlement to and amount of benefits. It is in a very real sense the operating law of the program. Regular and easy access to the manual was therefore essential to attorneys and paralegals who were representing SSI claimants and recipients on a regular basis. As a result of the *Abascal* suit, SSA has provided such regular access by mailing claims manual transmittals pertinent to the SSI program to all legal services programs in the country.

Santos v. *Weinberger*, No. 75-166G (D. Mass. 1975)

This case was brought on behalf of all applicants for SSI benefits filing claims at the Cambridge, Mass., Social Security district office and was designed

to enforce Congress' intention that SSI applications be disposed of at least as promptly by the Social Security Administration as were welfare applications by the States in the programs which preceded SSI. Despite Congress' design that SSI be a more efficient program than its predecessors, and despite the fact that applicants for benefits under these predecessor programs were entitled to receive a response to their applications within a time certain (either 30 or 60 days, depending on the program), the Social Security Administration has failed to impose any limits whatever on itself for issuing initial determinations in response to applications for SSI benefits. The *Santos* suit sought an order requiring the imposition of such limits and has to date resulted in the issuance of a preliminary injunction requiring that all applications for SSI benefits filed by claimants 65 years of age and over be acted upon by the Social Security Administration within no more than 45 days.

Health Cases

Franssen v. *Juras*, 406 F. Supp. 1375 (D. Ore. 1975)

This suit successfully sought on behalf of a class of medicaid patients residing in Oregon an injunction against the State's scheme of calculating a medicaid recipients income on the ground that it conclusively presumed that a recipient who was institutionalized in a nursing home had available the income and resources of his/her spouse, regardless of whether such income and resources were in fact available. The conclusive presumption was struck down by a three-judge panel as violative of title XIX of the Social Security Act.

Martinez v. *Richardson*, 472 F.2d 1121 (10th Cir. 1973)

Martinez was a notice and hearing case involving the medicare program. It successfully sought a permanent injunction barring the Social Security Administration from terminating inhome medical services provided to elderly people under the program without affording a prior hearing on the question whether such services continued to be needed.

If a nursing home goes out of business or is decertified from the medicaid program and the State and/or home wants to move patients immediately for financial or other reasons to another home, a major problem facing the patient is the high mortality rate resulting from nursing home "transfer trauma." Several legal services programs around the country have established, through litigation, rights of nursing home patients to prior hearings and adequate advance transfer planning.

Housing Cases

Underwood v. *Hills*, No. 76–469 (June 8, 1976)

Underwood was filed on behalf of a nationwide class of tenants in housing projects that are federally subsidized pursuant to §236 of the National Housing Act. It successfully sought an injunction requiring the Secretary of Housing and Urban Development to make the payments for operating subsidies to §236 housing project owners required pursuant to 12 U.S.C. §§1715z–1(f)(3),(g).

Hall v. *Flournoy*, California Superior Court, County of Alameda, No. 450144–4 (Jan. 15, 1976)

Hall held that recipients of SSI in California are entitled to homeowner's property tax relief thereby overturning the existing practices of the State taxing authority.

Even in the face of such major decisions, nothing is perhaps as moving as the following self-explanatory letter recently received by the National Senior Citizens Law Center with respect to a case involving the eligibility of the plaintiff for a civil service retirement annuity where denial was based upon alleged voluntary separation, but in point of fact, plaintiff had been forced to terminate employment in the face of unsupported allegations of homosexual conduct:

". . . So let me thank you most sincerely for whatever you did for me. I had tried for over 17 years to negotiate the return to me of my right to a pension for nearly 30 years of Government service—mostly abroad. Now it is all over—thanks to you, Mr. Hardin, and others of your service.

"It gives me great satisfaction to tell you that last Friday, Sept. 3, I received two U.S. Treasury checks viz: For $28,654 and for $1,200; the first one being a settlement for all back pension to February 29, 1976 and the other one for the monthly payments March–August 1976 at $200 per month. Also I was informed I would receive $200 monthly from now on.

"I am deeply grateful for everything—now that you and your service have accomplished what I tried to do alone for so long. . . ."

Obviously, benefits to clients derive not only from actual litigation, but from the general substantive expertise of legal services attorneys and from the enhanced credibility given the negotiations of such attorneys by the mere threat of potentially successful litigation. Thus, at the simplest level, merely being able to decipher and understand complex pension reports and their significance, recently resulted in the discovery of pension credits previously overlooked and the ultimate issuance of a check for $14,668.57 to the client for retroactive benefits. In addition, the retiree (and his spouse if he predeceases her) will now receive a monthly annuity of $357.77.

Some issues currently being litigated (and which might well prove extremely fertile for administrative or legislative change) include:

Income Maintenance Cases

1. Due process challenge to the 5-month waiting period which title II disability recipients must endure before their benefit payments may begin.
2. Eligibility of plaintiff for civil service retirement annuity where denial was based upon alleged voluntary separation but the plaintiff was forced to terminate employment in the face of unsupported allegations of homosexual conduct.
3. Unduly long SSI application delays.
4. Compliance by trustees of various pension plans with their duty to formulate reasonable eligibility criteria.
5. Whether the Federal Pension Reform Act of 1974 preempts California community property law so as to prevent a court from ordering that pension payments due one spouse be paid directly to the other spouse.
6. Whether pension plan discriminates against seasonal workers in the design and implementation of its eligibility conditions.
7. Constitutionality of Social Security Act provision terminating benefits of fully insured individual upon deportation under specified circumstances.
8. Constitutionality of Social Security Act provision denying to divorced husbands of fully insured individuals benefits equivalent to divorced wives of fully insured individuals.
9. Whether trustees of a pension plan requiring 15 years of credited service as a condition to entitlement to a pension may deny benefits to a worker who has completed 21 6/12 years of credited service on account of a break in service when the break occurred because the worker reasonably continued working for an employer whose employees had previously been covered by the plan; a subsidiary issue is whether the trustees may reasonably require that the minimum amount of future service credit necessary to trigger recognition of past service credit must be worked during the first 5 years of the plan's existence.
10. Constitutionality of the Civil Service Commission procedures for recoupment of overpayment of Civil Service pensions.
11. Validity of practice which limits SSI emergency advance payments to three categories of impairment and which fails to make presumptive disability determinations in advance of final determinations.
12. Validity of HEW regulations which inhibit the reopening of applications for disability benefits under title II of the Social Security Act by imposing time limitations and by creating the concept of "administrative res judicata" without statutory authority.

Health Cases

1. Constitutionality of medicaid deeming regulations which require the income of an out-of-institution spouse be applied to the institutionalized spouse's income in determining medicaid eligibility for nursing home care.
2. Constitutionality of provision in title XVIII which permits carriers to make final and binding determinations with respect to contested claims under part B.

3. Class action against an individual nursing home, the State and Federal governments alleging violations of the U.S. Constitution, Civil Rights Act, Federal medicaid regulations, breach of contract between the State and nursing home and intentional infliction of emotional distress on behalf of all recipients in the defendant nursing home. The specific rights alleged to be violated include: (1) the right to manage personal monies and/or receive an accounting, (2) the right to meet with legal counsel, (3) the right to notice before transfer, (4) right to have an adequate level of care, (5) right to access to medical files.

Other Cases

1. Constitutionality of the Federal food stamp regulations that permit benefits to be terminated at the end of a certification period without the right to a prior hearing.
2. Whether a public housing authority may reduce security measures in an elderly housing project without giving the occupants a meaningful opportunity to protest the change and present reasons in support of their protest.
3. Constitutionality of involuntary guardianship statutes.
4. Whether the imposition of a special assessment in excess of one-half the value of the property in question is constitutional.

Unfortunately, negotiation or litigation are not always successful and the only approach available may be legislative or administrative change. In this regard, the following issues come to mind:

1. Delays in processing applications for SSI and in the SSI appeals process are inordinately long, and legislation is needed to place reasonable time constraints upon the Social Security Administration.
2. The SSI "6-month rule" provides that a married individual, separated from his/her spouse, will continue to be treated as married for purposes of SSI benefits until he/she has been living apart from the spouse for more than 6 months. This means that each spouse will receive only one-half of the couple's payment (which is less than two individual payments) rather than each receiving a full individual payment (even though he/she is actually living alone) until 6 full months after their separation. The only exception to this 6-month rule is the termination of the marriage by death, divorce, annulment or when one spouse begins living with another party and they hold themselves out as husband and wife. Furthermore, a recipient's income includes the income of his or her eligible spouse. Thus the couple's grant is reduced by the spouses income before it is divided in half and paid to each separated spouse. For example, if a husband has a $200 per month pension benefit, the couple's SSI grant is $56.60. Husband and wife each receive a monthly check of $28.30. If they separate and he refuses to provide her with part of his $200 pension, she is left to live on $28.30 per month for a full 6-month period! Thus, the 6-month rule may operate to reduce aid below the level needed for subsistence or to terminate or deny it entirely despite the need of the separated spouse. This is particularly a problem of the older woman, for the male spouse is more likely to have resources and income other than that provided by SSI benefits; such as, social security and/or veterans benefits.
3. The Social Security Act presently authorizes the appointment of a representative payee (a fiduciary) for purposes of receiving title II and title XVI supplemental security income benefits without prior notice or a hearing.
4. In probably over half of the States (HEW has not indicated the exact number), a noninstitutionalized spouse is forced to pay an arbitrary amount of his or her monthly income to the institution for the care of the institutionalized spouse. Medicaid then pays the difference to the institution.

The amount which the noninstitutionalized spouse pays to the institution (the amount which is deemed available to the institutionalized spouse) is arrived at in any number of arbitrary methods, but always without regard to the actual expenses of the noninstitutionalized spouse. Consequently, if the cutoff level (that is, the amount which the noninstitutionalized spouse can keep) is low enough, that spouse will face a serious crisis. Since the individual will often have numerous fixed expenses—such as, rent payments, utilities, transportation costs, insurance, etc.—the arbitrary amount which he or she is allowed to keep will rarely reflect actual costs and income needs.

Often, the arbitrary amount which the noninstitutionalized spouse is permitted to keep will represent only a third or half of his or her previous income. In such a situation, the alternatives are: (1) to refuse to pay the deemed

amount to the institution, (2) to pay the amount, or (3) to obtain a divorce. The first alternative leads inevitably to the eviction of the institutionalized spouse, since medicaid has conclusively presumed that that income is available and does not meet those costs if the noninstitutionalized spouse fails to pay. The second alternative reduces the noninstitutionalized spouse to the poverty level, and will, at least, force a substantial change in the standard of living. The third alternative is an emotionally disturbing process, especially difficult for elderly couples.

5. Mandatory retirement and other forms of age discrimination are in need of legislative reform as numerous challenges through the courts have been unsuccessful.

I hope the above discussion serves to show some of the significant legal issues of concern to the elderly and, at the same time, the kind of expertise and sensitivity which resides within the legal services community. Legal services attorneys can thus be a tremendous resource to legislative and administrative bodies interested in designing or modifying programs so that they will most effectively help the Nation's elderly. I think there can be no greater argument for the expansion of legal services for the elderly than these activities and concerns. Although there has been, and will be, much discussion of the role which the private bar can and should play in the overall legal services delivery system, I would strongly underscore our feeling that the advocacy function illustrated by the above discussion and examples can only be effectively carried out by an adequately funded legal services program staffed by attorneys specifically dedicated to serving the less affluent members of society. Thus, although, for example, the present social security and SSI statutes specifically provide for fees for the handling of such cases, and numerous individual cases are handled by private practitioners, the major impact cases and suggestions for legislative and administrative reform are almost exclusively the domain of publicly funded legal services attorneys.

MAGNITUDE OF PROBLEM : PAUCITY OF RESOURCES

At least 20 percent of the Nation's 29 million poor people are elderly. Regarding the availability of legal services for the poor in general, Thomas Ehrlich, president of the Legal Services Corporation has said:

". . . all but a small fraction have no access to assistance when they face a legal problem. For all but that small fraction, the legal system is beyond reach.

"A recent study indicated that about 23 percent of the poor face a legal problem each year. In the main, they are relatively routine matters involving housing, consumer law, family law, and administrative benefits. But to the individuals involved, these matters often assume crisis proportions. For most people, a defective car can be a substantial irritant. But for a poor person, it may well mean unemployment. A poor person's problem with a landlord may mean no housing at all. Then denial of social security payments can be disastrous.

"Legal aid lawyers are currently able to handle only about 1 million of these problems each year—something less than 15 percent of the real need as determined on a conservative basis. . . ." [1]

Statistics concerning the availability of legal services for the elderly from Legal Services Corporation grantees present an even more grim picture. Although the elderly comprise over 20 percent of the Nation's poor, they comprise only approximately 6 percent of the client load of the average Legal Services Corporation grantee.[2] Thus, the low-income elderly receive only little of the

[1] Remarks of Thomas Ehrlich, president, Legal Services Corporation, on "Justice for the Poor: Public and Private Responsibilities"; presented before the Los Angeles County Bar Association, May 5, 1976.

[2] The 6 percent figure is an estimate resulting from an informal survey conducted by the Office of Legal Services, Office of Economic Opportunity (OEO). As to the disproportionately low representation of the elderly within legal services offices, see B. Terris, *Legal Services for the Elderly*, Senior Opportunity & Services Technical Assistance Monograph 9, National Council on Aging (1972). This early and well-documented work suggests that the reasons for this disproportionately low representation of the elderly may include the inability or lack of desire of elderly people to reach or use available poverty legal services, and the concentration of poverty attorneys on younger clients. A 1975 study of the availability of legal services to the general indigent population sheds further light on the plight of the elderly. This study, performed by the Legal Action Support Project of the Bureau of Social Science Research, demonstrates a ratio of one legal services attorney to 13,239 eligible poor persons. Further, over 40 percent of the financially eligible persons in the United States live in locations providing no access whatsoever to legal services projects. 9 Clearinghouse Review 469 (1975).

nominal legal services provided generally for the Nation's 29 million poor persons. The millions of elderly people who are above the poverty guidelines, but who cannot afford a private attorney have even less access to legal representation.

The problem of providing legal services to the rural elderly deserves special mention. Very little has been done to provide the rural elderly with access to legal services. Far fewer of the rural poor have access to legal services than do their urban counterparts.[3] Transportation problems further compound the problem of delivering legal services in rural areas to the elderly. Because of their limited mobility, and because of the great distances involved, the costs of providing legal services to the elderly in rural areas have traditionally been significantly higher than the costs of providing the same services in urban areas. The small number of attorneys (most often private attorneys, are the only ones available) in rural areas causes the burden of aiding the poor and near-poor to fall on the already overburdened shoulders of a few civic-minded attorneys who have very little time to spare.

POSSIBLE SOLUTIONS

Staffed Programs

In order to meet the legal needs of the elderly, specially staffed law programs funded primarily through title III of the Older Americans Act have been established to serve senior citizens. The location of these programs and examples of some of their innovative activities and experiments in the delivery of services are included within *A Manual of Funding Sources and Models for Delivering Legal Services to the Elderly*, published by NSCLC.[4] Unfortunately, to date, fewer than 100 such programs (which have less than an average of two attorneys per project) are in operation and even in conjunction with regular Legal Services Corporation programs these special law programs cannot begin to provide effective legal services coverage for the middle and low-income elderly.

The 1975 amendments to the Older Americans Act show Congress' clear intent that the Administration on Aging and its network of area agencies on aging place a high priority on the provision of legal services to the elderly. Although limited progress is being made in the expansion of legal services through this network, the other pressing social service needs of the elderly and the paucity of available funds lead to the conclusion that, absent drastically increased funding, the Administration on Aging will not be able to single-handedly shoulder the burden of providing legal services to the elderly.

A couple of specific problems have come to our attention, which relate to the scarcity of available funds, but which may be remedied by specific legislative changes. The first relates to the maintenance of effort requirements of the Older Americans Act. Thus, projects which are started with little monetary support or with support which is by its nature of short-term duration may well be unduly penalized when seeking title III funding for the continuation of their projects. In addition, although the "seed money concept" of title III and other Federal programs may have theoretical arguments in its favor, the extreme demands placed on local money, combined with the sometimes locally politically unpopular nature of an effective legal services project may lead to a situation wherein no funds are available for carrying on a legal services program for the elderly after the initial 3- or 4-year "seed money" period has expired. Although the concept may have validity and provide the desired results in certain circumstances—it may well be that the special nature of legal services requires an exception to this general rule.

As pointed out above, the knowledge and expertise of legal services attorneys, combined with the nationwide network they represent, can oftentimes be a major resource for legislative and administrative bodies concerned with the problems of the elderly. In this regard, such attorneys not only aid the cause of their clients as a group, but also provide a service to such agencies and bodies as they perform their oversight and administrative duties on behalf of the public at large. It is hoped that means will be developed and expanded by which legal services attorneys can be financially assisted in their efforts to

[3] As few as 17.5 percent of the poor in rural areas have access to legal services programs through the Legal Services Corporation, p. 57 of Legal Services Programs: Resource Distribution and the Low Income Population, Goodman, Leonard H., Walker, Margaret H., Bureau of Social Science Research, Inc., July 1975.)

[4] The table of contents of the manual is attached as appendix A [see p. 306]. Because of its length, it was impracticable to attach the entire Manual—it is, however, available from the National Senior Citizens Law Center (NSCLC) and the Administration on Aging.

make their services available to such public legislative and administrative bodies.

The Federal Trade Commission has recently adopted the policy of providing representation in its hearings to consumer interests. It does this by funding responsible organizations and attorneys to represent the consumers' interests. This appears to be an excellent beginning. However, most agencies may not be as receptive as the FTC and perhaps will need additional prodding or legislative mandates to expand their activities in such a way. For example, despite the recommendation of the SSI study group that legal services attorneys and other advocates of the poor be consulted by the Social Security Administration in the formulation of SSI policy, the elderly poor remain without representation at the policymaking level. Unlike other interest groups whose activities are regulated by a Federal agency, the elderly poor have no voice in the policies which affect their receipt of social security or SSI benefits. Although SSA has made an attempt to put together an advisory group of legal services attorneys, and this group has met with SSA officials twice, this project is doomed to failure because thus far SSA has refused even to agree to reimburse the attorneys for their travel and per diem expenses incurred in attending the meetings in Baltimore.

Regarding other alternatives for funding elderly law programs, I would call your attention to the appendix which describes and analyzes various government and private sources for funding special law programs. Additionally, I would like to briefly call your attention to two alternative methods of providing funding which although not generally utilized have great potential for providing a stable source of funding for elderly law programs:

Filing fee legislation, which has been enacted in Florida, Oregon and Nevada, generates revenue for legal services programs by imposing additional fees on pleadings and papers filed in court. What is unique about such legislation is that it provides a funding source without either using monies otherwise available for other social service programing or requiring an allocation of funds from the States' general revenue. Also, filing fee money can be used as local match in obtaining other monies with which to fund a seniors law program. (A more complete discussion and statutory citations are included in the appendix.)

Another alternative for capturing resources to provide manpower for legal services is a lawyer referral service. Such a service currently operates in Orange County, Calif., and generates $160,000 per year in revenue. The service requires a $10 or $15 fee (depending on the client's income) for initial consultation with an attorney. This money is donated to the legal services program and is used to supplement the monies the program receives from the Legal Services Corporation.

In an effort to determine the effectiveness of the network of elderly legal services programs, and how these programs perceived the problem of providing legal services to the elderly, the National Senior Citizens Law Center conducted a survey by questionnaire of 73 projects specifically providing legal services for the elderly.[5] From the 32 programs that responded to the survey, we discovered that among these services providers, there were serious questions regarding their ability to be effective because of the limited resources available. Fifty-eight percent of those responding indicated that their present staff size was inadequate to meet their projects' present elderly caseload. Eighty percent responded that their staff size was not adequate to meet the demands of the potentially eligible elderly community.

Our survey clearly indicated that the network of senior citizen law programs is still in its infancy. Administration on Aging efforts to expand the availability of legal services to the elderly must continue. The network of legal services programs serving the elderly must be expanded to provide senior citizens with access to legal services within every planning and service area within the nation. This means that area agencies on aging, Legal Services Corporation grantees, and others (both public and private) will have to contribute more of their resources toward funding staffed legal services programs.

Even if adequate funding for the staffing of special projects were available, lawyers and paralegals staffing these offices will only be as effective as the training, substantive materials and manuals and backup specialized services they have available to them. As has been noted before, the substantive areas

[5] See NSCLC survey attached as Appendix C [see p. 323].

of the law concerning SSI, nutrition programs, social security, public and private pensions, guardianship, medicare, medicaid, nursing homes, veterans benefits, mandatory retirement and age discrimination are very complex; training and other support services in these areas have traditionally been very meagre. The National Senior Citizens Law Center and several other AoA model project grantees may in actual fact represent very close to the sum total of these support services presently available.

An obvious way of increasing the effectiveness of existing special field programs (and, as is discussed below, the private bar also) is for the existing resources providing training and other technical assistance to receive continued and expanded financial support. It is hoped that both the Administration on Aging and the Legal Services Corporation will take a leading role in making certain that these critical support services will be provided.

Regarding training and other support services, 60 percent of the projects responding to NSCLC's survey indicated they have utilized backup services or other model project services for such assistance. Of the 40 percent who indicated they had not used a backup service, 96 percent of them said they would do so if an appropriate case arose. 96 percent of the respondents indicated that they were interested in attending training conferences at which training would be provided by a backup center. When asked the type of training and technical assistance which they felt was necessary, 87 percent requested training in the area of nursing homes, 80 percent requested training in the areas of social security and SSI, 77 percent requested training in consumer problems concerning the elderly and 73 percent requested training in guardianship and involuntary commitment. (The analysis of training needs are more completely delineated in Appendix C [see p. 323]).

The Private Bar: A Potential New Source of Legal Assistance [6]

Legal Services attorneys acting specifically on behalf of the elderly can increase their effectiveness by complementing rather than duplicating the conventional sources of legal assistance in the community. Here again, by stimulating other legal resources in the community to recognize and adopt roles in a coherent scheme for the representation of aged persons, legal services attorneys can reserve their time for services which they alone can provide.

Attorneys general, city attorneys, county attorneys, and other government attorneys, for instance, should be persuaded to devote more of their legal resources to aiding the elderly. This might include assistance with problems relating to consumer fraud, property tax exemptions, special assessments, guardianships, involuntary commitment, nursing homes, and probate matters. In each instance, individuals concerned with the rights of the elderly should examine the charters and statutes creating such legal offices for ways in which these offices can begin to assist the elderly.

On a nationwide basis, the organized bar has hitherto limited its activities to forming committees of the American Bar Association to study the legal problems of the elderly.[7] Hopefully, however, some concrete volunteer programs, especially programs utilizing the vast resources of retired attorneys, can be devised and implemented to serve the elderly. The ABA is apparently becoming aware of this latent potential in its older members. A past president of the association—taking a cue from the activities of retired business executives in SCORE [8]—recently suggested that retired attorneys be mobilized under ABA auspices to provide legal help for other retirees.[9]

Assistance may also be obtained from other organizations. A Jewish organization in Los Angeles, for example, is using member attorneys to provide volunteer assistance in a primarily elderly neighborhood. Another recent development has far-reaching potential. In Los Angeles, a reserve contingent of the civil affairs unit of the Army decided to devote the time of reservists to legal services for the needy. One office served primarily older people. Failing the necessary approvals from Washington, this program has been halted.

[6] A substantial part of the following testimony is combined in an expanded article cited as: Nathanson, Paul, *Legal Services for the Nation's Elderly.* 17 *Arizona L. Rev.* 275 (1975)

[7] The ABA family law section and probate and trust section have special subsections dealing with the elderly.

[8] SCORE is an acronym for Service Corps of Retired Executives. See generally 42 U.S.C. §§ 5031–5032 (Supp. III, 1973).

[9] Nationwide program to provide free legal service to elderly sought by ABA president, ABA Release No. 111574 (Nov. 18, 1974).

The problem of providing truly adequate legal representation to the elderly cannot be solved without full and effective participation by the private bar. Although members of the private bar may provide some services on a pro bono basis, their participation as private attorneys will largely be on a compensatory basis. The thrust of any effort to increase the availability of legal services for the aged from the private bar, therefore, must be to identify services which can be provided on a fee-generating basis and to develop methods for providing these services at a cost which the elderly can bear.

As noted, a substantial portion of the legal concerns of the aged relate to government benefit programs. The development of assistance from the private bar in the pursuit of these benefits is trapped in a vicious circle. The belief of private attorneys that practice in this area cannot be remunerative prevents them from developing expertise concerning entitlement to benefits.[10] The circle is completed when this lack of expertise prevents the development of office practice methods which permit assistance within feasible cost parameters including reasonable remuneration for the attorney.[11] Thus, if sufficient compensation were available for representing elderly clients with benefit disputes, an incentive would exist to develop the necessary expertise.

Social security, SSI, and veterans benefit statutes establish fee systems which may well act to deter private attorneys from pursuing claims on behalf of elderly clients[12] since the Social Security Act[13] and other programs[14] regulate fees. For example, the Social Security Administration sets a reasonable fee upon the application of the representative of a claimant successful in an administrative hearing.[15] The fee is contingent in nature. If the administrative proceedings result in the award of past-due benefits,[16] the representative may receive directly from SSA a fee not to exceed 25 percent of such benefits.[17] In successful proceedings before a court, the representative receives a reasonable fee set by the court, but not exceeding 25 percent of the past-due benefits resulting from the judgment.[18]

This system is irrational. The fact that fees are deducted from past-due benefits not only unduly burdens needy claimants, it also encourages attorneys to delay presenting claims so that retroactive benefits will accumulate, increasing the maximum fee.[19] Moreover, existing fee levels are considered grossly inadequate by those few attorneys practicing in the field.[20] As a result of the restrictive fee system, less than 2 percent of dissallowed claims ever reach the courts, even though courts have overturned the administrative decision

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[10] See generally, joint hearing on Improving Legal Representation for Older Americans, before the Senate Special Committee on Aging and the Subcommittee on Representation of Citizen Interests of the Senate Committee on the Judiciary, 93d Cong., 2d Sess. (1974) (hereinafter cited as joint hearing on legal representation).

[11] For an excellent overview of problems of access to legal services, including questions regarding use of paralegals, group legal services, government-funded legal services, and fee mechanism, see Symposium, 4 *U. Tol. L. Rev.* 353 (1973). For a lengthy and complete bibliography dealing with all aspects of delivery of legal services, see Brickman, *Legal Delivery Systems—A Bibliography*, 4 *U. Tol. L. Rev.* 465 (1973).

[12] The general situation is well summarized by Yarowsky, *Attorneys' Fees in Social Security Proceedings: A Criticism of the Official Restrictive Design*, 17 *Kan. L. Rev.* 79, 88 (1968):

> The issues of attorneys' fees in social security proceedings is closely tied to legal aid. If the claimant does not meet the standards for indigency established by the local legal aid program, he is generally referred to the local bar association. However, if no private attorney will take the case because of the fee problems involved, the claimant who desires an attorney has no one to champion his cause. While some legal aid societies will represent those for whom the referral system has failed, this places the burden of the claimant's litigation on society even though the claimant, through the fees allowed, has an "ability to pay." Such procedure seem (sic) contrary to the concept of legal aid. This problem would not arise if the private practitioner were permitted to earn what his time and effort were worth.

[13] 42 U.S.C. § 406(a) (1970).

[14] 42 U.S.C. § 1383(d)(3) (Supp. III 1973)(SSI); 38 U.S.C. § 3404(c) (1970) (veteran's benefits).

[15] 42 U.S.C. § 406(a) (1970); 20 C.F.R. § 404.975(b) (1975). Claimants may be represented before the Social Security Administration by lay persons, 42 U.S.C. § 406(a) (1970); 20 C.F.R. § 404.971 (1975); *cf. id.* § 404.972(b), but unlike attorneys, the particular qualifications of such lay representatives are taken into account in allowing fees. *id.* § 404.976(a)(6), and they are ineligible for direct payment from past-due benefits. *Id.* § 404.977(b)(2). See 42 U.S.C. § 406(a) (1970).

[16] *Hopkins* v. *Cohen*, 390 U.S., 530, 531035 (1968).

[17] 42 U.S.C. § 406(a) (1970); 20 C.F.R. § 404.977(b) (1975).

[18] 42 U.S.C. § 406(b) (1970); 20 C.F.R. § 404.977(a) (1975).

[19] *Blankenship* v. *Gardner*, 256 F. Supp. 405, 410 (W.D. Va. 1966); Yarowsky, *supra* note 12, at 84.

[20] For a practitioner's view of the fee scheme, see Yarowsky, *supra* note 12.

in 63 percent of the appealed cases.[21] In addition, only 5 percent of all claimants are represented by attorneys at the administrative level,[22] even though a vast majority of such cases involve complex matters regarding proof of disability.[23]

The fee situation with respect to veterans benefits may only be characterized as bizarre. The statute limits fees to $10 for any one claim before the Veterans' Administration (VA).[24] In addition, the decisions of the VA on any question of law or fact regarding a claim for benefits or payments are final and not subject to any judicial review.[25] The $10 fee limitation clearly inhibits private attorneys from ever taking a case on behalf of a veteran. Veterans' organizations argue that they, the Red Cross, and other groups provide very effective counseling for veterans. This is exactly the kind of counseling that should be encouraged, but it should not be considered a substitute for necessary legal assistance. These organizations depend largely on the good will of the VA for their efficacy. Moreover, these groups work with the VA on many matters other than benefit entitlement, and it is plainly in their interest to maintain good working relations. Therefore, a claim challenging a statutory or regulatory scheme and VA procedures has little chance of ever being asserted by these organizations. Without private counsel, it seems unlikely that such cases will come to the fore. Of course, without judicial review, there is even less chance of airing such issues. In light of the extremely restrictive provisions regulating fees in veterans benefit cases, the only solution to this stalemate appears to be amendment of the statutory scheme.

In cases that can generate even modest fees, including social security and SSI claims, another method exists for breaking the vicious circle inhibiting the private bar from pursuing government benefits for the elderly. An initial investment in developing office practice procedures, including specialization and routinization of a lawyer's tasks, could allow the private practitioner to increase his representation of the elderly without altering the basic practice of a small private firm. Greater efficiency results in greater profits for the time invested. If an attorney can represent many clients with small claims, charging small but adequate fees, it may be profitable to serve such clients. Many of the special legal services sought by the elderly are susceptible of routinization and simplification. For example, manuals could be prepared for social security and SSI claims which would allow assistants to prepare a case for ultimate review by an attorney. Many of the tasks presently performed by attorneys are unnecessarily complicated and could be simplified to allow more efficient treatment of individualized problems.

The natural adjunct to the specialization and routinization of the lawyer's job is the effective and expanded use of paralegals.[26] Paralegals are being employed increasingly in private practice; their utility is well established within Legal Services Corporation programs because of the very limited resources available to attorneys for the poor.[27] Paralegals can handle routine substantive matters, do initial client interviewing, go to aged individuals who cannot come into the office, handle administrative appeals, and do factual investigations.[28] It may be particularly advantageous to employ elderly people as

[21] *Id.* at 80. See also *Scott* v. *Celebrezze*, 241 F. Supp. 733, 736 n.21 (S.D.N.Y. 1965) (citing 47 reversals and 27 affirmances in volumes 227 to 236 of the Federal Supplement); *Seldomridge* v. *Celebrezze*, 238 F. Supp. 610, 620 n.17 (E.D. Pa. 1965) (75 percent reversals in volumes 231 to 234 of the Federal Supplement).

[22] Yarowsky, *supra* note 12 at 79.

[23] *Id.*

[24] 38 U.S.C. § 3404(c) (1970); *Hoffmaster* v. *Veterans Administration*, 444 F. 2d 192 (3d Cir. 1971) (constitutionality upheld). However, a recent decision by the Ninth Circuit in *Gendron* v. *Saxbe*, 501 F. 2d 1087 (9th Cir. 1974), holding that the question of the constitutionality of the $10 fee limitation did not present an insubstantial constitutional question for purposes of convening a three-judge court, is an indication that the provision might be found to deprive the veteran of his right to counsel, equal protection, or procedural due process. The court observed that the United States Supreme Court had never passed on the validity of the provision of the context of the constitutional rights of the veteran, as opposed to the rights of an attorney seeking fees. *Id.* at 1088–89. Accord, *Staub* v. *Johnson*, 44 U.S.L.W. 2169 (D.C. Cir. Sept. 15, 1975).

[25] 38 U.S.C. § 211(a) (1970); *De Rodulfa* v. *United States*, 461 F. 2d 1240 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 949 (1973) (constitutionality upheld).

[26] See B. Terris, *supra* note 2, at 23–25; Fry, *The Senior Citizen Paralegal: An Advocate for the Elderly Poor*, AGING Jan.-Feb. 1974, at 11.

[27] See Lander, *Legal Assistants: The Experience of the Legal Aid Society of the City and County of St. Louis*, 6 Clearinghouse Rev. 663 (1973).

[28] According to informal information and funding proposals reviewed by NSCLC staff, the vast majority of legal projects serving the elderly use paralegals extensively.

paralegals. Elderly clients may respond more openly to questions and suggestions from their peers than to those of a younger person.[29] A further benefit is that some older individuals will thus find meaningful employment.[30] It is however, critical to note that, in order to fully realize the potential of paralegals in the delivery system, restrictive regulations promulgated by local bar associations designed to preserve the entire delivery domain for licensed attorneys must be carefully scrutinized for their potentially adverse impact on the elderly's access to justice and needed legal services.

Experience in using standardized methods and paralegals in a variety of legal specialties indicates the potential of this practice method. Preliminary findings show lawyers saving from 25 to 50 percent of the time normally required to perform some services.[31] An analysis of the tasks involved in corporate formation confirms that delegation of ministerial tasks to paralegals can reduce the cost of providing this service by one-half.[32] Adequate figures have not been developed for legal services of interest to the aged. The reduction in cost to the client made possible by such efficiencies may bring many needed services within the reach of elderly people of moderate means. Legal services attorneys can encourage the private bar to involve itself in aiding the elderly by making their expertise available in the development and preparation of such methods.

A prime example of combining routinization, specialization, and the use of paralegals is the legal clinic of attorneys Jacoby and Meyers in Los Angeles.[33] This office has pioneered the use of kits and paralegals in order to provide low cost legal assistance to low and moderate income individuals. From all indications, a successful private practice has resulted.[34] The experience of Jacoby and Meyers, however, brings to the fore one problem which must be dealt with by the private bar if low cost legal assistance is to be available to the moderate income individual: the prohibition of advertising by private practitioners.[35] If profit, and derivatively, significant involvement of the private bar rests on a large volume of clients paying smaller fees, it is critical to let potential clients know about available low cost services.[36]

Another possibility for providing low cost legal services for the elderly is through a prepaid legal services plan. Without adding to the large and growing literature on such plans,[37] it is worth noting that they may be designed to conform almost perfectly to the needs of many elderly people. The elderly may participate in such plans on several bases—as union members or as members of senior citizen groups or of other organizations which have special benefit plans for older members. The first and perhaps most likely way is through union membership and participation in a plan which benefits retirees as well as active members. A recent amendment to the Taft-Hartley Act,[38] which permits employers to provide legal services as an employee benefit under collective bargaining agreements, promises to catapult group legal service plans

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[29] See, e.g. Fry, *supra* note 26, at 11; *Joint hearing on legal representation, supra* note 10, at 30–31; National Senior Citizens Law Center, *Senior Legal Assistants*, 7 Clearinghouse Rev. 273 (1973). See also Collins, Flanagan, & Donnelly, *The Senior Citizens Project of California Legal Assistance: An Action Arm of the National Senior Citizens Law Center*, 6 Clearinghouse Rev. 22 (1972).

[30] B. Terris, *supra* note 2, at 25.

[31] K. Strong & A. Clark, Law Office Management 93 (1974).

[32] American Bar Association special committee on legal assistants, Liberating the Lawyer: The Utilization of Legal Assistants by Law Firms in the United States, 44–45 (Prelim. Draft, 1971).

[33] Disco and Meyers, *Legal Supermarkets*, Harper's Magazine, July 1973, at 30.

[34] It should be noted that the office does not specialize in legal problems of the elderly, but in problems of the moderate income individual. Many of those problems, however, are also problems of the elderly, such as wills, social security, disability claims, and small claims court matters.

[35] ABA, code of professional responsibility, DR 2–101(B) (1975); Cal. Bus. & Prof. Code § 6076, rules 2–101 to –102 (West Supp. 1975). The California bar has instituted proceedings against Jacoby and Meyers. Disco and Meyers, *supra* note 33 at 30. It should be noted, however, that it has not been clearly established that advertising was involved in this case.

[36] Legal services attorneys are presently allowed to advertise the availability of free legal services to their potential client community. ABA, code of professional responsibility, DR 2–101(B) (1975); Ariz. Ethics Op. 74–7 (1974).

[37] See, e.g., Hallauer, *The Shreveport Experiment in Prepaid Legal Services*, 2 J. Legal Studies 223 (1973); Politz, *Prepaid Legal Services—The Shreveport Plan: The Long-Sought Answer?* 7 Trial, Mar.-Apr. 1971, at 29; Roberts, *The Shreveport Plan for Prepaid Legal Services—A Unique Experiment*, 2 *La. L. Rev.* 45 (1971).

[38] 29 U.S.C. § 186(c)(8) (Supp. III, 1973).

into prominence as a means of financing services for middle-income people.[39] Plans formed under the amendment should be designed to capture the amendment's benefits for retirees. One limitation on Taft-Hartley legal service plans which may restrict their utility for retirees is that such plans are barred from rendering services in actions against the employer or the union.[40] Thus, actions relating to some aspects of pensions or other retirement benefits could probably not be financed by these plans. However, actions against the pension trust or its trustees, as distinguished from the employer or the union, appear to be covered.[41]

It would also appear that senior citizen groups, by making small regular payments, could finance an insurance-like group legal service plan to benefit members. Such a group legal service plan should be designed specifically to benefit this age group. The services available under a closed panel plan, which are often restricted to employment related matters, should be expanded to include both a preretirement legal checkup and services in substantive areas of concern to the aged, such as special benefit programs, estate planning and probate, and guardianship. While open panel plans usually offer a wider range of services, the choice between open and closed panels should be guided by whether lawyers are available with expertise in the legal areas of concern to the aged. Where available expertise is limited, a closed panel plan permits development of needed expertise in areas of particular concern to the elderly. Finally, a plan should not automatically exclude legal representation in cases which could be taken on a contingent fee basis. Because the fees available in social security and pension matters are, as already noted, often insufficient to secure actual representation, attorneys with appropriate expertise may simply not be available to handle such matters. Thus, the contingent fee case would be no more than an illusion, with no attorney actually available.

As previously discussed, it is more difficult to provide legal services in rural areas. Assuming that no ongoing legal services program exists in a rural area, it may become necessary to contract with a local private attorney in order to provide legal services to the elderly community. These services might be provided on an as needed basis. If the legal needs of the elderly in the area require only 50 percent of an attorney's time for example, the attorney could be funded to do only half-time work on behalf of the elderly. Additionally, a local private attorney might be funded to supervise paralegals. As noted above, the use of paralegals can significantly reduce per case costs and allow the program to do outreach which might otherwise be infeasible because of the expense involved. Experiments (more fully discussed in Appendix C [see p. 323]) are currently going on which combine the extensive use of paralegals, WATS telephone lines, mobile vans and the rural private bar with an eye toward solving the special legal needs of the rural elderly. These projects should be carefully studied and assessed and additional model projects which attempt to solve the special access problems of the rural elderly should be generated and funded.

If the private bar is to become involved in handling cases for elderly clients, private attorneys and paralegals must be provided with the proper training and backup services. It must be demonstrated to the private bar that there are ways to handle seemingly complex issues for reasonable fees without spending unduly long periods of time in research. Training, backup, and research services provided to private attorneys and paralegals could potentially reduce fees charged to elderly clients. Without training, most attorneys could only, with great difficulty, handle cases involving issues concerning private or public pensions, social security, SSI, veterans matters or age discrimination in employment. The Administration on Aging and others should seriously consider funding programs designed to train and provide these backup services to the private bar thus enabling private attorneys to operate more efficiently and to reduce fees charged to elderly clients.

CONCLUSION

In order to develop a strong and meaningful national network of legal services providers, it will be necessary to do several things:

[39] Tunney, *Financing the Cost of Enforcing Legal Rights*, 122 *U. Pa. L. Rev.* 632, 633 n.2 (1974).
[40] 29 U.S.C. § 186(c)(8)(A) (Supp. III, 1973).
[41] See *Id.* § 186(c).

1. Technical assistance to State and area agencies on aging regarding the expansion of legal services for the elderly must be continued.

2. The cooperation of the Administration on Aging (and its network of area agencies on aging) with the Legal Services Corporation (and its network of local legal services programs) must be continued and expanded so as to establish additional staffed legal services programs serving the elderly. Funding for Legal Services programs must be expanded.

3. Innovative model legal services programs which demonstrate more efficient methods of providing legal services should be funded. (The funding of programs which show potential for developing a viable legal services delivery system in rural areas should be given top priority.)

4. A program designed to involve the private bar in the provision of legal services to the elderly should be undertaken. On a local level, volunteer panels and lawyer referral services for the elderly could be established; on a national level legislation which would allow for reasonable and appropriate fees for representation of a client in administrative matters (e.g., SSI, social security or veterans benefits) should be enacted.

5. Training, backup and research programs designed to make the necessary expertise available to staffed legal services programs and the private bar should be supported thus enabling all legal services providers to meaningfully and efficiently deal with legal issues of concern to the elderly.

The goal of providing adequate legal services for the elderly is obtainable, and the present national focus on this crucial access service shows that the time is right for action.

[Appendix A]

TABLE OF CONTENTS OF THE MANUAL OF FUNDING SOURCES AND MODELS FOR DELIVERING LEGAL SERVICES TO THE ELDERLY

Appendix I:

1. List of Projects Funded to Provide Legal Services to the Elderly.

Appendix J:

1. List of States for which NSCLC is Responsible under its AoA Grant.

Appendix K:

1. Contract to be Used as a Model by Area Agencies on Aging Contracting with Legal Services Providers.
2. Example of a Memorandum Agreement of Cooperation and Coordination between Legal Services Project and Area Agency on Aging.

Appendix L:

1. Example of Senior Citizens Advisory Committee By-Laws.

Appendix M:

1. Ethical Considerations in Delivering Legal Services to the Elderly.
   (a) The Bar's Obligation to Provide Legal Services.
   (b) The Use of Paralegals in Providing Legal Services to the Elderly.
   (c) A Statement by the National Paralegal Institute on the Use of Paralegals in Providing Legal Services to the Elderly.

Appendix N:

1. Significant Responses to NSCLC's Questionnaire to Projects Funded to Provide Legal Services to the Elderly.

Appendix O:

1. Prepaid Legal Services plan of New York County Legal Services Corporation.
   (a) Questionnaire for lawyer participants.
   (b) Plan description.
   (c) Participant's agreement.
   (d) Subscription agreement.

[Appendix B]

NATIONAL SENIOR CITIZENS LAW CENTER

January 1, 1976 to June 30, 1976

ACTIVITY REPORT

IV. LITIGATION ASSISTANCE

1. *Basel* v. *Butz*, United States Court of Appeals for the District of Columbia, No. 75-1494.

ISSUE

Constitutionality of the federal food stamp regulations that permit benefits to be terminated at the end of a certification period without the right to a prior hearing.

LEGAL SERVICES PROGRAM ASSISTED

Legal Services of Eastern Michigan, 412 Genesee Bank Bldg., Flint, Michigan, Food Research and Action Center, 25 West 43rd Street, New York City 10036, and Michigan Legal Services, 900 Michigan Bldg., 220 Bagley Avenue, Detroit 48226.

STATUS

On May 14, 1976, oral argument was conducted before the U.S. Court of Appeals for the District of Columbia. Extensive discussion was held at the argument with regard to *Eldridge* and the court requested post-argument briefs on the subject. A decision is expected in late summer or fall.

NSCLC PARTICIPATION

NSCLC participated in the discussion of strategies with FRAC attorneys. Also, the basic arguments of the post-argument brief on *Eldridge* were taken from draft memos prepared by NSCLC.

2. *Barr* v. *DiGiorgio, et al.*, United States District Court, Central District of California, No. CV 76-0493-FW.

ISSUE

Challenge to denial of disability pension to worker who retired in reliance on representations of union official when trustees of the Seafarers Pension Trust used the union to communicate with covered workers about the Seafarers Pension Plan.

LEGAL SERVICES PROGRAM ASSISTED

We are working with a private attorney in Wilmington, California who is working with us on a pro bono basis. The case was originally referred to him by the Legal Aid Foundation of Long Beach.

STATUS

Complaint was amended in April to assert ERISA as a source of jurisdiction chiefly in order to blunt efforts by the union and trustees to shift the case to New York on venue grounds. Answers from both were received in May. Since then we have been preparing our first wave of discovery and putting together a response to some 150 pages of interrogatories served by the trustees in June. Most of these interrogatories are boiler plate and appear to reflect a decision by the trustees to make it very burdensome to litigate against them in California.

NSCLC PARTICIPATION

NSCLC has assumed primary responsibility for the case. We drafted the complaint, amended complaint and are handling all discovery matters.

3. *In Re the Dissolution of Marriage of Kurt Benninghoff and Karen Benninghoff*, Indiana Superior Court, County of Lake, No. 576-2760.

ISSUE

Constitutionality of Medicaid deeming regulations which require the income of an out-of-institution spouse be applied to the institutionalized spouse's income in determining Medicaid eligibility for nursing home care.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Greater Hammond, Inc., 232 Russell Street, Hammond, Indiana 46325.

STATUS

The court, during the divorce proceeding, joined the State of Indiana as a party and denied the divorce and ordered that Indiana grant the institutionalized spouse Medicaid, despite the deeming regulations.

NSCLC PARTICIPATION

We appeared as co-counsel in the divorce proceedings and wrote the majority portion of the brief on the constitutionality of the deeming procedure. We are also involved heavily in all strategic decisions made in the case.

4. *Branch and Biggins* v. *Weinberger*, United States District Court, Middle District of Florida, No. 74-122-Civ-J-S.

ISSUE

Due process challenge to the five month waiting period which Title II disability recipients must endure before their benefit payments may begin.

LEGAL SERVICES PROGRAM ASSISTED

Duval County Legal Aid Association, Downtown Office, 205 E. Church Street, Jacksonville, Florida 32202.

STATUS

The government's motion to dismiss on *Salfi* jurisdictional grounds has been under the court's submission for some nine months.

NSCLC PARTICIPATION

We have worked with Carolyn Zisser all along on this case providing advice and information chiefly on the class action aspect of the litigation and on the legislative history of the waiting period. We have also assisted with the brief in opposition to the government's motion to dismiss providing arguments in support of Administrative Procedure Act jurisdiction, Social Security Act jurisdiction, and in opposition to the government's argument that the suit had to be filed within 60 days of Mrs. Biggins' award.

5. *Burroughs* v. *Board of Trustees of the Pension Trust Fund for Operating Engineers, et. al.*, United States Court of Appeals for the Ninth Circuit, No. 75–2897.

ISSUE

Whether the district court erroneously denied plaintiff's application for an award of attorney's fees and whether the district court's holding that the plan's break in service rule could not be applied to Burroughs was correct.

LEGAL SERVICES PROGRAM ASSISTED

Plaintiff is being represented by private counsel.

STATUS

All briefing to the Ninth Circuit is completed and oral argument has been set for September 7, 1976.

NSCLC PARTICIPATION

NSCLC submitted an amicus brief in support of the district court's decision on the merits and appellant Burroughs' claim for attorneys fees.

6. *Cardinale* v. *Mathews*, United States District Court, District of Columbia, No. 74–930.

ISSUE

Constitutionality of HEW regulations allowing reduction, suspension or termination of benefits in certain circumstances, e.g., clerical error, without advance notice.

LEGAL SERVICES PROGRAM ASSISTED

Western Center on Law and Poverty, 1709 W. 8th St., Suite 600, Los Angeles, CA 90017.

STATUS

The government's motion to stay the district court's order holding the regulations unconstitutional was denied. Our proposed settlement was then accepted by the government which decided not to appeal the order to the D.C. Circuit. Upon HEW's expected adoption of final regulations implementing this settlement, final judgment will be entered.

NSCLC PARTICIPATION

We assisted in preparing the response to the government's motion for a stay of the district court's order and in formulating the settlement proposal.

7. *Cheney* v. *Hampton*, United States District Court, District of Oregon, Civ. No. 75–974.

ISSUE

Eligibility of plaintiff for civil service retirement annuity where denial was based upon alleged voluntary separation but the plaintiff was forced to terminate employment in the face of unsupported allegations of homosexual conduct.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Service, East County Office, 4420 South East 64th Ave., Portland, Oregon 97206.

STATUS

The Civil Service Commission has agreed to pay Mr. Cheney's claim in its entirety pursuant to either of two formulas based on alternative dates on which Mr. Cheney could have chosen to retire. In light of Mr. Cheney's relatively brief life expectancy, we elected the option offering the larger lump sum payment ($28,000) and the smaller prospective monthly annuity ($200).

NSCLC PARTICIPATION

NSCLC drafted pleadings and assisted in the formulation of theories under which to bring the case in federal court. Once the government's offer of settlement was made, we researched the tax consequences of the alternative offers.

8. *Commonwealth of Massachusetts Board of Retirement* v. *Murgia*, U.S. Supreme Court, No. 74–1–44.

ISSUE

Constitutional validity of state law requiring mandatory retirement of uniformed police officers at age 50.

LEGAL SERVICES PROGRAM ASSISTED

NSCLC appeared amicus curiae in collaboration with the American Association of Retired Persons and the National Retired Teachers Association.

STATUS

On June 25, 1976 the U.S. Supreme Court decided this case and reversed the lower court's judgment in favor of Murgia. The decision was predicated in large part upon the fact that the retirement statute was aimed at policemen, and the interest of the state in maintaining a vigorous police force. The Court did not reach the procedural due process issue argued by the NSCLC in its amicus brief and Justice Marshall, in his dissent, apparently invoked further challenges upon that ground by mentioning the absence of a procedural due process contention by the appellee and the fact the majority was dealing with policemen. Of interest is the fact that Mr. Justice Marshall apparently relied heavily on the NSCLC brief in tailoring the procedural due process arguments set forth therein to the equal protection clause.

NSCLC PARTICIPATION

NSCLC prepared a brief amicus curiae.

9. *Deutsch* v. *Vandenberg Air Force Base Exchange*, United States District Court, Central District of California, No. 752928; United States Court of Appeals for the Ninth Circuit, No. 76–1803.

ISSUE

Whether an employee of a federal non-appropriated fund activity can be involuntarily retired at age 62, pursuant to a pension plan, consistent with the Federal Age Discrimination in Employment Act of 1967.

LEGAL SERVICES PROGRAM ASSISTED

California Rural Legal Assistance, 126 W. Mill Street, Santa Maria, CA 93454.

STATUS

The lower court granted the government's motion to dismiss, on the authority of *Steiner* v. *National League*, another California federal district court case which decided the case contrary to the plaintiff's contentions. The appeal has been docketed and the appellant's brief has been served and filed; the government has offered to settle, reinstating Deutsch with back pay and the appeal will be dismissed.

NSCLC PARTICIPATION

The NSCLC has assumed primary responsibility for prosecution of this case, including preparation and filing of pleadings in the federal district court and in the Ninth Circuit Court of Appeals.

10. *East Hills Safety Comm.* v. *Pittsburgh Housing Authority*, United States District Court, District of Pennsylvania, No. 1151–75.

ISSUE

Whether a public housing authority may reduce security measures in an elderly housing project without giving the occupants a meaningful opportunity to protest the change and present reasons in support of their protest.

LEGAL SERVICES PROGRAM ASSISTED

Neighborhood Legal Services Association, 310 Plaza Bldg., Pittsburgh, Pa. 15219.

STATUS

A complaint has been filed, interrogatories served and preparation of a motion for summary judgment is under way.

NSCLC PARTICIPATION

NSCLC has done extensive research on both jurisdictional and substantive issues, assisted in the preparation of the complaint, and provided a revised version of the brief in support of a motion for summary judgment.

11. *Ferguson* v. *Mathews*, United States District Court, Central District of California, No. CV 75–2620–RF.

ISSUE

SSI application delay case.

LEGAL SERVICES PROGRAM ASSISTED

Western Center on Law and Poverty, 1709 W. 8th St., Suite 600, Los Angeles, CA 90017.

STATUS

Still no word from Judge Firth on cross motions for summary judgment filed by plaintiffs and defendant.

NSCLC PARTICIPATION

This case originated with the Western Center on Law and Poverty where it was brought by Miriam Goslins. She came on our staff for the duration of the case and we assumed all backup responsibilities. NSCLC prepared all the pleadings in support of the motion for summary judgment. The motion seeks an order requiring the promulgation of regulations establishing alternatively time limits of 30 and 60 days within which aged and disabled applications for SSI benefits must be processed or reasonable time limits subject to court approval within which such applications must be processed.

12. *Gadsden* v. *Weinberger*, United States District Court, Central District of California, No. CV 75–2946–ALS.

ISSUE

Constitutionality of provision in Title XVIII which permits carriers to make final and binding determinations with respect to contested claims under Part B.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Orange County, 1932 W. 17th St., Santa Ana, California 92706.

STATUS

A motion was made to intervene an additional party plaintiff in the suit; however, it had to be withdrawn because the plaintiff died prior to any hearings in the court. In addition, numerous communications were made to the court concerning new cases involving the jurisdictional issues under consideration. Plaintiffs also filed a supplemental memorandum of law on the jurisdictional issues because of the numerous cases that had been decided prior to the filing of the earlier brief. Motion to dismiss of defendants is still under submission.

NSCLC PARTICIPATION

NSCLC prepared all pleadings submitted to the court in Gadsden, including the intervention papers and the supplemental memorandum.

13. *Goodpaster* v. *Mid-America and California Iron Workers Pension Plans*, California Superior Court, County of Los Angeles, No. C 143975.

ISSUE

Whether the Mid-America Plan can apply its break in service provision to a period during which Mr. Goodpaster was working outside its geographical jurisdiction, albeit in the covered industry and at the behest of the company which employed him during his period of coverage by the Mid-America Plan.

LEGAL SERVICES PROGRAM ASSISTED

Southeast Legal Aid Center, 1331 E. Compton Blvd., Compton, California 90221.

STATUS

In late April an answer to our complaint was finally received from the California Trust denying each and every one of plaintiff's allegations. In the meantime, we have provided answers to interrogatories served by the Mid-America Trust. We are also preparing our own initial discovery to the trusts designed to remove as many factual issues as possible from Mr. Goodpaster's claim.

NSCLC PARTICIPATION

NSCLC did the research and prepared the complaint in this case and has assumed primary responsibility for pursuing all discovery prior to filing a motion for summary judgment.

14. *Hall* v. *Flournoy*, California Superior Court, County of Alameda, No. 450144-4.

ISSUE

Whether, under new legislation, recipients of Supplemental Security Income are entitled to homeowners' property tax relief (the statute disqualifies individuals whose property taxes are paid in whole or in part, directly or indirectly by the State).

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Alameda County, 4600 E. 14th St., Oakland, CA 94601.

STATUS

By judgment dated January 15, 1976, the court found for the plaintiffs, ruling that they are entitled to receive the homeowners exemption, and overturning the then existing practice of the State taxing authorities. The State has appealed and the appellant's brief has been served and filed.

NSCLC PARTICIPATION

The NSCLC formulated the theories upon which the suit was initially based and assisted the Legal Aid Program in drafting the memorandum in support of the motion for summary judgment which was granted. We are now writing a segment of the respondent's brief.

15. *Harrison* v. *Crowell, et al.*, United States District Court, Central District of California, No. 73-1402-RF.

ISSUE

Compliance by trustees of the Southern California Construction Laborers Pension Trust with their duty to formulate reasonable eligibility criteria.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Foundation of Los Angeles, 2301 South Hill Street, Los Angeles, CA 90007; California Rural Legal Assistance, 126 West Mill St., Santa Maria, CA 93454.

STATUS

At the end of March, Judge Firth finally ruled on the trustees' motion for summary judgment, denying it, and on the proposed intervenors' motion for intervention, granting it. The trustees then sought certification of both rulings as appealable orders, apparently part of a strategy to place the case before the Ninth Circuit as quickly as possible. Judge Firth, however, denied this motion as well, leaving us free to bring the case to resolution with our own summary judgment. To that end, we have, along with CRLA, retained Howard Winklevoss of the Wharton School to do actuarial consulting work, both in connection with *Harrison* and *Martinez* v. *Ivers*. Our next step will be to secure the tapes (we hope voluntarily) containing the work records of all employees who have passed through the plan for Howard to use.

NSCLC PARTICIPATION

NSCLC has handled this case in its entirety since its filing in June, 1973.

16. *State of Indiana* v. *Superior Court of Lake County, et al.*, Indiana Supreme Court.

ISSUE

Constitutionality of Medicaid deeming regulations which require the income of an out-of-institution spouse be applied to the institutionalized spouse's income in determining Medicaid eligibility for nursing home care.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Greater Hammond, Inc., 232 Russell Street, Hammond, Indiana 46325.

STATUS

After the order in the *Benninghoff* case, listed above, the State of Indiana filed an original action in the Supreme Court to challenge the authority of the Superior Court judge to knock out the state deeming regulations. The Supreme Court and the defendant Superior Court requested that the parties to the divorce also file briefs in the case. The brief has been filed and the case argued and is awaiting decision by the Supreme Court of Indiana.

NSCLC PARTICIPATION

We drafted the brief and filed an appearance on behalf of the husband in the action.

17. *International Brotherhood of Electrical Workers Pension Plan* v. *Superior Court*, United States District Court, Central District of California, No. CV 76-1768-F.

ISSUE

Whether a state court preliminary injunction requiring IBEW Pension Plan, on community property grounds, to pay half the husband's pension bene-

fit to the wife pending final resolution of his suit for divorce is subject to collateral attack in a federal court on the ground that ERISA preempts California community property law insofar as it "relates" to any pension plan.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Foundation of Long Beach, 4790 E. Pacific Coast Highway, Long Beach, CA 90804.

STATUS

Complaint filed by the trustees of the IBEW Pension Plan was dismissed by Judge Ferguson following his issuance to all parties of an Order to Show Cause why the complaint should not be dismissed.

NSCLC PARTICIPATION

NSCLC assisted Diane Messer of Long Beach Legal Aid in preparing a brief on behalf of the defendant wife in the pending state divorce suit urging that the trustees' complaint be dismissed.

18. *Johnson* v. *Seafarers' Union Pension Fund*, California Superior Court, County of Los Angeles, No. C108480.

ISSUE

Must a pension plan's disability payments be made retroactive to the date Social Security determines disability to have begun, or may the plan commence payment only for dates subsequent to the date Social Security issues its determination?

LEGAL SERVICES PROGRAM ASSISTED

Legal Services for the Elderly Poor, 2095 Broadway, Suite 304, New York City 10023.

STATUS

Since the class action motion in a similar New York case was denied, we have begun working with a Los Angeles attorney who filed the *Johnson* case in California Superior Court. The defendants filed a motion to quash service and to dismiss the case. The attorney responded and oral argument is set for early July.

NSCLC PARTICIPATION

We have extensively discussed strategy (with both New York and local counsel), including intervention in the New York case versus filing a separate action in California.

19. *Johnston* v. *Johnston*, California Superior Court, County of Los Angeles, No. SO–D–54559.

ISSUE

Whether the federal pension reform act of 1974 preempts California community property law so as to prevent a court from ordering that pension payments due one spouse be paid directly to the other spouse.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Foundation of Long Beach, 4790 E. Pacific Coast Highway, Long Beach, CA 90804.

STATUS

The wife's motion to have the pension plan joined as a party and have them preliminarily enjoined so as to require all pension payments paid directly to the wife was granted by the superior court. The pension plan then filed a notice of appeal of the preliminary injunction and while that has been pending the divorce case has been moving toward a final judgment with hearings scheduled in early July.

NSCLC PARTICIPATION

Our participation included discussion of all strategy involving the pension issue and assistance in preparation of briefs with regard to the pension issue

and intepretations of the federal pension law. NSCLC has also agreed to enter as counsel of record for the appeal in the California Court of Appeals and in any subsequent court hearings with regard to the pension issue.

20. *Kennedy* v. *Mathews*, United States District Court, District of Columbia, No. 76–0390.

ISSUE

Legality of withholding authorized funds from the Title VII nutrition program for the elderly.

LEGAL SERVICES PROGRAM ASSISTED

Food Research and Action Center, Inc., 25 West 43rd St., New York, New York 10036 and numerous Legal Services programs throughout the country who appeared as of counsel in the case.

STATUS

Plaintiffs' moved for a preliminary injunction and on May 17, 1976 the court issued an opinion and order granting plaintiffs' permanent injunction requiring that all monies appropriated be spent no later than the end of fiscal year 1977, ending all forward funding of the program, and requiring that states who do not spend their full allocation of funds return the money to the federal government for reallocation to states who need more monies.

NSCLC PARTICIPATION

Participated in the formulation of theories and strategies of the case and appeared as local counsel in the suit.

21. *Lix, et al.* v. *Edwards, et al.*, California Superior Court, County of Los Angeles, No. NCC–10209–B.

ISSUE

Propriety of the pension trustees' interpretation of a pension plan, the effect of which was to deprive the plaintiffs of their pensions; application of the "short term contributory employer" provision to the plaintiffs is contrary to the intent behind that provision.

LEGAL SERVICES PROGRAM ASSISTED

San Fernando Valley Neighborhood Legal Services, 13327 Van Nuys Blvd., Pacoima 91331.

STATUS

Trial has been set for August 24, 1976, but the parties have been able to achieve an agreed statement of fact and a stipulation to the effect that the matter may be submitted to the court on briefs. Because the plaintiffs pensions were terminated in November, 1975, it was believed appropriate to expedite the case because of the likelihood of an appeal regardless of the outcome and the desirability of a simple, easily compiled record.

NSCLC PARTICIPATION

The NSCLC has assumed the major responsibility for prosecution of this case. We have prepared all pleadings, motions and discovery materials. Lately, Percy Anderson, of SFNLS, has been participating in strategy sessions and attending the court proceedings with us.

22. *McGrath* v. *Weinberger*, United States Court of Appeals for the Tenth Circuit, No. 75–1839.

ISSUE

Constitutionality of "representative payee" provision in the Social Security Act which authorizes the appointment of such a fiduciary, for purposes of receiving Title II benefits and Title XVI Supplemental Security Income benefits, without a prior notice and hearing.

LEGAL SERVICES PROGRAM ASSISTED

Northern New Mexico Rural Legal Services, P.O. Box 1464, Las Vegas, New Mexico 57701.

STATUS

Following the district court's decision in favor of the government, plaintiff appealed to the Tenth Circuit. Briefs have been submitted and oral argument heard and we are currently awaiting the court's decision.

NSCLC PARTICIPATION

We appeared by way of amicus curiae and assisted in the briefing of all issues.

23. *Mathews* v. *Sanders*, United States Supreme Court, No. 75–1443.

ISSUE

Whether a federal district court has jurisdiction under either the Social Security Act or the Administrative Procedure Act, over a Social Security disability applicant's claim that his request that an earlier application be reopened was unreasonably denied by the Social Security Administration.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Bureau, Inc., 341 North Calvert Street, Baltimore, Maryland 21202.

STATUS

In June of 1976 the Supreme Court granted the petition for writ of certiorari filed by HEW Secretary Mathews. The government's brief is due in mid-August, respondent Sanders' brief will come due a month later.

NSCLC PARTICIPATION

NSCLC is assisting attorneys with Baltimore Legal Aid in preparing an amicus brief in support of the position of respondent Sanders.

24. *Martinez* v. *Ivers*, United States District Court, Northern District of California, No. C–75–0198 RHS.

ISSUE

Whether pension plan discriminates against seasonal workers in the design and implementation of its eligibility conditions.

LEGAL SERVICES PROGRAM ASSISTED

California Rural Legal Assistance, Senior Citizens Program, 115 Sansome St., Suite 900, San Francisco, California 94104.

STATUS

This case has required a considerable amount of discovery. There was a full day session in San Francisco with our pension expert, Howard Winklevoss, a person from the Teamsters' Pension Plan, and lawyers for both sides to discuss the way in which the plan gathers data and how we may use that data for our expert. Other data continues to be sought through interrogatories and a major deposition of the Prudential Insurance Company's actuary is scheduled for early fall in Newark, New Jersey.

NSCLC PARTICIPATION

CRLA attorneys are doing the primary work on discovery. NSCLC attorneys have appeared on several occasions to assist in oral argument and in negotiation with attorneys for the trustees on discovery questions. NSCLC continues to be involved in determining overall strategy for the case and are counsel of record for plaintiff.

25. *Martinez* v. *Weinberger*, United States District Court, Central District of California, No. CV–75–1651–RJK.

ISSUE

Constitutionality of Social Security Act provision terminating benefits of fully insured individual upon deportation under specified circumstances.

LEGAL SERVICES PROGRAM ASSISTED

International Institute of Los Angeles, One Stop Immigration Center, 1441 Wright St., Los Angeles, California 90015.

STATUS

The government's motion for summary judgment was briefed by both sides and argued before Judge Kelleher. The case has been taken under submission by the court and a decision on the summary judgment motion should be soon forthcoming.

NSCLC PARTICIPATION

The NSCLC has assumed primary responsibility for prosecution of the case, prepared, served and filed the pleadings, and has drafted memoranda and other documents resisting the motion for summary judgment.

26. *Miller* v. *DePaulo Health Plan*, California Superior Court, County of Los Angeles, No. C–122674.

ISSUE

Compliance by a private pre-paid health plan with state and federal laws regulating the operation of such plans, as well as ordinary tort law of the state.

LEGAL SERVICES PROGRAM ASSISTED

Community Legal Assistance Center, 1800 W. 6th St., Los Angeles, CA 90057; National Health Law Program, 10995 LeConte Ave., Los Angeles, CA 90024.

STATUS

Several hearings have been held with regard to defendant's failure to comply with discovery and plaintiffs have been successful in all hearings. Discovery continues to take place in the case.

NSCLC PARTICIPATION

We have been involved in discussion of some of the strategy in the case; however, we have begun to discuss whether or not NSCLC will remain in this case and to that effect have held a meeting with the National Health Law Project to discuss whether or not we will continue to be involved in the case.

27. *Miranda* v. *Audia*, United States District Court, Southern District of California, No. 75–0517–GT.

ISSUE

Compliance by the trustees of the San Diego County Construction Laborers Benefit Funds with their duty to formulate reasonable eligibility criteria and with their responsibility not to discriminate against lower paid employees.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of San Diego, 964 5th Avenue, San Diego, California 92101.

STATUS

The complaint was filed and plaintiffs began discovery by serving interrogatories on defendants and requests for production of documents. Defendants have complied with discovery and a status conference was held in May to discuss progress in the case. Plaintiffs are planning to amend the complaint to make the case a class action and add ERISA jurisdiction. A further status conference was scheduled for October, 1976.

NSCLC PARTICIPATION

We assisted in drafting all the pleadings and discovery, as well as appearing as counsel of record in the case.

28. *Munoz* v. *Timber Operators Council*, California Superior Court, County of San Joaquin.

ISSUE

Propriety of pension fund trustees denying a pension to an employee of a former employer who went out of business where a dispute exists concerning compliance with certain notice requirements and where, under the terms of the pension plan, employees of employers who went out of business are given more favorable treatment with respect to future service credit than are other employees.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of San Joaquin County, 110 N. San Joaquin St., Stockton, CA 95202.

STATUS

The complaint has been filed in California Superior Court.

NSCLC PARTICIPATION

The NSCLC formulated the theories underlying the suit and drafted the complaint; the suit has been filed and the defendants are being served.

29. *Oliver* v. *Mathews*, United States District Court, Northern District of California, No. C–74–1416–SC.

ISSUE

Constitutionality of Social Security Act provision denying to divorced husbands of fully insured individuals benefits equivalent to divorced wives of fully insured individuals.

LEGAL SERVICES PROGRAM ASSISTED

American Civil Liberties Union Foundation, 22 E. 40th St., New York, New York 10016.

STATUS

Following the court's dismissal on *Salfi* jurisdictional grounds, Mr. Oliver exhausted the Social Security Administration's administrative appeals process through the Reconsideration stage. Upon completion of that stage, we asked counsel for Secretary Mathews to invoke the expedited appeals process which permits Mr. Oliver to refile his complaint without further administrative exhaustion. The stipulation has been drafted and sent to Mr. Oliver for signature and we expect to refile as soon as it is returned.

NSCLC PARTICIPATION

NSCLC drafted and filed the pleadings in this case, prepared the memoranda in connection with Mrs. Oliver's petition for intervention, conducted all discovery and prepared the motion for summary judgment on Mr. Oliver's behalf along with Kate Peratis of the ACLU. Since the court's *sua ponte* dismissal of the complaint, NSCLC has shepherded Mr. Oliver's claim through the administrative appeals process.

30. *Rosenthal* v. *Mathews*, United States District Court, District of Columbia, No. 76–601.

ISSUE

Constitutionality of provision in Title XVIII which permits carriers to make final and binding determinations with respect to contested claims under Part B.

LEGAL SERVICES PROGRAM ASSISTED

Legal Counsel for the Elderly, 1424 Sixteenth St. N.W., Washington, D.C. 20036.

STATUS

Plaintiff has filed interrogatories which are scheduled to be answered in early July, defendants have in turn filed a motion to dismiss and a request for protective order not to have to answer the interrogatories and both of which will be heard in early July. In addition, plaintiffs have filed a motion for a nationwide class action also to be heard in early July.

NSCLC PARTICIPATION

We were involved in formulating and drafting the complaint and interrogatories, wrote the briefs for the class action and in opposition to the motion to dismiss.

31. *Schultz* v. *Borradaile,* United States District Court, Eastern District of Michigan, No. 74–4123.

ISSUE

Constitutionality of involuntary guardianship statutes.

LEGAL SERVICES PROGRAM ASSISTED

Legal Services of Eastern Michigan, 412 Genesee Bank Bldg., Flint, Michigan and Michigan Legal Services, 900 Michigan Bldg., 220 Bagley Avenue, Detroit 48226.

STATUS

Plaintiffs have responded to defendants' motions and have moved the court for summary judgment. Defendants have responded to that motion and the motion is currently under submission.

NSCLC PARTICIPATION

NSCLC attorneys have assisted in writing the briefs to be filed, is co-counsel for the plaintiffs and is expected to participate in oral argument. In addition, NSCLC as an organization has filed an amicus brief.

32. *Sesanto* v. *Construction Laborers Pension Trust for Southern California* (will be filed in the United States District Court, Central District of California).

ISSUE

Whether trustees of a pension plan requiring 15 years of credited service as a condition to entitlement to a pension may deny benefits to a worker who has completed 21 and 6/12ths years of credited service on account of a break in service when the break occurred because the worker reasonably continued working for an employer whose employees had previously been covered by the plan; a subsidiary issue is whether the trustees may reasonably require that the minimum amount of future service credit necessary to trigger recognition of past service credit must be worked during the first five years of the plan's existence.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Foundation of Los Angeles, 326 S. Lincoln Blvd., Venice, CA 90291.

STATUS

Exhaustion of the administrative remedies provided by the trustees has been completed unsuccessfully and complaint is now in preparation.

NSCLC PARTICIPATION

NSCLC has assumed complete responsibility for this case at the request of the Venice office.

33. *Shannon* v. *U.S. Civil Service Commission,* United States District Court, Northern District of California, No. C–76–1364–SW.

ISSUE

Constitutionality of the Civil Service Commission procedures for recoupment of overpayment of Civil Service pensions.

LEGAL SERVICES PROGRAM ASSISTED

Seattle Legal Services, 5308 Ballard St., N.W., Seattle, Washington 98107.

STATUS

Plaintiffs, upon filing their complaint for a nationwide class action, received a temporary restraining order ordering the defendants not to recoup any money from the named plaintiff. A motion for preliminary injunction and the class action was set down to be heard in late August and a briefing schedule set up. In addition, plaintiff anticipates some discovery which will include production of documents and a deposition.

NSCLC PARTICIPATION

NSCLC attorneys have done all the work on this matter.

34. *Shaw* v. *Weinberger*, United States District Court, District of North Carolina, No. C–C–74–105.

ISSUE

Validity of practice which limits SSI emergency advance payments to three categories of impairment and which fails to make presumptive disability determinations in advance of final determinations.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Mecklenburg County, 6th Floor, Professional Services Center, 403 N. Tryon Street, Charlotte, North Carolina 28202.

STATUS

Don Gillespie, of the Legal Aid Society of Mecklenburg County, has responded to the Government's report on the processing of presumptive disability and emergency advance applications in North Carolina by urging that the court dismiss our presumptive disability claims as moot but grant our motion for summary judgment with respect to emergency advance payments.

NSCLC PARTICIPATION

NSCLC drafted pleadings, briefs and participated in the oral argument of the motions for summary judgment. NSCLC has also assisted in the evaluation of and response to the government's reports submitted pursuant to the court's order.

35. *Smith* v. *O'Halloran*, United States District Court, District of Colorado, No. 75–M–539.

ISSUES

Class action against an individual nursing home, the state and federal governments alleging violations of the U.S. Constitution, Civil Rights Act, federal Medicaid regulations, breach of contract between the state and nursing home and intentional infliction of emotional distress on behalf of all medicaid recipients in the defendant nursing home. The specific rights alleged to be violated include 1) the right to manage personal monies and/or receive an accounting, 2) the right to meet with legal counsel, 3) the right to notice before transfer, 4) right to have an adequate level of care, 5) right to access to medical files.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Metropolitan Denver, 912 Broadway, Denver, Colorado 80203.

STATUS

The motions to dismiss and for summary judgment are still pending; however, the judge has discussed with all attorneys the possibility of ordering a special master expert appointed to study the nursing home conditions in the state of Colorado. The feasibility of that study is currently being considered.

NSCLC PARTICIPATION

We continued to assist Legal Aid Society of Denver as needed, including advice on strategy, possibilities for funding of the special expert, and assistance in research when needed.

36. *Stoskus* v. *City of Baldwin Park*, United States District Court, Central District of California, No. 73–2646.

ISSUE

Whether the imposition of a special assessment in excess of one-half the value of the property in question is constitutional.

LEGAL SERVICES PROGRAM ASSISTED

Community Legal Assistance Center, 1800 W. Sixth Street, Los Angeles, CA 90057.

STATUS

The case has survived a motion to dismiss predicated upon the res judicata effect of earlier state court litigation. We are now preparing our own motion for summary judgment.

NSCLC PARTICIPATION

We have agreed to take an active part in this case which has previously been handled by CLAC. We have obtained copies of all files, completed a preliminary study of the case, and prepared a draft motion for summary judgment.

37. *Tomlin* v. *Crowell*, California Superior Court, County of Los Angeles, No. C–108967.

ISSUE

Validity of provision in pension plan restricting circumstances under which pro rata credit can be earned through work generating contributions to a pension plan having a reciprocity agreement with the defendant pension trust.

LEGAL SERVICES PROGRAM ASSISTED

Community Legal Assistance Center, 1800 W. 6th St., Los Angeles, CA 90057.

STATUS

Our motion for summary judgment has been filed with the court and oral argument will be heard in the early fall.

NSCLC PARTICIPATION

NSCLC assisted the Community Legal Assistance Center in drafting the complaint, the memorandum in opposition to a motion to dismiss and the interrogatories. NSCLC staff prepared the summary judgment motion and points and authorities in support thereof and will take responsibility for oral argument on the motion.

38. *Watkins* v. *Mathews*, United States District Court, Middle District of Louisiana, No. 75–124.

ISSUE

Validity of HEW regulations which inhibit the reopening of applications for disability benefits under Title II of the Social Security Act by imposing time limitations and by creating the concept of "administrative res judicata" without statutory authority.

LEGAL SERVICES PROGRAM ASSISTED

Legal Aid Society of Baton Rouge, 2303 Government St., Baton Rouge, La. 70806.

STATUS

The court dismissed the suit for lack of jurisdiction and an appeal is being taken to the Fifth Circuit.

NSCLC PARTICIPATION

We will participate in the appeal either by way of a brief amicus curiae, or by being of counsel.

39. *Wilson* v. *Operating Engineers Pensions Fund*, United States District Court, Northern District of California, No. C–75–1820.

ISSUE

Propriety of pension trustees giving conclusive effect to Social Security records in finding a break in employment where an ambiguity existed concerning whether the claimant was, during the questioned time, an employee or an independent contractor and where claimant had earned sufficient credit to qualify for a pension prior to his alleged break.

LEGAL SERVICES PROGRAM ASSISTED

Fresno County Legal Services, Inc., Brix Building, 1221 Fulton Mall, Fresno, CA 93721.

STATUS

Chief Judge Carter treated the March hearing on our motion for preliminary injunction as a trial. Accordingly, we spent two days presenting witnesses designed chiefly to show the irreparable injury suffered by the Wilsons and Cliff Wilson's work in covered employment during the period of his supposed break in service. Before a date could be set for the trustees to put on their opposition, Judge Carter died suddenly of a heart attack. We have since renoticed our motion which will now be heard by Judge Ingram on August 18th and 19th. In the meantime, the trustees have deposed both Cliff Wilson and another union member who worked for Wilson's employer during the period of his break.

NSCLC PARTICIPATION

NSCLC has prepared all pleadings and conducted all negotiations with the trustees of the Operating Engineers Pension Fund. In addition, we will be responsible for all oral arguments before the Northern District.

[Appendix C]

SURVEY OF STAFF PROVIDING LEGAL SERVICES TO THE ELDERLY SURVEY DESCRIPTION

In October, 1975, the National Senior Citizens Law Center conducted a survey, by questionnaire, of 73 projects specifically providing legal services for the elderly. The purpose of the survey was to obtain an accurate assessment of problems confronted by legal services providers. The questionnaire was designed to provide a wide range of information on legal problems. Nine broad areas were covered: I. Services, II, Eligibility, III, Funding, IV, Staff, V. Paralegals, VI. Relations with the Local Bar, VII. Accessibility of Services, VIII. Coordination with Other Services, and, IX. Availability of Resources.

The questionnaire which was prepared by the Staff of NSCLC incorporates within it questions solicited from the other model project grantees. Survey responses were received from 32 of the 73 law programs receiving the questionnaire (a response rate of 44%). We are presenting a preliminary analysis of our survey responses which indicates how manpower problems are perceived by legal service providers working with the elderly.

SUMMARY ANALYSIS OF STAFFING PATTERNS

Legal service programs for the elderly, like those of other social service programs in the field of aging, have a multiplicity of goals. We are concerned that older people are employed and adequately trained to fill the staffing needs wherever possible. We are also concerned that staff attorneys, paralegals and community workers have competency in their specialties, are sensitive to the needs of the elderly, and that personnel have knowledge of the special issues that impact the lives of the elderly.

Legal service programs, especially, need specific knowledge in the substantive areas that are most commonly addressed in dealing with the aged. For the most part, lawyers have not been trained in law school or in private or public practice in these substantive areas.

This part of our survey attempts to look at present staffing patterns to see how well we have met our goals, as well as finding out which areas we must improve. In this part of our statement five broad categories are covered: 1. Statistical profile of staffing patterns, 2. Adequacy of present staff, 3. A demographic profile of present attorneys, 4. Project training needs, and 5. Paralegals.

STATISTICAL PROFILE OF STAFF—WHO AND WHAT KINDS OF WORKERS ARE EMPLOYED

Staff utilization

In the 32 projects there were a total of 49.5 (50 rounded) attorneys employed for an average of 1.66 attorneys per project [Table I]. Approximately 56% of the projects had one or fewer attorneys [Table II]. No project had more than 4 attorneys and only 3% had 4. In fact, almost 85% of the projects employed 2 or fewer attorneys.

Paralegals, another category, [Table III] are utilized in approximately 72% of the projects. Twenty-eight percent have no paralegals, 38% of the projects have 1 or 2 paralegals and 9% have 9 or more. Statistical averages, however, can be misleading: 40% of the 116 paralegals employed (48) are in four projects.

Community and social service personnel are used relatively infrequently [Table IV], with almost 47% of the projects utilizing none. Approximately 47% utilize some type of social service personnel with some projects utilizing administration staff for social service tasks. Only 9% of the projects have 5 or more community or social service workers.

Part-time vs. full-time employment was another category studied. Almost 48% of the projects responded that they didn't use part-time workers. Of those who used part-time personnel [Section B, Table VI], 16% of the projects had all part-time personnel and another 19% used part-time personnel extensively. That, of course, means that close to 66% utilized part-time workers little or none at all.

Law students were utilized in 47% of the projects while 53% made no use of law students [Section B, Table V].

Adequacy of present staff

This section in the survey was concerned with the adequacy of staff size and projected needs for future staffing if these projects were to become adequate to meet the legal needs of the elderly. An interesting and significant difference arises [Table I and II, Section B] when legal service providers are asked to assess the adequacy of their staff size.

When asked about the adequacy of staff size to meet the demands of their project's present elderly caseload, 58% responded that present staff is inadequate to meet the demand, which is a good indication of their needs. However, when asked if their staff size was adequate to meet the demands of the *elderly community eligible for legal services*, an overwhelming (80%) majority responded that their staff was inadequate. It indicates that there is dissatisfaction with their ability to meet their caseloads, but an even greater dissatisfaction with their ability to assist the potentially needy elderly community.

Further questions were asked to see what kind of staff was needed to meet both caseload and community legal needs. The greatest need was for attorneys (74%) and for paralegals (60%) ([Section B, Table III]. Only 7 cases (26%) mentioned community and social service workers.

A further concern was whether part-time older workers were employed. Often older workers, because of social security regulations, physical condition, etc., are unable to work full time. Out of the 23 projects which utilized older workers (61%), when asked how successful this was, 12 out of 14 (86%) said it was successful, while 2 said only partially successful.

Profile and demography of attorneys' ages, experience, bar membership

Attorneys in the legal services projects are relatively young [Section C, Table II]. Sixty-eight percent of the attorneys are under 30, while 80% are under 35 and 86% under 40. Only 14%, or 8 attorneys, are 55 and older while 4 are over 65 with the oldest attorney 72. It is interesting to note that no attorneys fall into any age categories between 41 and 55.

When hired, 88% are either active or retired members of the bar. Sixty-two percent of all attorneys had less than three years experience when hired, with 28% having 0 to 11 months. Only 8 lawyers, or 14%, had over 10 years experience. This data exactly correlates with the 14% of the lawyers 56–65 and older.

Paralegals

The fifth section deals with paralegals: utilization, desirability to legal services projects, sources of funding and demographic characteristics. Twenty-

three of the 32 legal service projects use 116 paralegals, an average of 3.62 paralegals per project. Average statistics often represent skewed pictures. Four of the projects utilize approximately 40% (or 48) of the total number of paralegals. Eighteen out of the 23 projects have some type of salaried paralegal.

Fifty percent of the paralegals are part-time non-salaried, while approximately 26% (25.9%) are full-time salaried employees, with approximately 24% full-time non-salaried. We were unable to do any correlation to see what proportion of elderly paralegals were paid or non-paid. The age breakdown for paralegals showed approximately 35% over 65 and 25% between 55–64. The next largest age group was 21–30 with 18% of the total paralegal population.

Of the 9 projects not presently utilizing paralegals, approximately 67% (66.7%) said they would like to employ paralegals. Of those projects presently employing paralegals, an overwhelming 82% (81.9%) said they would like to expand their paralegal staff. By overwhelming numbers, 87% of the respondents indicated insufficient funding to secure adequate training for paralegals. Even if the training money were available, 70% indicated NO adequate training for senior citizen paralegals was available in their community.

GENERAL INFORMATION FROM THE 32 PROJECTS: STAFFING AND MANPOWER

SECTION A.—TYPES OF WORKERS UTILIZED

Table I.—The number of attorneys per the 32 projects surveyed. *Average* number of attorneys *per project*—1.66. Total number of attorneys—49.5 (*including part time*).

TABLE II.—NUMBER OF ATTORNEYS

Number of attorneys	[1] 0	1	2	3	4
Projects having specific attorneys	2	16	9	4	1
Percent of projects	6.2	50	28.1	12.5	3.1

[1] Approximately 84.3 pct of the 32 projects have less than 3 attorneys; 56.2 pct have 1 or fewer attorneys.

TABLE III.—NUMBER OF PARALEGALS PER PROJECT [1]

Paralegals	0	1 to 2	3 to 4	5 to 6	7 to 8	9 plus
Projects	9	12	2	5	1	3
Percent of projects with paralegals	28.1	37.5	6.3	15.6	3.0	9.3

[1] Approximately 28 pct of the survey projects use no paralegals; 38 pct have 1 to 2 paralegals; 66 pct between 0 and 2 paralegals; 34 pct between 3 and 18 paralegals.

TABLE IV.—NUMBER OF COMMUNITY OR SOCIAL SERVICE PERSONNEL PER PROJECT

Community and social service workers	0	1 to 2	3 to 4	5 to 6	9 to 10	11 plus	No Response
Projects	15	8	3	1	1	1	(2)
Percent of projects having community or social service workers	46.9	25.0	9.3	3.0	3.0	3.0	6.25

NOTES

Almost 50 pct do not have community or social service workers.
71.9 pct have 0 to 2 community or social service workers.
81.2 pct have 0 to 3 community or social service workers.
9 pct have more than 4.
The survey showed some overlap between this classification and paralegals in that it seems as if some paralegals were used as community workers and vice versa.

TABLE V.—UTILIZATION OF PART-TIME WORKERS

[27 projects responding]

Part-time workers	0	1 to 2	3 to 4	5 to 6	7 to 8	9 plus	No Response
Projects	13	8	1	2	1	2	(5)
Percent projects with part-time workers	48.1	29.6	3.7	7.4	3.7	7.4	

Almost 50% have no part time workers, 30% have 1–2. Only approximately 21% have over 3 part time workers.

SECTION B

Another set of questions revolved around the adequacy of the staff size and the projected needs if the projects were to become adequate to meet the needs of the elderly population. There were two questions specifically geared to this problem.

Is staff size adequate to meet the demands of your project's *present* elderly caseload?

TABLE I

	Yes	No	No response
Number of staff	13	18	1
Percent of total responses	41.9	58.1	

Is this staff size adequate to meet the *demands* of the *elderly community eligible* under your project's guidelines?

TABLE II

	Yes	No	No response
Number of staff	6	24	2
Percent of total responses	20	80	

When asked what does your program need to adequately serve the elderly community and your present caseload (total figures greater than 100%—some participants citing more than one need), the greatest additional staff needs were for attorneys (74%) and paralegals (59.3%).

TABLE III.—CHANGES NEEDED IN STAFF

[27 projects responding]

	Percentage	Number of cases
Additional paralegals	59.3	16
Additional attorney	74.0	20
Support staff—administrative-clerical	22.2	6
Community and social service personnel	25.9	7
Law students	7.0	2
Pay for volunteers	3.7	1
Additional full-time personnel	3.7	1

On the question of salaries for attorneys and support staff pay (not including paralegals), most respondents said that salaries are not competitive (approximately 60%).

TABLE IV.—COMPETITIVE SALARIES

	Yes	No	No response
Salaries competitive (28 responses)	11	17	(4)
Percent of projects responding	39.2	60.7	

TABLE V.—PROJECT UTILIZATION OF LAW STUDENTS

[32 responses]

	Yes	No
Number of cases	15	17
Percent of total projects responding who use law students	46.9	53.1

Do you utilize part-time personnel?

TABLE VI.—PROJECT USE OF PART-TIME PERSONNEL

[32 responses]

	None	Little	Extensively	All
Number	9	12	6	5
Percent	28.1	37.5	18.75	15.6

Of those cases who utilize part-time personnel, 65% have paid and 60% have volunteer. Only 15 programs responded to the question.

TABLE VII.—PART-TIME PERSONNEL

[32 responses]

	Number	Percent
Paid	15	65.2
Volunteer part time	14	60.8

TABLE VIII.—UTILIZATION OF OLDER PEOPLE PART TIME

[23 responses]

	Yes	No	Number available
Number	14	7	2
Percent	61.0	30.4	

TABLE IX.—ARE THESE PART TIME OLDER WORKERS SUCCESSFUL?

[21 responses]

	Yes	Partially
Number of cases	12	2
Percent of people responding	86	
Is the use of part-time older workers feasible	30	2
Percent of people responding	94	6

SECTION C

The next set of questions concerned attorneys' qualifications and age.

Questions on attorneys' qualifications, primarily questions of age, previous experience before working in this program, membership in the bar when hired based on the total number of attorneys (49.5) (rounded to 50 attorneys) in projects.

TABLE I.—AGE OF ATTORNEYS IN PROJECT

Age	Number of attorneys	Percent of attorneys
21 to 25	4	8
26 to 30	30	60
31 to 35	6	12
36 to 40	3	6
41 to 45	0	0
46 to 50	0	0
51 to 55	0	0
56 to 60	1	2
61 to 65	2	4
65 plus (oldest 72)	4	8
Total	50	100

NOTES

68 pct of the attorneys are under 30.
80 pct of the attorneys are under 35.
86 pct of the attorneys are under 40.
14 pct of the attorneys are over 55.
12 pct of the attorneys are over 60.

TABLE II.—EXPERIENCE OF ATTORNEYS BEFORE BEING HIRED FOR THE PROJECT

	0 to 11 mo	1 to 2 yr	3 to 4	5 to 6	10 to 20	21 to 30	31 to 40	40 plus
Number	14	17	9	2	2	1	4	1
Percent	28	34	18	4	4	2	8	2

62% of all attorneys had less than three years experience.

80% of all attorneys employed had less than five years experience when hired.

Only 18% had 10 or more years experience when hired.

TABLE III.—MEMBER OF THE BAR WHEN HIRED

	Yes	No	Retired
Number	43	6	1
Percent	86	12	2

The overwhelming majority of attorneys were admitted to the bar when hired to staff the respective projects.

SECTION D

Category D had to do with specialized training for professional staff in elderly law or legal issues affecting the elderly, whether it was received and how it was given. The preponderance of in-house training specified that, although it was in-house, it utilized materials from outside—organizations such as NSCLC and NPI training documents.

When asked whether specialized training was given, an overwhelming majority of projects said yes.

TABLE I.—GIVE SPECIALIZED TRAINING

	Yes	No
Number of cases	25	7
Percent of cases	78.1	21.8

TABLE II.—IS TRAINING IN-HOUSE[1]

	Yes	No
Number of cases	18	7
Percent of cases	72	28

[1] 75 pct give some form of in-house training.

TABLE III.—OUTSIDE TRAINING

	Yes	No
Number of cases	18	7
Percent of cases	72	28

TABLE IV.—SOURCES OF OUTSIDE TRAINING

[18 cases responding]

Source	Number	Percent
Legal education programs	9	50
Backup centers	17	94
Bar association	4	22.2
Law school seminars and training	5	27.8
Other legal aid programs	3	16.7
Workshops	3	16.7
Outside materials	1	5

TABLE V.—RECRUITMENT OF FULL TIME STAFF

[27 cases responding]

Source	Number	Percent
Advertising	22	81.5
Law schools	12	44.4
Vista	4	14.8
Legal aid offices	4	14.8
Elderly organizations	2	7.4
Other	2	7.4
Word of mouth	9	33.3

The prime method of recruit full-time staff is through advertising in various journals and at law school. Few legal service projects utilize senior citizens organizations or publications.

SECTION E.—PARALEGALS

TABLE I.—PAY STATUS OF PARALEGALS

[116 cases responding]

	Full-time salaried	Full-time non-salaried	Part-time salaried	Part-time non-salaried
Number	30	1	27	58
Percent	25.9	.8	23.8	50

TABLE II.—SOURCES OF FUNDING FOR PAID PARALEGALS

[57 cases responding]

Source	Number	Percent
Title III OAA	15	26.3
Title XX		1.7
SOS	3	14
VISTA	9	15.8
CETA	6	10.5
United Way	5	8.8
FRS	11	19.3
Other	2	3.5

TABLE III.—DEMOGRAPHIC BREAKDOWN OF PARALEGALS

[114 cases]

Age	Number	Percent
Under 21	4	3.5
21 to 30	21	18.4
31 to 40	12	10.5
41 to 55	9	7.9
55 to 65	28	24.6
65 plus	40	35.1

Notes.—59.7 pct of all paralegals over 55; 21.9 pct of all paralegals under 30.

	Sex	
	Males	Females
94 responses	32	62
Percent	34	66

	Black	Caucasian	Spanish speaking	Other
94 responses	10	73	7	4
Percent	10.6	77.7	7.5	4.2

Paralegals in these projects were likely to be female (66%) and Caucasian 78% (77.7%). Blacks and Spanish-speaking personnel were being utilized.

Table IV.—Of the 58 paralegals funded, there was a great disparity of funding sources. The prime *single source*, Title III—OAA, was 26.3%, with Federal Revenue Sharing 19.3%, and RSVP, VISTA, CETA and Wins comprising 40% funding source for paid paralegals. RSVP could be considered a non-paid position since transportation and lunches may not be adequate pay. Several respondents declared that if they could, they would request "*real*" pay for their RSVP workers.

Table V.—Training is primarily in-house—65%.

TABLE VI.—TRAINING OF PARALEGALS

[23 cases responding]

	In-house	Outside
Number	15	8
Percent	65.2	34.8

TABLE VII.—DESIRABILITY AND VALUE OF PARALEGALS

	Yes	No
Number	6	3

Note.—Of the 9 projects presently without paralegals, 6 would like to employ them.

	Yes	No
Number	18	4
Percent	81.9	18.1

Note.—Of those projects presently employing paralegal staff—desire to expand paralegal staff (22 cases responding).

TABLE VIII.—SUFFICIENCY OF FUNDS TO PROVIDE TRAINING FOR PARALEGALS

[30 cases responding]

	Yes	No
Number	4	26
Percent	13.3	86.7

	Yes	No
Number	9	21
Percent	30	70

Note.—Availability of training for senior citizens paralegals in the community (30 cases).

SECTION F.—AVAILABILITY OF RESOURCES

Has your elderly legal services project used a backup center or model grant program for technical or other assistance?

TABLE I.—USE OF BACKUP CENTERS AND MODEL GRANT PROGRAMS

	Yes	No
Number of projects	18	12
Percent of projects	60	40

TABLE II.—WHAT WAS YOUR EXPERIENCE WITH THE BACKUP CENTER?

[18 cases]

	Good	Average	Bad
Number of projects	15	2	1
Percent of projects	84	10	6

TABLE III.—TYPE OF TRAINING FELT NECESSARY

	Number of projects	Percent of projects
A—Substantive Areas of Elderly Law (30 Cases)		
Age discrimination	15	50
Older women	12	40
Consumer problems	23	77
Private pensions	14	47
Federal Government pensions	12	40
Probate	14	47
Funding	19	63
Guardianship and involuntary commitment	22	73
Social security	24	80
Health and nutrition	18	60
SSI	24	80
Housing	18	60
Transportation	13	43
Nursing homes	26	87
Veterans' matters	19	63
B—Funding Sources for Elderly Legal Services Programs		
Title III	18	60
Title XX	13	43
Revenue sharing	9	30
LEAA	8	27
CETA	9	30
Other	4	10

Summary of findings

The sixth section of our survey had to do with the availability of outside resources. There were two areas of questions: (1) the use of back-up or model grant projects; and (2) substantive areas of training needed.

Sixty percent of the projects had utilized a back-up or model project. Out of those, 84% felt that the experience was very good, 10% felt it was satisfactory, and one case felt it was unsatisfactory. Out of the 40% who had not been able to or who had not used a model project or back-up center, 96% said they would use them if an appropriate case arose.

Another question in the survey was whether the elderly legal project would use specialized training provided by a back-up center at a training conference. Ninety-six percent of the cases said that they would attend such training.

When asked what type of training they felt is necessary for their elderly project, responses were as follows:

	Percent		*Percent*
Age discrimination	50	Nursing homes	87
Consumer problems	77	Older women	40
Federal Government pensions	40	Private pensions	47
Funding	63	Probate	47
Guardianship and involuntary commitment	73	Social security	80
Health and nutrition	60	SSI	80
Housing	60	Transportation	43
		Veterans' matters	63

Mr. AFFELDT. Now we shall hear from Mr. David Marlin, director, Legal Research and Services for the Elderly.

Mr. Marlin has always been most helpful to the committee, serving us well in many capacities. The working paper which he and his staff prepared in 1970 on "Legal Problems of the Elderly" helped launch our study on improving legal representation for older Americans.

Dave will soon prepare another working paper for the committee on another timely topic, "Protective Services for the Elderly."

Now we will hear from Mr. Marlin.

STATEMENT OF DAVID MARLIN, DIRECTOR, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY, WASHINGTON, D.C.

Mr. MARLIN. Thank you.

I would like to start by expressing gratitude to the committee, its Senators and staff, who have provided a focus on this important issue for the last several years. The interest of the committee has accounted for a lot of the progress that has been made.

I also would like to call special attention to the staff members who are here this late today.

The advantage to being last, if there is one, is the opportunity of hearing everything that goes before and, therefore, having the opportunity to comment on anything that you heard. I would like to make some comments on some of the things that have been said today and yesterday.

You have the testimony that I was prepared to provide and I will just hit a few highlights from it.

We have been privileged since 1968 to be working in this field. By "we," I mean the legal program of the National Council of Senior Citizens. I think our special strength and validity as lawyers is that we represent an organization of 3.5 million older persons, which is well known in the country for championing the causes of older persons. Our focus has been, is, and will continue to be, how to solve the problems of senior citizens. We approach issues in terms of how they impact on older people.

Since 1968, more than 100 legal services programs for the elderly have been funded, largely with title III funds. We estimate they serve more than 100,000 persons a year. There also have been about 10 law schools that have initiated programs—clinical, academic, or both.

The organized private bar, upon which I wish to comment a little bit later, in recent years has recognized the need and begun to provide some assistance to resolve legal problems of older persons. But the lightning rod has been and continues to be governmental support.

Much remains to be done in spite of the substantial progress that has been made.

We believe the vast majority of older persons today do not have access to adequate legal representation. In addition to the 100,000 persons we previously estimated are served by the 100 elderly law projects, we estimate 200,000 older persons per year are represented by the Legal Services Corp., legal aid offices, the private bar, and law school clinics.

As the current population of persons 65 and over is in excess of 22.3 million, over 22 million older persons are potential legal clients. Discounting the 30 percent with incomes presumptively sufficient to retain a private attorney, that still leaves 15.6 million.

SIX MILLION ELDERLY WITHOUT LEGAL REPRESENTATION

As the American Bar Foundation estimates that 37.3 percent of the adult population will face a legal problem each year, a conservative estimate of the number of older persons per year who face im-

minent legal action, but are without access to legal representation, is 5.8 million persons.

In our prepared statement,[1] we provide some illustrations of the need. Picking one largely rural area—the States of Mississippi, Tennessee, and Alabama—with 706,500 older persons, let me refer the committee to our prepared statement where we elaborate on that.

We have recommended four goals to accomplish and I would like to very briefly state those and comment on them.

Goal One: Prioritize Services

First, that the Legal Services Corp. programs be mandated by Congress to establish priorities for their services so that all segments of the poor are served equally according to their proportion of the poor population.

Now there has been testimony this morning about Congress earmarking funds. That provides a lot of problems for any program, and for Congress. I don't think it is necessary to earmark funds in order to prioritize services. We suggest, for example, in our prepared statement, the creation of some special units or persons within legal services projects who are given the responsibility to represent the elderly. They would be therefore, obligated to perform, and their performance will be one measure of the test that Senator Kennedy posed this morning to Mr. Ehrlich.

In addition, there is the subject of alternative delivery systems which has not been mentioned today or yesterday, to my surprise. Our prepared statement refers to one of them—the voucher system—which is one of the delivery methods that the corporation is testing. Its application to older persons still remains. There are a number of other methods including prepaid plans that I could elaborate on subsequently.

I am trying to keep it short because I know we all want to go to lunch, but there are a number of alternative delivery systems that are possible and that should be experimented with.

I now want to comment on Mr. Ehrlich's testimony. I had an opportunity during the break to outline to him the sort of comment that I intended to make.

There is, unfortunately—and I don't blame anyone for it—a historical imbalance in the amount of legal services that indigent older persons have been receiving from our public legal services movement which was created in 1964.

Whether the figure is 6 percent, a little bit more, or a little bit less—granted we don't know exactly, but I don't think anybody who is attuned to the situation would argue that there is not a historical imbalance.

So the question is: How do we close that gap? I suggest that it has got to be more than training in substantive legal issues affecting older persons and more than paralegalism and more than mobile units to reach older persons. That is why we suggest that Congress take a hand and provide some sensible and rational basis for asking the corporation to prioritize its services.

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[1] See p. 336.

Goal Two: Encourage Public Interest Legal Services

Our second recommendation is that the private bar be encouraged by Congress to fulfill its articulated professional responsibility of providing public interest legal services.

I appreciate Mr. Schneider asking Mr. McCalpin about Justice Brennan's quote. I have known Mr. McCalpin for years. I know the sincerity that he and others in the leadership of the American Bar Association have toward fulfilling that professional responsibility, but I think there has to be more than acceptance of the principle. There must be a test of performance for the Bar Association also. It has to be more than accepting the principle. The word we were using this morning was "quantify." It has not been quantified yet.

I suggest it has to be quantified, otherwise it is an illusory promise that in some places will be fulfilled and other places will not.

In our prepared statement we point out some of the examples of the lack of private bar fulfillment of that responsibility. We suggest certain pro bono and reduced-fee services that could be and should be available.

We pick up a suggestion made in 1933 by Carl Llewelyn which is to impose a tax on the incomes earned by large firms to subsidize legal services for the poor.

In addition, we talk about consideration of an amendment to section 170(c) of the Internal Revenue Code which would allow a charitable deduction for lawyers and other professionals who render services to or through a tax-exempt organization such as a legal aid society.

Goal Three: Funding for AoA Staff Person

Our third recommendation is that Congress approve as part of the Older Americans Act amendments, in 1977 or in the appropriation process for fiscal 1977, a staff position at AoA. This would provide them the capacity and the authority to hire someone to administer all these programs, the model projects, the training grants. They would have someone on the staff who could provide leadership within AoA.

I know Commissioner Flemming is very much in favor of this. He is trying to find ways to bring a person like that aboard, but is relegated to nondirect methods since there is no authorized staff position.

May I respectfully suggest to the committee that it provide consideration for that?

Goal Four: Earmarked Funding for Elderly

Finally, our suggestion is that a portion of the appropriations for such Federal programs as the Law Enforcement Assistance Act, the Legal Services Corp., the Older Americans Act, title I of the Higher Education Act, or the consumer education programs be earmarked for educational programs in the legal rights and problems of the elderly.

I don't have to point out to the committee or to persons in the room how important it is that older persons themselves be made

aware of their legal situation. They know they have problems, but sometimes they don't appreciate they are legal and can be solved through the assistance of lawyers and paralegals. There is a great need for educational programs for older persons.

I think I will stop at this point, Mr. Affeldt.

If there are any questions, I will be happy to answer them.

[The prepared statement of Mr. Marlin follows:]

PREPARED STATEMENT OF DAVID MARLIN

I appreciate this opportunity to appear here and share our recommendations regarding the development of legal representation for the elderly.

Since its inception 8 years ago, the mission of our office has been to work with State and area offices on aging, Legal Services Corporation and legal aid offices, bar associations, law schools, and organizations of older persons to develop programs of legal representation for the elderly. The National Council of Senior Citizens, under a grant from OEO from 1968 to 1972, established the first 12 legal services for the elderly demonstration projects in the country—projects which have since been replicated throughout the Nation.

Beginning in 1974, we pioneered the first legal services technical assistance effort to State and area offices on aging funded by the Administration on Aging. Under this grant covering the States in HEW Region III, we helped develop direct legal service delivery systems, drafted and critiqued State legislation impacting older persons and trained State and area agency staff, legal services providers, and older persons themselves in the legal rights and problems of the elderly. Based upon this experience, AoA in July 1975 expanded this program to include all 50 States and increased NCSC's responsibilities to include the 19 States in HEW Regions I, III, and IV.

The advances in legal representation for the elderly that we have stimulated during the past eight years have been significant. Prior to 1968, there were no legal programs in the country focusing on older persons; elderly law seminars and clinical programs were unheard of by the Nation's law schools; the private bar had not yet awakened to the fact that older persons are a significant and largely unserved segment of the population, and government support for legal services for the elderly was virtually nonexistent.

Since 1968, over 100 legal services for the elderly projects have been funded, largely with title III funds, and continue to serve over 100,000 persons per year. Ten law schools have initiated law and aging seminars and/or clinical programs which not only provide direct legal representation for the elderly but train future lawyers in the substantive areas of the law impacting older persons and sensitize them to their needs. The organized private bar—although slow—is beginning to recognize the legal needs of the elderly. Finally, governmental support has been and is the lightning rod of the movement.

Direct legal services programs for the elderly have been initiated and sustained by support from such Federal programs as the Older Americans Act, ACTION, the Housing and Community Development Act, revenue sharing, CETA, the Legal Services Corporation, and title XX of the Social Security Act. Most recently the designation by this Congress of legal services as a priority social service under the Older Americans Act has been a boon to the effort of insuring adequate legal representation for older persons. State and area agencies who had been indifferent to the development of legal representation for the elderly are, because of this congressional mandate, becoming eager to learn about legal services delivery, to provide training for their staff in the legal rights and benefits of the elderly, and to work toward the establishment in their areas of direct legal services programs.

Although substantial progress has been made, much remains to be done. The vast majority of older persons today remain without access to adequate legal representation. Approximately 200,000 older persons per year are served through Legal Services Corporation/legal aid offices, law school clinics and the 100-plus elderly law units. As the current population of persons 65 and over is in excess of 22.3 million, over 22 million older persons still remain in the potential client population. Discounting the 30 percent with incomes presumptively sufficient to retain a private attorney, 15.6 million remain. As

the American Bar Foundation estimates that 37.3 percent of the adult population will face a legal problem each year, a conservative estimate of the number of older persons per year who face imminent legal action but are without access to essential legal representation is 5.8 million.

The lack of access is particularly acute for older persons in the South. For example, in the three States of Mississippi, Tennessee, and Alabama, there are 163 counties with a total elderly population of 706,500 without any form of legal assistance for the poor. In those 74 counties in which legal aid is available, the attorney-client ratio is at times as high as 1 attorney per 31,000 eligible poor persons.[1] As the basic policy of such programs is to serve clients in the order in which they appear at the door, older persons who are at best reluctant consumers of legal services get lost in the shuffle. Legal Services Corporation estimates of older persons serviced by LSC offices bear this out. Although older persons nationally represent 20 percent of the poor population, only 6 percent of LSC clients are elderly. The 1975 caseload totals for Georgia Legal Services, the only HEW Region IV legal services program to claim statewide coverage, supports this estimate. Of the 15,550 cases handled by Georgia Legal Services during 1975, only 776 involved older persons.

In addition to the millions of older persons per year who recognize that they have a legal problem and thus require a legal advocate to intervene on their behalf, there are millions more who do not know enough about their legal rights to recognize when they are unjustly denied public benefits, defrauded in consumer transactions, or victimized in real estate transactions, long-term care arrangements or protective services proceedings. Although ignorance of the law is not peculiar to older persons, the effects of such ignorance is particularly devastating to them because of their vulnerability, marginal resources, and dependence on public benefit programs.

This ignorance of the law and lack of access to adequate direct representation can and must be remedied. To accomplish this goal, we recommend the following:

(1) *That Legal Services Corporation programs be mandated by Congress to prioritize their services so that all segments of the poor be served equally according to their proportion of the poor population.*

Although it is true that the Legal Services Corporation offices, even with the increased appropriation of $123 for fiscal year 1977, cannot possibly serve all 29 million poor persons in this country eligible for their services, all segments of the poor population should be assured equal access to the limited services that are available. For the poor elderly to receive their fair share of representation, Legal Services Corporation projects must commit more of their resources to outreach and education of older persons.

Let me emphasize we are talking about congressional appropriated Legal Service Corporation funds, not Older Americans Act funds. Poverty legal services projects should not be permitted to neglect the elderly unless they receive the scarce funds from an area agency on aging.

One way of implementing this mandate would be to develop within each LSC project which is presently underserving older persons a special unit which is sensitive to the legal needs of the elderly poor and has the proper training and outreach capacity for dealing with the legal problems of the elderly.

Another step which the corporation should consider is to allocate a portion of the money reserved for the study of alternative delivery systems to projects which focus on reaching the elderly poor. The voucher system, one of the delivery methods designated for testing by the corporation, combined with an outreach and educational component may be a more effective method of reaching the elderly poor than the existing staff attorney system. For many poor older persons, the present staff attorney system, because of its development under OEO, has the taint of welfare, and thus is rejected as a source of services. The voucher system, in addition to being free of that taint and providing a choice as to which attorney provides the representation, may also help to remedy the physical problem of access which presently inhibits many older persons from seeking LSC program services.

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[1] This is the current attorney-client ratio in the 40 counties serviced by North Mississippi Rural Legal Services.

(2) *That the private bar be encouraged by Congress to fulfill its articulated professional responsibility of providing public interest legal services.*[2]

Justice Marshall, at the 1975 ABA convention, noted that: "While the organized bar has philosophically adopted the idea of its responsibilities in securing adequate representation of all persons, it has yet to come to grips with its responsibility for enforcing this obligation."

This lack of commitment of the private bar is borne out by the results of a survey of a nationwide sample of lawyers conducted in 1973–74 by the Wisconsin Institute for Research on Poverty. Of the 1,450 lawyers responding, 870—or 60 percent—spent less than 5 percent of their billable hours doing public interest work and nearly half of these spent no time at all. A second interesting fact revealed by this study is that lawyers in large urban firms reported doing no more public interest work than smaller firm lawyers and did considerably less than solo practitioners. Seventy percent of the large firm lawyers spent less than 5 percent of their billable hours on public interest work, as compared to 45 percent of the solo practitioners.

The import of these statistics with regard to legal representation for the elderly is obvious. As publicly funded legal services will never be sufficient to serve the millions of persons unable to afford the normal fees of private attorneys, the private bar itself must significantly increase its pro bono or reduced fee services if the vast number of lawyerless poor and elderly persons are to be served. A rule of thumb suggested by Justice Brennan in a speech at Harvard in 1967 on "The Responsibilities of the Legal Profession" is that each member of the bar be required to expend 5 hours per week in pro bono representation. No bar association has yet imposed such an obligation upon its members.

If the private bar continues to evade its own articulated responsibility Congress should seek a means to achieve Justice Brennan's goal. Although direct Federal regulation of the private practitioner's services may be both difficult and unwise, Congress could consider adopting a suggestion made by Carl Llewelyn in 1933 and impose a tax on the income earned by large firms to subsidize legal services for the poor. Or Congress could adopt a carrot-and-stick approach. For a number of years, private practitioners have been advocating an amendment to section 170(c) of the Internal Revenue Code to allow a charitable deduction for lawyers and other professionals who render services to or through a tax exempt organization such as a legal aid society. Although such an amendment should be drawn very narrowly to avoid large windfalls to lawyers, Congress may wish to consider such an amendment with the added condition that the value of such services are deductible only after the lawyer has provided 100 nondeductible hours per year of pro bono services.

(3) *That Congress approve as part of the fiscal year 1977 AoA appropriation a legal services development staff position to monitor and evaluate the programs of the State and national contractors in developing legal representation for the elderly, to negotiate with Federal manpower and legal services funding agencies to insure that older persons receive their fair share of such resources and to formulate AoA policy regarding the implementation of legal services as a priority service under the Older Americans Act.*

Although the initiative of Commissioner Flemming in launching the State legal services development grant program is an important step in the process of providing adequate legal representation for the elderly, this program lacks adequate staff support at the federal level. There is presently no one at the policymaking level within AoA with the qualifications, experience, and time to assimilate, evaluate, and develop policy based upon the experiences at the State and area agency levels. The effect of this gap in the aging network is unnecessary duplication of efforts and inconsistencies of services between programs and geographic areas.

Finally, (4) *That a portion of the appropriations for such Federal programs as the Law Enforcement Assistance Act, Legal Services Corporation, Older Americans Act, Title I of the Higher Education Act, or the consumer education program be earmarked for educational programs in the legal rights and problems of the elderly.*

As noted earlier on in this testimony, many older persons fail to assert valid legal claims because they are uninformed as to their rights under the law.

[2] A resolution approved by the house of delegates of the 1975 ABA convention states: ". . . it is a basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services. . . ."

In-depth but comprehensible law education programs for the elderly could remedy this gap in knowledge. LEAP (Legal Education and Participation), a consumer law program operated through senior centers in Philadelphia by Temple University Law School, might serve as one model for such programs. Through this 10-week, 20-hour program, older persons are taught basic principles of contract law, the public benefit programs, legal and illegal advertising, and consumer credit. Legal concepts are translated into comprehensible terms by teams of lawyers and teachers, and the elderly participants are actively engaged in the learning process through debates, role playing, and independent research. This process teaches older persons not only their substantive rights under the law but demystifies the law so that they will feel comfortable in asserting their own rights and serving as advocates for others.

Now that models for legal education for older persons have been developed with foundation support, the basic difficulty is obtaining funding to implement the models on a national basis. Such Federal programs as the Law Enforcement Assistance Act, the Legal Services Corporation, Older Americans Act, the Higher Education Act, and the consumer education programs would seem to be natural funding sources for such efforts. However, thus far, few legal education for the elderly proposals have been funded under these programs. One way to spark both increased proposals and greater attention by the agencies administering these Federal programs is for Congress to earmark a portion of the appropriations for one or more of these programs for educational programs in the legal rights and problems of the elderly.

In the long run an investment in such preventive law education programs is more effective and cost efficient than our present system of remedial law.

New Legal Services Title?

Mr. Affeldt. First, let me pose a question that I don't expect you to respond to now, but I am hopeful that you would provide some information for the committee's hearing record. In addition, this question will be posed to Mr. Nathanson. I would appreciate a memo [1] from you concerning a suggestion made at yesterday's hearing with regard to establishing a new title under the Older Americans Act dealing specifically with legal services.

At the hearing, the precise requirements of that title were not spelled out in detail. However, I would be interested in your general reaction to this conceptually and whether you oppose it or support it. Please give us your reasons.

If you do support it, I would be interested in what should be included in the title.

Mr. Marlin. I would be glad to do that.

Mr. Schneider. That is one of the questions Senator Kennedy put to Dr. Flemming and I think one aspect of the response should be how that program would relate to legal services activities and other ongoing activities.

Would it be in addition to or would it be a coordinating mechanism? How would it relate to providing services, training, and also to the private bar?

Mr. Affeldt. I have a second question.

AoA's Efforts To Strenghten Legal Representation

Do you believe that the Administration on Aging's efforts to strengthen legal representation for older Americans is developing satisfactorily now? If not, what steps do you think are needed?

[1] See appendix 1, item 8, p. 353.

Mr. MARLIN. I believe that the Administration on Aging has been extremely responsive to the legal problems of older persons in terms of trying to originate and maintain some programs that would meet those needs, solve those problems.

The Administration on Aging is an organization with a responsibility to 22 million older persons in this country. Many millions are in great need of assistance, frequently of an emergency nature which can include a place to sleep, food, and other essentials to life.

Through the efforts of Congress, particularly over the last few years, the appropriations and mandate of Administration on Aging have been so substantially increased that they are able to make a credible effort to resolve some of those problems.

Being biased that lawyers can significantly contribute toward solving problems, I am very much in favor of adding legal services and legal representation to those lists of services that can be provided for older persons under the Older Americans Act. I believe the Administration on Aging and its administrator have responsibility to be a Government catalyst to help the older persons.

That is kind of a premise. I am sorry it took so long. What I am trying to say is that I think Administration on Aging has responsibilities in legal services and that they have started to exercise them well. It may be somewhat premature to put a lawyer on the staff of every State office on aging, but Commissioner Flemming is trying to create the capacity and the sensitizations within State offices on aging to assist the elderly with their legal problems.

Mr. AFFELDT. I have another question which I would expect a written response to after our hearing.

In your testimony—which, I want to add, is excellent—you pointed out that 10 law schools initiated law on aging seminars. I was wondering if you could provide us with a listing [1] of those 10 law schools?

PRIVATE BAR AND AVAILABILITY OF LEGAL SERVICES

Mr. MARLIN. Yes.

Mr. AFFELDT. One more question, and then I shall ask the other staff members if they would like to pose any questions to you.

What do you think should be the private bar's role for making legal services more readily available for the elderly? In other words, what do you think is the private bar's responsibility? How does it fit in with the overall effort to make effective representation more readily available?

Mr. MARLIN. Well, the private bar has the responsibility through its professional oath to make its services available without charge, if necessary, to those who need them. That effort, since 1964, has been pretty largely relegated to OEO and now the Legal Services Corp. That has been the approach that has been followed in this country, a satisfactory one in the sense it has produced persons who are qualified and trained in issues of poverty law. They become experts and are able to render more efficient services.

If I were to point a direction, Mr. Affeldt, it would be toward those persons who are not indigent but still cannot afford legal fees

[1] See appendix 1, item 8, p. 353.

of $50, $75, and $90 an hour, and some even more astronomical rates that are charged by private practitioners in this country.

It can be done through prepaid plans, through clinics. Bar associations should, I believe, assess lawyers and establish plans through paid staff.

Bar associations should, while they have the opportunity, in a voluntary way, be original and develop programs in cities and States to serve the interests of persons who cannot afford the fees and who need an education themselves in knowing how lawyers can help them.

Mr. AFFELDT. Mrs. Fayé.

Mrs. FAYÉ. No questions.

Mr. AFFELDT. Mr. Schneider.

Mr. SCHNEIDER. It was excellent testimony. My questions were answered in the testimony.

Mr. MARLIN. Thank you.

Mr. AFFELDT. The hearing is adjourned, subject to the call of the Chair.

[Whereupon, at 1:30 p.m., the hearing was adjourned.]

APPENDIXES

Appendix 1

CORRESPONDENCE AND MATERIAL SUBMITTED BY SENATOR KENNEDY AND HEARING WITNESSES

ITEM 1. LETTER FROM SENATOR EDWARD M. KENNEDY TO HON. ARTHUR S. FLEMMING,[1] DATED SEPTEMBER 30, 1976

DEAR COMMISSIONER FLEMMING: Once again, I want to commend you for an excellent presentation at the Committee on Aging's hearing on "Improving Legal Representation for Older Americans." You provided a valuable addition to our overall hearing record.

As soon as a transcript of the proceeding is available, a copy will be sent to you for any necessary editing.

I was unable to ask all the questions that I intended to raise at the hearing because I had to attend a bill-signing ceremony at the White House. For this reason, I would appreciate a response to the following questions:

(1) I understand that you have issued a memorandum directing that State legal service developers should be employees of State agencies, except in "extenuating circumstances." However, it appears that some States plan to subcontract out the development function—in most cases to legal services projects. Your technical assistance memorandum states that a subcontracting arrangement, such as this, would require a waiver from the Administration on Aging. Do you plan to grant waivers in cases when the State agency merely prefers to subcontract, or will you require a showing that it is not possible to put the developer on the State payroll?

(2) The State legal services developer will have the task of coordinating legal services. In this capacity the developer would have considerable influence over the disposition of money available to the States under the Older Americans Act. Do you think that there may be a possible conflict of interest if the development function is subcontracted to an agency which is also an applicant for funding from the State? What limitations, if any, would you put on a subcontracting developer from also receiving State funding to operate programs?

(3) Many local offices on aging have awarded title III funds to legal services programs, which, in turn, impose income limits for persons applying for assistance. This seems to contradict congressional intent, prohibiting the imposition of a means test under the Older Americans Act. What have you done to resolve this problem? Do you think that this issue can be resolved through an interagency agreement with the Legal Services Corporation?

(4) The Administration on Aging is now funding some national projects which provide technical assistance and training to States and area agencies on aging. These model projects, however, will not be continued indefinitely. Assuming these projects are needed in the future, would the Administration on Aging plan to continue these programs on a permanent basis?

(5) One of the witnesses at the hearing suggested that the Administration on Aging should have a designated person assigned to legal services. Would you favor specific authority for the Administration on Aging to employ an attorney to supervise the Administration on Aging's activities in developing legal services? If so, would this require legislation or could this be achieved through other means?

Thank you and best wishes.

EDWARD M. KENNEDY.

[1] See statement, p. 254.

ITEM 2. LETTER AND ENCLOSURE FROM HON. ARTHUR S. FLEMMING TO SENATOR EDWARD M. KENNEDY, DATED NOVEMBER 3, 1976

DEAR MR. CHAIRMAN: Thank you for your letter of September 30 identifying several additional questions you would like me to respond to in connection with the Special Committee on Aging's hearing on "Improving Legal Representation for Older Americans." My response to those questions is enclosed.

I enjoyed appearing before you on this issue. As I indicated at the hearing, I believe legal services can help to meet many of the problems of today's older persons. I appreciate your leadership in helping to promote and strengthen these services.

Very sincerely and cordially yours,

ARTHUR S. FLEMMING.

[Enclosure]

Question 1. I understand that you have issued a memorandum directing that State legal service developers should be employees of State agencies, except in "extenuating circumstances." However, it appears that some States plan to subcontract out the development function—in most cases to legal services projects. Your technical assistance memorandum states that a subcontracting arrangement, such as this, would require a waiver from the Administration on Aging. Do you plan to grant waivers in cases when the State agency merely prefers to subcontract, or will you require a showing that it is not possible to put the developer on the State payroll?

Response. As a matter of basic policy I do not intend to approve proposals to subcontract the development function to organizations outside the State agency on aging. I believe this is a sound policy because it is the State agency on aging under the Older Americans Act that has responsibility for developing the annual State plan on aging, approving annual area agency plans and budgets, managing the title III program, and providing effective, vigorous leadership in the State in the field of aging. We strengthen the role of the State agency on aging, and help to insure that legal services become part of the coordinated comprehensive service systems being developed by State and area agencies when we assign this leadership and developmental function to the State agency.

In cases where personnel ceilings or State policy preclude adding the legal services specialist to the State agency staff we intend to pursue with the State the possibility of the State agency using its model project funds to retain an individual as a consultant to the State agency to perform the legal services development function. As a consultant, this individual, though technically not a staff member, would be expected to participate in staff meetings and act, in effect, as a regular member of the staff.

I would consider exceptions to this policy only in cases where a State could fully document its inability to add a staff member or work out an arrangement with a consultant in the manner I have described.

Question 2. The State legal services developer will have the task of coordinating legal services. In this capacity the developer would have considerable influence over the disposition of money available to the States under the Older Americans Act. Do you think that there may be a possible conflict of interest if the development function is subcontracted to an agency which is also an applicant for funding from the State? What limitations, if any, would you put on a subcontracting developer from also receiving State funding to operate programs?

Response. First, as I indicated in response to question number 1, I do not expect to approve any proposals to subcontract the development function to an organization outside the State agency on aging.

As you appreciate, under the title III program, it is the area agency, not the State agency, that make awards to organizations to provide services. Nonetheless, the State obviously can exercise some degree of influence on the funding decisions of area agencies. Therefore, in order to limit the potential conflict of interest problem your question suggests, we will not allow States that in certain exceptional situations may be allowed to subcontract the development function to fund, or allow area agencies to fund, the subcontractor for any other legal service projects.

Question 3. Many local offices on aging have awarded title III funds to legal services programs, which, in turn, impose limits for persons applying for assistance. This seems to contradict congressional intent, prohibiting the imposition of a means test under the Older Americans Act. What have you done to resolve this problem? Do you think that this issue can be resolved through an interagency agreement with the Legal Services Corporation?

Response. I agree that imposition of a means test is contrary to the letter and spirit of the Older Americans Act of 1965, as amended. Unlike our authorizing legislation the Legal Services Corporation requires that there be a means test to determine eligibility for services under the act.

You have, therefore, identified a very difficult problem, inasmuch as the Congress evidently did not intend that legal services provided under the Older Americans Act be provided as a publicly supported competitor for taxpaying lawyers in private practice, regardless of whether the older person could otherwise avail himself or herself of the services of a private practitioner. For example, suppose that an older person wants to sue a large corporation for triple damages for violation of antitrust laws, in a case involving millions of dollars. Since he would have no difficulty whatever obtaining the services of a lawyer in private practice, and since representing him would take an inordinate amount of the time of a legal service project for the elderly, it would seem quite enough for the project to assist such a prospective client to find an attorney who specializes in antitrust litigation, and to help him in other ways to find suitable legal representation.

Therefore, one solution to the problem might be to make available legal services to all older Americans, but to tailor-make the service according to the needs and circumstances of the individual. For example, if the client is so needy as to qualify for free representation by a legal aid society or an organization supported by the Legal Services Corporation, the Older Americans Act program might limit its legal service to him to advising him of the availability of that service and helping him get it. If the client is wealthy enough to afford the services of a private practitioner, our project might advise him of the mechanisms established by the organized bar to identify which lawyers specialize in which types of cases, and might advise him what type of specialist he needs. But where the older person is too indigent to afford a private practitioner but not enough so to qualify for free legal services in another program, our project might give him free legal advice or represent him in litigation.

Because of the complexity of the issues we clearly need to reach an understanding with the Legal Services Corporation, and I hope to do this in the context of the interagency agreement we are developing with them.

Question 4. The Administration on Aging is now funding some national projects which provide technical assistance and training to States and area agencies on aging. These model projects, however, will not be continued indefinitely. Assuming these projects are needed in the future, would the Administration on Aging plan to continue these programs on a permanent basis?

Response. AoA will continue to support projects responsive to the stated technical assistance and training needs of State and area agencies on aging in the legal services area. These projects might be awarded to organizations that currently have awards with us for this purpose, or to other organizations with expertise in this area.

Question 5. One of the witnesses at the hearing suggested that the Administration on Aging should have a designated person assigned to legal services. Would you favor specific authority for the Administration on Aging to employ an attorney to supervise the Administration on Aging's activities in developing legal services? If so, would this require legislation or could this be achieved through other means?

Response. I believe that we should have an attorney who is familiar with legal services on our staff supervising our activities in the legal services area. We are currently negotiating with the Legal Services Corporation to have them detail an individual with these qualifications to us to handle these responsibilities. I believe we can provide effective leadership in the legal services area.

ITEM 3. INFORMATION MEMORANDUM AND ATTACHMENTS FROM HON. ARTHUR S. FLEMMING TO VARIOUS STATE AGENCIES, DATED AUGUST 25, 1975

To: State agencies administering titles III and VII of the Older Americans Act of 1965, as amended.

Subject: Model project grants for the development of legal services for the elderly.

Content: Among the model project grants recently awarded by the Administration on Aging were 11 totaling over $1 million designed to foster the improvement of legal service programs for the elderly, especially to contribute to the capacity of State and area agencies on aging to increase the availability and raise the quality of such services in their jurisdictions.

The objectives of this program are:

I. *To inaugurate a process which will ultimately result in the inclusion of a legal service component within each of the comprehensive coordinated services structures being developed through the State and area agencies on aging.*

The efforts projected to achieve this objective include: (a) technical assistance to State and area agencies in the establishment, development, expansion, and support of an evolving network of legal services activities focused on the needs of older persons, and (b) technical assistance to State and area agency staff in gaining the understanding of the substantive aspects of law expected to impact on older persons, also planning more effectively for legal services needs of the older persons in their jurisdictions.

II. *To initiate a process which will help insure that such legal services activities designed to meet the needs of older persons, can be staffed with adequately trained professional and paraprofessional personnel.*

The efforts planned to accomplish this include: (a) technical assistance to legal service providers, through the State and area agencies on aging, by development of training materials and assistance in the effort to insure the provision of quality services; (b) development of curricular materials, both learning and teaching, for use in programs for training paraprofessionals in the legal issues confronting older persons. Such materials are to be suitable for use by university extension services, community colleges, special post-secondary education training programs, and on-the-job reinforcement; (c) development of training materials suitable for use in law schools, clinical law programs and attorney refreshers. Such materials include handbooks and/or casebooks on law issues confronting the aging, as well as other appropriate legal training materials.

III. *To support a limited number of innovative model projects.*

It is our intention that these projects, working with and through the appropriate State and area agencies would: (a) expand accessibility to trained legal service personnel through the effective use of volunteers and paralegals; (b) create opportunities for trained older persons to take an active role in the provision of legal assistance to other older persons; (c) meet the needs of special disadvantaged groups; and (d) supplement activities carried out under objectives I and II.

A list of the grantees, giving the name of the project director, the amount, the geographic focus and the address for each project is attached. A more comprehensive technical assistance memorandum will follow that provides additional information about these legal service grants.

We regard this development as a very significant one within the field of aging. We are giving it a very high priority in our list of priorities. Any help you can give the grantees will be deeply appreciated.

ARTHUR S. FLEMMING.

[Attachments]

LIST OF LEGAL SERVICES PROJECTS

(1) Jonathan A. Weiss ($50,000; HEW Region I, State and area agencies), Legal Services for the Elderly Poor, 2095 Broadway, New York, N.Y.

(2) Douglas M. Crockett ($33,406; Willimantic, Conn.), Connecticut Aging Legal Services, 746 Main Street, P.O. Box D, Willimantic, Conn.

(3) Margaret Stone Brodsky ($85,000; Washington, D.C.), National Retired Teachers Association/American Association of Retired Persons, Senior Citizens Legal Assistance Office, 1909 K Street, N.W., Washington, D.C.

(4) David Marcello ($70,432; Primarily Metropolitan New Orleans and also Louisiana State), Louisiana Center for the Public Interest, 700 Madison Blanche Building, Suite 1222, New Orleans, La.

(5) Mike Gilfix ($47,322; Palo Alto and vicinity), Senior Adults Legal Assistance, 2211 Park Boulevard, Palo Alto, Calif.

(6) Paul Nathanson ($225,000; Technical assistance in a variety of forms to State and Area Agencies in locations not covered by other grantees), National Senior Citizens Law Center, 1709 W. 8th Street, Los Angeles, Calif.

(7) David Marlin ($249,607; Technical assistance to State Agencies and localities in HEW Regions I (excluding Connecticut, III and IV)), Legal Research and Service for the Elderly, National Council of Senior Citizens, 1511 K Street, N.W., Washington, D.C.

(8) Donald P. Rothchild ($75,860; Washington, D.C.), George Washington University, National Law Center, 716 20th Street, N.W., Washington, D.C.

(9) Steven Pepe ($91,032; Primarily Michigan and other parts of the nation), University of Michigan Law School, 917 Legal Research Building, Ann Arbor, Mich.

(10) William R. Fry ($150,000, National Focus), National Paralegal Institute, 2000 P Street, N.W., Suite 600, Washington, D.C.

(11) Susan Stofkoper ($121,000; Sacramento, Calif.), California Office on Aging, 455 Capital Mall, Sacramento, Calif.

(1) PROJECTED ACTIVITIES OF AOA LEGAL SERVICE GRANTEES

Grantee	(1) Development of training materials for—						(2) Technical assistance to State and area agencies		
				Legal service personnel					
	State and area agencies	Paralegals	Law students	Free legal service personnel	Social service personnel	Private bar	Paralegal use	Program development	Substantive law
1. National Council of Senior Citizens.	X	X	X	X	X	X	----------	X	X
2. University of Michigan Law School.	X	----------	X	X	----------	X	----------	X	X
3. Legal Services for Elderly Poor (New York, N.Y.).	X	X	----------	X	X	----------	----------	X	X
4. George Washington University Law School.	X	X	X	----------	X	----------	----------	----------	----------
5. National Retired Teachers Association and American Association Retired Persons.	----------	X	----------	----------	----------	----------	----------	X	X
6. State of California	X	X	----------	----------	X	----------	X	----------	----------
7. Palo Alto Senior Adults Legal Assistance.	----------	----------	X	----------	----------	X	----------	----------	----------
8. National Paralegal Institute.	X	X	----------	----------	X	----------	X	----------	----------
9. National Senior Citizens Law Center.	X	----------	----------	X	X	----------	----------	X	X
10. Louisiana Center for Public Interest.	?	----------	X	----------	X	X	----------	X	X
11. Connecticut Aging for Legal Services.	X	----------	----------	----------	X	----------	----------	X	X

(2) PROJECTED ACTIVITIES OF AOA LEGAL SERVICE GRANTEES

Grantee	(3) Training personnel		(4) Provision of legal services to the older persons by—			
	State and area agency personnel	Paralegals	Students	Legal service person	Social service person	Private bar
1. National Council of Senior Citizens.	X		X	X		X
2. University of Michigan Law School.	X			X		X
3. Legal Services for Elderly Poor (New York, N.Y.).	X		X	X		
4. George Washington Law School		X	X	X	X	
5. National Retired Teachers Association and American Asscciation of Retired Persons.		X				
6. State of California	X	X		X		
7. Palo Alto Senior Adults Legal Assistance.		X	X			
8. National Paralegal Institute	X					
9. National Senior Citizens Law Center.	X			X	X	
10. Louisiana Center for the Public Interest.	X		X		X	X
11. Connecticut Aging for Legal Services.	X			X	X	

(3) PROJECTED ACTIVITIES OF AOA LEGAL SERVICE GRANTEES

Grantee	(5) Litigation	(6) Technical assistance to lawyers	(7) Direct community education	
			Material	Training
1. National Council of Senior Citizens	X	X		
2. University of Michigan Law School			?	?
3. Legal Services for Elderly Poor (New York, N.Y.)	X	X	X	?
4. George Washington Law School			X	X
5. National Retired Teachers Association and American Association Retired Persons.	X			X
6. State of California				
7. Palo Alto Senior Citizens Legal Assistance	X	X	X	X
8. National Paralegal Institute		X		
9. National Senior Citizens Law Center	X	X	X	
10. Louisiana Center for the Public Interest	X	X	X	X
11. Connecticut Aging Legal Services	X	X	X	X

ITEM 4. LETTER FROM SENATOR EDWARD M. KENNEDY TO THOMAS EHRLICH[1] DATED OCTOBER 1, 1976

DEAR MR. EHRLICH: Once again, I want to commend you for an excellent presentation at the Committee on Aging's hearing on "Improving Legal Representation for Older Americans." You provided a valuable addition to our overall hearing record.

As soon as a transcript of the proceeding is available, a copy will be sent to you for any necessary editing.

I was unable to ask all the questions that I intended to raise at the hearing because I had to attend a bill signing ceremony at the White House. For this reason, I would appreciate a response to the following questions:

(1) It has been estimated that persons 65 or older account for only about 6 to 7 percent of all clients in the legal services program. Yet, they constitute almost 24 percent of the adult poverty population. What steps, if any, does the Corporation plan to take to redress this imbalance of services to elderly clients?

(2) On August 13 the Legal Services Corporation solicited proposals to test out alternative legal delivery systems, including judicare, vouchers, prepaid

[1] See statement, p. 258.

legal insurance, and contracts with law firms. I understand that these demonstration projects are to be awarded prior to October 1. Do any of the demonstration projects focus on the delivery of legal services to the elderly poor? If not, do you anticipate that any future demonstration projects would fulfill this mission?

(3) Does the Corporation plan to use the increased funding for Fiscal 1977 to strengthen legal representation for the elderly?

Thank you and best wishes.

Sincerely,

EDWARD M. KENNEDY.

ITEM 5. LETTER FROM SENATOR EDWARD M. KENNEDY TO THOMAS EHRLICH, DATED OCTOBER 12, 1976

DEAR MR. EHRLICH: I would appreciate it if you would respond to the following questions for the Committee on Aging's hearing record on September 29 on "Improving Legal Representation for Older Americans."

(1) Of the 2,300 legal services lawyers, how many are specialists in legal problems of the elderly?

(2) Approximately 25 percent of the adult poor (persons aged 18 or older) are older Americans (65 or older). Have you considered designating a specialist in each office to focus on the legal problems of the elderly?

(3) What is the Legal Services Corporation doing to provide training for legal services attorneys in areas which affect the elderly, such as Social Security, Railroad Retirement, Supplemental Security Income, and others?

(4) Is the legal services program taking steps to provide information to the aged about the availability of legal services? Have you considered establishing legal services projects or making legal services attorneys available at scheduled hours at elderly housing projects, nutrition sites or senior citizen centers? Has the Corporation considered mobile units, particularly in rural areas?

These questions are in addition to those I submitted in my letter to you, dated October 1, 1976. I'd appreciate a reply by November 1.

Once again, I wish to thank you for your cooperation and your valuable contribution to the Committee's study.

Sincerely,

EDWARD M. KENNEDY.

ITEM 6. LETTER AND ENCLOSURES FROM THOMAS EHRLICH TO SENATOR EDWARD M. KENNEDY, DATED OCTOBER 29, 1976

DEAR SENATOR KENNEDY: Enclosed are the responses to the questions you asked in your letters to me of October 1 and October 12. If there is any further information we can provide to complete the record of the hearing, please let us know.

Cordially,

THOMAS EHRLICH.

[Enclosures]

RESPONSE TO QUESTIONS CONTAINED IN SENATOR KENNEDY'S LETTER OF OCTOBER 1, 1976

1. What steps, if any, does the corporation plan to take to redress this imbalance of services to elderly clients?

Recent informal surveys done by the corporation indicate that the figures on the proportion of legal services clients who are elderly vary greatly from program to program, from as little as 5 percent to as much as 15 to 20 percent. Last week, we received figures from a program in Waco, Tex., demonstrating that 12.5 percent of their clients were 65 or older, and 22.5 percent were 55 or older. The Appalachian Research and Defense Fund of Kentucky has sent us figures showing that the percentage of the clients over age 55 served by their four offices are respectively 14.8, 17.8, 14.1, and 16.9.

It is not clear, therefore, whether and to what extent an imbalance exists. The 6 and 7 percent figures that you cite are apparently based on a 1969

Office of Legal Services survey. We have not been able to determine how those figures were derived. There is reason to believe that legal services programs have significantly expanded services to the elderly since 1969. The advent of the SSI program in 1974, for example, has resulted in substantial activity by legal services programs to secure the benefits of the law for older persons. Creation of the National Senior Citizens Law Center in 1972 to support litigation on behalf of the elderly has increased the capacity of local programs to handle legal problems of the elderly in areas such as pensions, nursing homes, social security, and protective services, in addition to SSI.

As we have already indicated to the committee, the corporation is putting into place a program reporting system that will give us much more precise information about the extent of services for the elderly. Again, however, we emphasize the substantial amount of impact work done by legal services programs that benefits the elderly. Such activity is not reflected in statistics regarding the age of individual clients.

We do not suggest that we are able to provide anything approaching an adequate level of service to the elderly poor. We are taking steps that will enable local programs to respond more fully to their special needs:

(a) Existing legal services programs, particularly those that are least well-funded, will be receiving significant increases in operating funds during fiscal year 1977. In addition, new programs will be started in areas that have never had legal services before, particularly in the South, Southwest, and Midwest. These added funds will enable programs to serve more clients, including elderly clients, and to engage in the kinds of community education and outreach activities that are especially important in reaching older persons. Further, $1.8 million has been set aside for "special needs." Programs can apply for these funds for special projects to serve the elderly, if that is the locally determined priority for the use of such funds.

(b) Training of legal services program personnel will be significantly expanded during the current fiscal year, through the corporation's office of program support. The office is seeking proposals and recommendations from the national litigation programs, including the National Senior Citizens Law Center, for specific training sessions in substantive areas of the law, including those that have particular impact for the elderly. In addition, the office plans a very substantial expansion of training activities for paralegals, including encouraging the use of older persons as paralegals in local projects. This is particularly useful in expanding services to the elderly.

(c) The corporation is entering into a joint agreement with the Administration on Aging designed to maximize the resources of both organizations to improve legal services for the elderly. We are particularly interested in encouraging the use of the outreach, transportation, and community education activities of area aging agencies and title III and title VII grantees to inform more older persons of their legal rights and to get them to the legal services programs. We also hope to work out an arrangement to disseminate to legal services projects the materials prepared by AoA's model project, technical assistance, and training grantees.

2. Do any of the demonstration projects focus on the delivery of legal services to the elderly poor?

On September 30, the corporation awarded grants to 19 demonstration projects under the delivery systems study. All of the projects will include the elderly in their client groups. Three will place special emphasis on the elderly and one will serve only the elderly.

Utah Legal Services was awarded $76,160 to provide specialized legal services to the elderly in the southern rural part of the State. This judicare project will utilize the existing aging network to reach eligible clients and will establish a WATS line to increase access for older persons. The National Senior Citizens Law Center will provide training and back-up materials for the judicare attorneys.

Judicare of Anoka County, Inc., was awarded $97,000 to provide general legal services to eligible clients, with a special emphasis on reaching the elderly. The project will attempt to reach the elderly through the existing aging network in the county, but if it is clear after 6 months that this is not sufficient, it will hire an elderly staff person for more intensive outreach activity.

The Legal Aid Society of Birmingham will be funded to contract with the private law firm of Crittenden and Still to provide special services that the legal aid society does not generally offer. One-quarter of the $40,000 grant is set aside to prepare wills and testamentary instruments for eligible clients who are elderly.

Group legal services was awarded $56,000 to provide prepaid legal services to a selected group of clients in Los Angeles County. Those clients will be selected from Social Security Administration and public assistance roles, thus assuring that a significant portion of the clients will be elderly.

3. Does the corporation plan to use the increased funding for fiscal year 1977 to strengthen legal representation for the elderly?

As indicated in response to your first question, nearly $29 million of the increased funding for fiscal year 1977 will be used to improve the capacity of existing programs to serve clients and to expand legal services to areas where there are now none. We expect that these funds will be used to support general legal services, since the corporation's mandate is to serve persons who are least able to afford legal assistance, regardless of their age, their race, or any other characteristic. We anticipate, however, that the increased funding will have particular impact on services for the elderly because, as programs reach more adequate funding levels, and have more staff to deal with client problems, they will be able to expand outreach and community education activities that are particularly important for elderly persons. As this committee knows, such costly activities have not been possible during the 5-year period of high inflation when legal services budgets were frozen.

Our response to your first question indicates other ways in which additional funds for fiscal year 1977 will improve services to the elderly.

RESPONSE TO QUESTIONS CONTAINED IN SENATOR KENNEDY'S LETTER OF OCTOBER 12

1. How many elderly specialists are there?

Two points should be kept in mind in considering whether it is possible or most useful to designate "specialists" for the elderly:

(a) Most local legal services programs are not very large. Some have only one or two attorneys and the vast majority have less than eight. Small programs cannot afford to specialize in any area of the law. Moreover, some programs argue persuasively that they are able to provide better service by using a general practice model.

(b) Even when specialization is feasible and practical, experience has often shown that it is much more important to have specialists in substantive areas of the law, like SSI, medicare and medicaid, employment, or housing, that have particular impact for the elderly, than to have persons generally designated as specialists for the elderly. For example, a public benefits specialist thoroughly knowledgeable about medicare and medicaid is probably better able to help an elderly client with a health-related problem than is somebody charged generally with dealing with the problems of the elderly.

Of the approximately 260 legal services programs around the country, we estimate that at least 100 have designated "specialists" on legal services for the elderly. This is in addition to specialists in areas like SSI, health, employment, and housing that have special impact for the elderly. One of the items we have suggested for our joint agreement with the Administration on Aging is the designation of a legal services person in each State to serve as a liaison with the State aging agency. In addition, we would encourage each local legal services program to designate an individual to work directly with the area aging agencies and with title III and title VII projects.

2. Have you considered designating a specialist in each office?

As indicated in response to question number 1 above, we will encourage programs to designate individuals to serve as liaison with State and area aging agencies, to assure cooperation at the local level. The question of what kind of specialists, if any, a program should have is one that should be answered by the board and staff of the individual program, based on a determination of client needs and an assessment of the best way to respond to those needs in the community. To reiterate, the most urgent needs of clients, including elderly clients, in a given community might be better served by an SSI specialist, or a housing specialist, or a health law specialist or by

expanding the capacity of the staff to deal with general consumer and domestic problems, than by designating specialists for discrete client groups. That is a judgment that only local programs can make in consultation with their client communities.

It goes without saying that, if the corporation receives evidence that a program discriminates against the elderly poor, then an investigation would be made and corrective action taken if necessary. No such complaints have been received.

3. What is LSC doing to provide training on issues affecting the elderly?

A substantial amount of training of legal services attorneys and paralegals on issues affecting the elderly has taken place. As the committee knows, section 1006(a)(3) of the Legal Services Corporation Act prohibits the corporation from support of training through grant or contract, and this activity is now carried on by the corporation's office of program support.

Over the past 2 years, the National Senior Citizens Law Center in Los Angeles, a support center funded by the corporation, has conducted training for legal services lawyers in every region of the country. About 15 such sessions have been held, with attendance at each reaching as high as 100 to 120 persons from local legal services programs. The training sessions have focused on SSI, pensions, social security, protective services, age discrimination in employment, medicare, and nursing homes. The Senior Citizens Law Center has prepared materials for local legal services attorneys on substantive areas of the law including SSI, protective services, social security, nursing homes and age discrimination in employment. All of those materials have been distributed and are still available through the National Clearinghouse for Legal Services. The center has in draft now two publications, one on management of assets for older persons and the other on pension litigation.

The corporation already noted in its testimony to the committee on September 29, 1976, the work of other national litigation centers on substantive areas of the law affecting the elderly, particularly nursing homes, home health care, public benefits, and pensions, all of which assist local programs to improve their services to older clients.

The *Clearinghouse Review*, a publication of the corporation's office of program support reporting on developments in areas of the law affecting legal services clients, regularly publishes material on issues affecting senior citizens.

The corporation's office of program support plans to conduct training sessions on specific areas of poverty law and can hold such sessions on issues of particular impact for the elderly, as the need arises. In addition, the office provides "minigrants" to local legal services programs for their own staff training activities. The office has just recently awarded such a grant to Delaware County Legal Assistance in Chester, Pa. to train 22 senior volunteer advocates in the areas of social security, SSI, wills, and estates.

4. Is the legal services program providing information?

It is to just these questions that we hope the joint agreement with the Administration on Aging will be addressed. We do want to explore with AoA the possibility of developing community education materials for the elderly to inform them of their legal rights and the availability of legal services. It may be that such materials should be prepared at a State and local level, however, in order to provide elderly persons with locally applicable information. Many legal services programs prepare community education materials now, and this would seem to be a particularly fruitful area for cooperation between the programs and area aging agencies.

We do not think it appropriate or wise for the corporation to tell local legal services programs how to operate their offices on a daily basis. Many of the programs we fund do make attorneys and paralegals available regularly to speak at places where senior citizens live or gather, including housing projects, nursing homes, nutrition sites, and senior citizens centers. Some programs actually conduct intake interviews at such locations. We encourage such activity and hope to make that a subject of the joint agreement.

A local legal services program may use corporation funds to finance a mobile unit to serve the elderly, and could apply for special needs money for that purpose. The decision about whether that is an effective use of limited funds should be made by each program, according to the needs of its client community. The corporation featured such a mobile unit, operated by the Maricopa County Legal Aid Society in Phoenix, in its October/November 1976 newsletter. In that particular instance, funds available under the Older Americans Act were used to purchase the unit.

ITEM 7. LETTER FROM THOMAS EHRLICH TO SENATOR EDWARD M. KENNEDY, DATED OCTOBER 27, 1976

DEAR SENATOR KENNEDY: This is in response to your letter of October 13, suggesting ways to improve the availability of legal services for the elderly.

You ask whether it might be feasible to compile a list of private practitioners who have some expertise in areas of the law that affect the elderly and whose fees are affordable. Such lists could then be distributed in pamphlets available in senior citizens centers.

This is something that certainly might be explored with the local bar associations and particularly with the lawyer referral service. It is the kind of effort that the legal services development specialist of the State aging agency most appropriately could undertake. Local legal services programs do make referrals now, when a client whose income is above eligibility guidelines comes to the office for legal assistance. In addition, some programs have made arrangements with the local bar to handle certain types of cases for eligible clients, on a pro bono basis, in order to relieve the caseload of the attorneys in the legal services office. Thus, programs could certainly be helpful to the State legal services development specialist or to an area aging agency that was interested in compiling such information.

With regard to your suggestion about a poster campaign, the corporation has printed posters that can be readily adapted for local use and we are distributing them in quantities to local programs to be placed in community facilities, including senior citizens centers. A copy of that poster is enclosed, for your information. As you can see, there is a place on the poster for the local program to put its address, telephone number, office hours, and other identifying information.

You have submitted a list of questions as follow-up to my testimony on September 29. I am sending you our response under separate cover.

Your interest in improving legal services for the elderly is deeply appreciated and I look forward to continuing to work with you toward that goal.

Cordially,

THOMAS EHRLICH.

ITEM 8. LETTER AND ENCLOSURE FROM DAVID MARLIN[1] TO SENATOR EDWARD M. KENNEDY, DATED OCTOBER 22, 1976

DEAR SENATOR KENNEDY: During the course of my testimony on September 29, 1976, at the hearing on "Improving Legal Representation for Older Americans," I was requested by Staff Chief Counsel David A. Affeldt to respond to two requests.

First, I was requested to submit a list of the law schools now providing academic and clinical education programs relating to law and aging. An annotated list, plus a copy of an article from the *Gerontologist* on clinical programs, is attached.

Secondly, I was asked for the judgment of the National Council of Senior Citizens on whether a separate title should be created in the Older Americans Act to consolidate and develop AOA policy on legal counsel, representation and training.

We do not favor the creation of a new legal services title. It would not only distort the present structure of the Older Americans Act, but could also result in decreased rather than increased funding for legal services.

Under title III of the Act, State and area agencies on aging are responsible for assessing local needs and for developing a comprehensive social services support system for older persons within their areas. The 1973 amendments to the act specify that legal services are one of the social services which may be provided in this comprehensive support system. The 1975 amendments provide that legal services is a priority. Given the structure of title III, the creation of a separate title for legal services may obscure rather than reinforce the importance of including legal services in the title III planning process.

In addition, the creation of a separate title for legal services would also necessitate a separate appropriation. Although a separate appropriation would earmark funds for legal services, there is no assurance that every administration would request such an appropriation or that Congress would

[1] See statement, p. 333.

appropriate such funds. Legal services, as compared with other social services such as transportation, home care, and home repair, remains for many public officials a controversial and misunderstood service. Although it is unlikely that Congress would refuse to appropriate money for title III social services including legal services, it is possible that an appropriation request for legal services alone could fail.

Rather than creating a separate legal services title, I suggest that the following amendments to titles III and IV be considered:

(1) In section 305(b), delete the words "of some or all" so that the section reads as follows:

"(b) Every State plan shall provide for the establishment or maintenance of programs (including related training) for the provision [of some or all] of the following services designed to assist older persons in leading independent lives and avoiding unnecessary institutionalization:

"(1) Transportation services.

"(2) Home services, including homemaker services, home health services, shopping services, escort services, reader services, letter writing services, and other services designed to assist such persons to continue living independently in a home environment.

"(3) Legal and other counseling services and assistance programs, including tax counseling and assistance and financial counseling, for older persons.

"(4) Residential repair and renovation programs designed to enable older persons to maintain their homes in conformity with minimum housing standards or to adapt homes to meet the needs of elderly persons suffering from physical disabilities."

The effect of this amendment is to strengthen Congress's mandate to the States to develop programs in all four priority services areas. Under the existing formulation of the law, some States are avoiding responsibility for developing legal services, home care or residential repair programs by technically complying with the law through the funding of existing transportation programs.

(2) To section 308(a), add the following subsection (8):

"(8) enable state agencies on aging and other public and private nonprofit organizations to assist in the development of legal assistance and representation for older Americans."

At the present time, section 308 model project money provides essential support for the state legal services development grant program, the technical assistance efforts of five national contractors and several innovative legal services demonstration projects. This is attributable to the fact that both Commissioner Flemming and key members of the 94th Congress have consistently endorsed the use of model project money to expand and improve the delivery of legal services to the elderly. However, to insure the continued availability of model project money for such purposes, section 308 should be amended to specifically include legal services for the elderly as one of the model project priority categories.

(3) To Title IV–A, add the following Section 405:

"Training Programs for Older Persons, Sec. 405. The Commissioner may grant to any public or nonprofit private agency, organization, or institution or with state agencies referred to in section 304, and he may enter into contracts with any agency, organization or institution for the purpose of

"(1) developing educational programs for older persons in the areas of law, nutrition, health care and home repair;

"(2) training older persons in basic delivery skills."

As presently structured, Title IV–A authorizes training support only for persons who are *employed or preparing for employment* in the aging field. Proposed amendment No. 3 expands the potential beneficiaries of Title IV–A training support to include older persons themselves.

As the above amendments would, I believe, advance Congress's often articulated goal of ensuring adequate legal representation for the elderly, I urge consideration of them.

Sincerely,

DAVID H. MARLIN.

[Enclosures]

LISTING OF CLINICAL/SEMINAR PROGRAMS SERVING THE ELDERLY

(1) Denver Senior Citizens Law Project, Legal Aid Program of Metropolitan Denver, 912 Broadway, Denver, Colo., George Hacker.

The law student program in Denver operates out of the Legal Aid Office, with Legal Aid supervision. Legal Aid requires a commitment of two quarters of the trimester for participation, and a time commitment of 10-15 hours per week. Students handle intake and follow-up on cases, and conduct outreach to shut-ins, all with attorney supervision. There are presently two students participating in the program; if there were more of them, they would probably also work in the area of nursing homes. There is no written description of the program available.

(2) University of Michigan Law School, Ann Arbor, Mich., Steve Pepe.

Approximately ten students from the University of Michigan Law School act as attorneys for the elderly, in administrative and judicial proceedings. In the course of the program, the students attend training seminars, have individual supervision sessions with the director of the program, and participate in an outreach program. They commit 20-25 hours per week to the program, for 7 credits of law school value.

(3) Duke University, Department of Law, Durham, N.C., Jim Lewis.

The program for the elderly at Duke is primarily a seminar course, as part of which students spend a few hours per week at Legal Aid or at the Older Americans Centers. This clinical component consists of giving informational speeches at senior centers and rendering legal assistance. No student has ever taken a case as far as litigation, but it is possible, since there is a state third-year practice rule.

(4) Waxter Senior Center, 861 Park Avenue, Baltimore, Md., Ann Pecora.

The Waxter Center is a large senior citizen center which provides varied services, one of them legal services provided by a sole attorney. Law students assist the attorney in all phases of legal work: office and field interviewing, legal research, negotiations, and, potentially, in litigation under third year practice rules. Students, presently six, put in varied hours per week, for a total of 50 hours per credit.

(5) PEP (Protection for Elderly Persons), 1806 Adams Mill Road, N.W., Washington, D.C., Prof. Donald Rothchild or Eric Sirulnik.

PEP, operated by the George Washington University Law School, runs a storefront office for the elderly in northwest Washington, D.C. There are currently three separate organizations working under the PEP storefront umbrella. The George Washington Consumer Protection Center (Consumer H-E-L-P) provides 12 law students and one faculty advisor to conduct initial interviews with the elderly, provide advertising for the PEP Center, and enlist, train, counsel, and supervise Senior Citizen Aides and Volunteers who work at the storefront. The National Council of Senior Citizens has placed 5 Senior Aides at PEP, who are trained as paralegals. The third organization, Community Legal Clinic, presently has 20 students at PEP, providing legal services and handling cases for individuals.

(6) Syracuse Law School, Ernest I. White Hall, Syracuse, N.Y., Prof. Richard Ellison.

The Syracuse Law School elderly clinical program presently exists only on an ad hoc basis as part of the overall clinical program. The elderly component was previously run by Bob Brown, who is now a professor at the University of Detroit.

(7) University of Detroit School of Law, 651 E. Jefferson Avenue, Detroit, Mich., Bob Brown.

There are plans for an elderly rights seminar as well as a three-hour elderly clinical program open to students enrolled in the Seminar, and run in conjunction with the Wayne County Legal Aid Society under an Older Americans Act Title III grant.

(8) Stanford Law School, Stanford, Calif., Mike Gilfix.

Stanford Law School students participate in the Senior Adults Legal Assistance program in Palo Alto, California.

(9) Louisiana Center for the Public Interest, 700 Maison Blanche, New Orleans, La.

In conjunction with Tulane and Loyola Law Schools, the Louisiana Center for the Public Interest conducts a seminar/clinical program for social work and law students focused on the needs of the elderly. This course, "Legal Problems of the Elderly," involves a weekly four hour commitment to work in the LCPI offices as well as a weekly two hour classroom experience. The uniqueness of the LCPI program is the integrated social work and legal services approach to the problems of older persons.

(10) University of Kentucky, Room 209, Dean's Office, Lexington, Ky.

A substantive law seminar on the legal problems of the elderly is being offered for the first time during the 1976–77 academic year by Carolyn Bratt. Ms. Bratt intends to expand this seminar into a seminar/clinical program as soon as funds become available.

Clinical Training and Legal Services for Older People: The Role of the Law Schools [1]

(By Joseph D. Harbaugh, LLB, LLM [2])

In early Fall of 1973, a man entered a newly formed law office in downtown San Diego, seeking the assistance of an attorney. Upon investigation, it was determined that the local District Attorney had issued an Order to Show Cause in a paternity action against the man. A staff attorney at the law office was assigned to represent the client and accompany him to court. During the course of the court hearing, the attorney for the defendant requested that a blood test be performed at State expense. The trial judge denied the request but indicated that he was inclined to order a sperm analysis to determine whether or not the defendant was impotent. At the conclusion of the hearing, the case was dismissed when the judge found the evidence insufficient to support a charge of paternity.

The resolution of this relatively minor dispute can hardly be cited as a landmark decision in American jurisprudence. Certain facts about this case, however, cause it to stand out from the other ordinary matters on that crowded lower court docket, facts that indicated an alteration in the delivery system of legal services. In the first place, the law office where the client sought assistance was located in a new Senior Citizens Service Center supported by a $60,000 grant from the Southern California First National Bank. Second, the client was a 71-year-old man whose limited retirement income qualified him for the free legal services that were offered by the Senior Citizens Law Clinic. Third, the attorney who represented the 71-year-old client in the paternity case was a 24-year-old woman who was a third-year student at the University of San Diego Law School and enrolled in a clinical program that provided the bulk of the legal staff for the Law Clinic.

The fact that a law student actually appeared in court on behalf of any client, much less an aged client, is a phenomenon of recent vintage. Prior to 1957, only one state, Colorado, permitted students to directly assist clients. By 1968, a total of 14 jurisdictions had enacted student practice rules. Between 1969 and 1970 another 16 states added such statutes to their legislative books. (CLEPR, 1973).

Clinical education in a law school setting

Although legal education in the USA began in a clinical setting with students "reading the law" in a lawyer's office, it moved relatively quickly to the classroom in a university-affiliated law school. When Christopher Columbus Langdell assumed the deanship of the Harvard Law School in 1870, he instituted a pedagogical technique that has dominated legal education to the present day and guaranteed that a substantial distance would be maintained between the law student and the law client, between neophyte lawyer and the courtroom. Langdell claimed that the most efficient and effective method of learn the law was to read and analyze the decisions of appellate court judges. Thus, Langdell asserted that all lawyers needed to know was contained in law books and that the law library was the lawyer's laboratory.

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[1] Paper presented at the 28th annual scientific meeting of Gerontological Society, Louisville, Oct. 29, 1975.

[2] Associate Dean and Director of Clinical Studies, Temple Univ. Law School, Philadelphia.

By 1910, when the foundation of medical education trembled upon the release of the Flexner Report calling for a greater emphasis on the clinical training of physicians, the legal profession had smothered opposition to the case method and rallied behind the Harvard model of the academic training of lawyers. The report to the Carnegie Foundation on the American law school experience recorded the academic lawyers' prevailing view that clinical work for law students should be restricted to the analysis of appellate-court decisions (Redlich, 1914).

It was not until the mid-1960s that clinical legal education was to experience a rebirth. On the heels of the creation of the Office of Economic Opportunity's Legal Services Division came a rekindling of interest in the practical training of law students. Sparked by the Council on Legal Education for Professional Responsibility (CLEPR), law schools tentatively began to create clinical programs for academic credit. The American Bar Association encouraged their development by adopting a model student practice rule which has now been enacted in whole or in part in 46 states, the District of Columbia, and the Commonwealth of Puerto Rico (CLEPR, 1976). Generally, these rules permit third-year law students to represent indigent civil or criminal clients as long as an attorney supervises the students' work.

ABSENCE OF CLINICAL PROGRAMS FOR THE ELDERLY

Even though there has been a dramatic surge in both legal assistance for the poor and clinical programs in law schools, older people, as an identifiable group in need, have not been the beneficiaries of this increase in available services. While the Survey of Legal Services Programs (Legal Services Corp., 1976) by the Legal Services Corporation reports that there are now slightly in excess of 2,250 *full-time* lawyers in legal services programs, less than 150 can be marked as specialists in law pertaining to the aged. These specialists are located in 87 communities and include both full- and part-time people (National Senior Citizens Law Center, 1975). Better than 90% of the approximately 150 approved American law schools have viable clinical programs for academic credit. Yet, only 6 schools (Dickinson, Duke, George Washington, St. Louis, Tulane, and Washington Universities) were reported to have clinics that concentrate on the legal problems of the aged (CLEPR, 1973). As noted below, however, at least 2 other schools (University of San Diego and University of Baltimore) also have such programs. At best, there are less than 10, or about 2%, devoted to aging out of more than 420 separate clinical programs.

Directly related to this unawareness is the fact that law schools have failed to educate their students in those areas of the law that most affect the elderly. Although every law school has courses in taxation, corporations, and securities regulation, rarely can one be found to have offerings in Social Security regulations, Medicare, or governmental entitlements. Without basic training in these intricate areas of the law, it is not surprising that few lawyers are found to be specializing in these problems, particularly when the financial rewards are minimal.

Law schools and legal service programs are also faced with the task of delivering legal assistance to older clients. Lawyers in private or public practice and in law school legal clinics have traditionally waited patiently in their offices until a client walked in with a legal problem. Indeed, they are restrained by the Code of Professional Responsibility from seeking out those that need legal help for fear that solicitation of clients would demean the profession. Since older people as a group are both restricted in their ability to travel and reluctant to seek out assistance, lawyers are forced to meet the challenge by reaching out of their offices to locate the elderly in need of their services.

Overriding all of these other concerns, however, is the ever-present problem of financial resources. In addition to inheriting Langdell's case method, today's law schools have the dubious honor of being the trustees of his approach to educational economics. In comparison to all other forms of professional training, legal education is incredibly inexpensive from an institutional point of view (Swords & Walwer, 1974). While medical, dental, and even music schools enjoy a student/faculty ratio of 8 or 4 or even 2 to 1, law school ratios run between 25 and 30 to 1 (AALS, 1976). Although this

may be academically sound in large case method classrooms, it is both intolerable and reckless in a clinical program. In order to provide adequate supervision for dynamic clinic offerings, law schools must seek outside funding, a new venture for most institutions. Consequently, it is understandable that most law school clinics have not specialized in their clinical programs, since this would constrain and restrict their funding opportunities.

EXISTING CLINICAL PROGRAMS IN LAWS PERTAINING TO THE AGED

In the midst of this gloomy report of weak excuses, there is a ray of hope. In the past 4 years, more than a half dozen law schools have initiated clinical programs that deal directly with the legal problems of older people. Some of these are bold, multifaceted ventures, while others are at best tentative, and a few have even been withdrawn for lack of financial support. Although all the models described here are different, having been developed independently of each other, there are some common attributes. Every program awards students academic credit in varying amounts for participation in the clinic. Each clinic delivers direct legal services to aged clients. The respective programs are directed by a full- or part-time member of the law school faculty. Each one is beset with problems and deficiencies.

The first program was initiated by Prof. Travis Lewin at Syracuse University Law School. It was also the first to succumb to financial pressures. Originally funded by the Shimper Foundation, a local family philanthropy, the clinic was an outgrowth of the Syracuse University All-Gerontology Center, a multidisciplinary effort to study the problems of the elderly. In 1972, 6 law students joined social work, psychology, architecture, medicine, public administration, and home management students in an intensive analysis of issues facing older people. By 1973, the students increased to more than 20, and the Law School appointed a visiting professor to direct a spinoff legal clinic that would deliver legal services to aged clients. The project operated out of the Law School's clinic office in downtown Syracuse but soon expanded to include home visitations when it became obvious that this approach was necessary. The students concentrated on cases that dealt with Social Security, Workmen's Compensation, Supplemental Security Income (SSI), and property tax problems. Efforts were expanded to include legislative advocacy with law students forming a part of an interdisciplinary team that researched, drafted, and supported bills in the New York legislature on barrier-free design for public buildings, conservatorship laws, and property tax exemptions for older people. The law students also cross-registered for courses in the other professional schools and met in a lawyer-skills training course. For some strange reason, the latter course failed to emphasize the special transactional skills lawyers must possess to effectively assist older people. Unfortunately, the Syracuse clinic died in the Spring of 1975 when the Shimper Foundation failed to renew the grant because of its own economic problems.

1973 was a banner year for clinical programs concentrating on questions pertaining to the elderly. San Diego, George Washington, and Duke Universities all entered the field at about the same time. In 1973 and 1974, the University of San Diego placed 7 to 10 students a semester in the downtown Senior Citizens Service Center under the supervision of a young lawyer assisted by a number of retired people who acted as paralegals. Although the students received 3 academic credits for their work in the clinic, the Law School did not maintain a classroom component to deal with the substantive legal issues that the students faced in their cases. Student participation dwindled in 1975, although plans are underway to encourage increased enrollment in the clinical program on law and the aged.

VARIED APPROACH AT GEORGE WASHINGTON UNIVERSITY

Prof. Erik Sirulnik of George Washington University Law School directs the most ambitious clinical effort to date. The recipients of a recent $70,000 Title III (Older Americans Act) grant, the George Washington University Aged Clinic involves more than 100 law students a year who represent more than 1,500 older people with legal problems. Sirulnik is assisted by two other lawyers in the supervision of two divisions of the Clinic. In the litigation division, students represent elderly clients in the Small Claims and Landlord

and Tenant parts of the District of Columbia Superior Court. Students assist older plaintiffs and defendants in such matters as consumer cases, contract problems, tort claims, and housing disputes. In the nonlitigation phase of the Clinic, the emphasis is upon representation of senior citizens before administrative agencies such as the Social Security and Veterans Administrations. These students also aid clients who need wills drafted and estates planned and who have disputes with nursing homes. In addition to the financial investment in the Aged Clinic, George Washington University has made a substantial academic commitment to the program. Students are entitled to receive up to 8 academic credits for their work in the Clinic, and efforts are being made to increase this to 11 credits. Students gather each week in a 2-hour seminar session, 1 hour of which is devoted to the study of substantive law affecting older people and the other to a group analysis of the open cases on which the students are working.

Beyond the law student clinic, George Washington University has inaugurated a Paralegal Training Program for Retired People with a class of 25 elderly students. These future paralegals are between 65 and 68 years old, some with only high school diplomas and half of them retired federal government workers. The students attend classes in such subjects as legal research and interviewing, office management and referral practices, and Social Security, housing, and SSI law 3 days a week during their first semester. Following this academic phase, each paralegal student is paired with a senior law student, and the team works in one of the public housing centers in Washington. There the paralegal trainees assume responsibilities in such diverse areas as will drafting, fair hearing administrative matters, income tax assistance, and the like. Placement plans are underway to locate the graduates in part-time jobs with the National Capitol Housing Administration, Neighborhood Legals Services, and similar agencies. Without a doubt, George Washington University has the most extensive program for the aged of any law school in the nation.

Duke University, on the other hand, has a much smaller but more academically intense program on behalf of the elderly. Begun in 1973, this program was stimulated by the efforts of George Maddox, Director of the Center for the Study of Aging, and supervised by Howard Gelt, now the Acting Director of the Human Resources Administration of the State of Colorado. Students in the Clinic receive 4 academic credits for their combined fieldwork and classroom responsibilities. Working out of the Center for the Study of Aging, the students represent older patients of the Center who are faced with a variety of legal problems ranging from Social Security and SSI to estate planning and taxation matters. Law students have access to members of other professional disciplines who form the staff of the Center to assist them in the development of their cases. In addition to this direct representation phase, the Duke Clinic in Law and the Aged has an active legislative component which has already had considerable success at the State Capitol in Raleigh. It is, however, the classroom portion of the Duke Clinic that is unique among law school efforts in this field. The pedagogical theory that supports this program is that in order adequately to train law students in the legal problems of the elderly, they must be concurrently exposed to lawyering skills development, to a study of the law that directly affects senior citizens, and to the scholarly research of complementing professional disciplines. Through the use of simulation and gaming techniques, students combine skills training in interviewing, counseling, and administrative and legislative advocacy with the analysis of the legal principles involved in Social Security pension laws and right-to-die legislation. At the same time they investigate aspects of social economics and the physiological and psychological effects of aging. The breadth of the Duke academic program provides the law students with an understanding of the range of problems facing older people and thus places legal issues in proper context.

In the past 2 years, two other law schools started law projects for the elderly. At the University of Baltimore Law School, Prof. William Weston directs a multiple division program that provides outreach home service as well as a full-time office in a nearby multipurpose complex. Beyond the legal aid program of direct representation in contested legal cases, the Law School, in conjunction with the Business School, operates a special Tax Clinic to assist older people with their federal, state, and local tax problems. The

School also runs an education series for older people in consumer law, SSI, Medicare, and the like, seminars for social workers to pinpoint the differences between legal and social problems of the aged, and a continuing education program for lawyers on legal issues affecting the elderly. About 10 students per semester receive up to 6 credits on the basis of 50 hours of fieldwork per academic unit. Although there is no classroom phase of the program, student representation has been provided to more than 200 clients in the past year. Moreover, the School has arranged to refer older clients who can afford to pay a fee to a special panel of the Baltimore Bar who have agreed to develop expertise in problems of the aged, thereby broadening the legal services base for senior citizens.

Under the direction of Prof. David Marcello, the program at Loyola University Law School in New Orleans has the largest staff, expanded with the assistance of an AoA model projects grant in 1975 to include four attorneys, two social workers, and two secretaries. It is the only clinic that combines training for law students and graduate social work students working in teams. It is also the only program that draws students from more than one academic institution. Law students from Loyola and Tulane and social work students from Atlanta University and the University of Louisiana participate in the project.

Conceived in May of 1974 as the Louisiana Center for the Public Interest, a nonprofit corporation supported by funds from the local Area Agency on Aging (AAA), a private foundation, and the Council on Legal Education for Professional Responsibility, it has assisted more than 400 older clients with a variety of legal problems. It is also actively engaged in legislative advocacy in support of such bills as conservatorship, expanded voting rights for handicapped aged, and consumer legislation relating to hearing aid sales and open advertisement of drug prices. The basic delivery scheme has the social work students visiting the 15 local nutritional centers and interviewing aged people to discover legal or social problems. Students from both disciplines join forces for follow-up work in appropriate cases. The classroom component concentrates on substantive lectures in areas of the law critical to older people. The principal weaknesses in the program are that the law students only receive 2 academic credits, there is little or no skills training, and the social work students are not specifically instructed to recognize and isolate legal issues.

DEVELOPING MODEL AT TEMPLE UNIVERSITY

The final program described here is still in the development stage. A combined classroom and fieldwork experiment under the direction of Prof. Dolores Sloviter will be launched at Temple University Law School in the coming academic year. The academic component, which focuses on state and federal legislation affecting the elderly, has been in operation for the past year. Next year satisfactory completion of this course will be a prerequisite to enrolling in the clinical phase of the program. The fieldwork portion of the project is still undergoing analysis, but it will definitely include the direct representation of older people faced with legal problems involving income and health maintenance and other forms of benefits and entitlements.

In August, 1975, the Law, Education, and Participation Project (LEAP) at Temple Law School was awarded a Title I (HEA) grant to develop and conduct the Consumer and Legal Rights of the Elderly Program. Led by Sharon Browning, the project is designed to help older persons learn about and to understand the law as it affects their lives. The 10-week, 2-hour class sessions held in senior centers in Philadelphia include instruction in such areas as contracts and money management, advertising and shopping frauds, landlord/tenant relations, age discrimination, entitlement programs, and wills and probate practices. During its first year, the LEAP staff has trained more than 200 seniors and plans to conduct sessions for an even larger number next year. If funding becomes available, Temple Law Center will train 15 older persons, identified through the LEAP seminars, as paralegals. These paralegals will then be placed in nutrition and senior centers throughout Philadelphia and will work with the clinical faculty and law students to provide legal services for the elderly.

ESSENTIAL COMPONENTS OF EFFECTIVE CLINICAL PROGRAMS

Though this is not an all-inclusive listing of clinical programs involving old age and the law, the other law schools operating clinics duplicate in whole or in part the services provided by these seven. We can see that there are a number of models in the very early stages of development. It is too soon to seek a paradigm, but some elements stand out as important. Law school programs must grant sufficient academic credit to allow the clinical student to explore the full range of legal issues in a project for the aged. Schools must be willing to commit sufficient resources to guarantee adequate professional supervision of the fledgling lawyers. Academic components should emphasize skills development and interdisciplinary study as well as a review of the appropriate substantive law. The delivery system must include an outreach component in order to locate and serve those elderly with legal problems.

One last thing is also very clear. Law school legal clinics devoted to the problems of the aged are an effective and efficient method of delivering legal services to the elderly poor. By harnessing the energy, enthusiasm, and talent of law students. we can be assured of quality legal services for our public or private investment. By any cost-benefit analysis, a properly conceived and operated law school clinic provides low-cost, high-quality legal services for older people.

The response of the nation's law schools, although too little and very late, has at least tended to be positive. With encouragement and support, the law school clinic may yet develop into a major system for the delivery of legal services for older people.

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ITEM 9. AMERICAN BAR ASSOCIATION: SPECIAL COMMITTEE ON FEDERAL LIMITATIONS OF ATTORNEYS' FEES REPORT TO THE HOUSE OF DELEGATES; SUBMITTED BY F. WILLIAM McCALPIN[1]

RECOMMENDATIONS REGARDING FEES FOR ATTORNEYS REPRESENTING CLAIMANTS BEFORE FEDERAL AGENCIES

The Special Committee on Federal Limitations on Attorneys' Fees recommends that the house of delegates support the following concept for adoption by the U.S. Congress:

1. The Congress should enact a statute governing attorneys' compensation for each Federal agency when contingent fees are not already provided for by statute.

2. As a first step in implementing point 1 of this recommendation, the Congress should adopt the following scheme for attorneys' compensation in the Veterans Administration:

[1] See statement, p. 271.

(A) The rating board which hears veterans' claims in the first instance shall award attorneys' fees when appropriate, such fees not exceeding $10.

(B) The Board of Veterans Appeals which hears veterans' claims de novo shall determine attorneys' fees based on the following factors (The first seven factors have been taken from the American Bar Association's *Code of Professional Responsibility*, DR 2–106):

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly.

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the attorney.

(3) The fee customarily charged in the locality for similar legal services.

(4) The amount involved and the results obtained.

(5) The time limitations imposed by the client or by the circumstances.

(6) The nature and length of the professional relationship with the client.

(7) The experience, reputation, and ability of the attorney or attorneys performing the services.

(C) The award of attorneys' fees by the Board of Veterans Appeals shall be subject to review by the Administrator of the Veterans Administration.

(D) The determination of attorneys' fees by the Administrator of the Veterans Administration on review as provided for in C shall be subject to review by the Federal district court of the judicial district in which the claim is processed or in the Federal district courts in Washington, D.C.

REPORT ON RECOMMENDATION

The Committee on Federal Limitations on Attorneys' Fees believes that the Congress, once veterans' claims have been passed upon at the Rating Board level, should require allowance of a reasonable attorney's fee based upon recognized and usual criteria for services rendered beyond the Rating Board level and consider factors such as the nature of the claim and the amount of the claim in tailoring fee compensation statutes to each federal agency. With respect to the Veterans Administration, the Committee recognizes that the current $10.00 fee limitation pursuant to statute (38 U.S.C. 3404) effectively prevents any meaningful participation by attorneys in the prosecution of VA claims. Since veterans' awards may be claimants' exclusive or only substantial means of support, especially with respect to disability claimants, it is important to preserve the award to the greatest extent possible. Since many claimants are successful at the Rating Board level (viz., the hearing of first instance), on balance it would be wise to preserve the $10.00 limitation, especially since representatives have not been shown to be more effective than claimants in securing awards at the Rating Board level.

By contrast, Veterans Administration data have shown that the representative has been more effective than the claimant at the Board of Veterans Appeals. Moreover, the claims which reach the Board of Veterans Appeals are usually more difficult to present than the claims resolved at the Rating Board level because of the need of preparing a proper record, especially since experience has shown the claimant should be prepared to challenge the procedural or substantive fairness at the Rating Board level. Therefore, since an attorney would be effective and often necessary at the Board of Veterans Appeals, the limitations on attorneys' fees should be relaxed as indicated above to encourage attorney participation. In determining fees, consideration should be given to the following: The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly; the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the attorney; the fee customarily charged in the locality for similar legal services; the amount involved and the results obtained; the time limitations imposed by the client or by the circumstances; the nature and length of the professional relationship with the client; the experience, reputation, and ability of the attorney or attorneys performing the services [and, the financial ability of the claimant to compensate the attorney]. Finally, the Committee believes that review by an independent body, namely, the federal courts, is essential in ensuring the effectiveness of the fee compensation scheme.

BACKGROUND

One approach an attorneys' compensation statute can take is to provide *omnibus* guidelines governing the compensation to be awarded to attorneys representing claimants before all federal agencies. This approach is desirable to the extent that it gives all claimants an equal opportunity to secure counsel, regardless of which agency they petition for redress. Indeed, it is difficult to argue that an airline should be able to secure an attorney to represent it before the FAA, while a veteran should be denied similar protection before the VA. Conversely, it appears unjust that attorneys specializing, say, in aviation matters, are encouraged to participate in agency decision-making, while others specializing in different areas are precluded from participating. Therefore, the following omnibus model statute provides equal protection both for claimants and attorneys:

FEES FOR LEGAL SERVICES

(A) A lawyer shall not enter into an agreement to charge, or collect an illegal or clearly excessive fee.

(B) A fee is clearly excessive when, after a review of the facts, a lawyer of ordinary prudence would be left with a definite conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:

(The first seven factors have been taken from the American Bar Association's *Code of Professional Responsibility*, DR 2–106).

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly.

(2) The likelihood, if apparent to the client that the acceptance of the particular employment will preclude other employment by the lawyer.

(3) The fee customarily charged in the locality for similar legal services.

(4) The amount involved and the results obtained.

(5) The time limitations imposed by the client or by the circumstances.

(6) The nature and length of the professional relationship with the client.

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services.

(8) [The financial ability of the claimant to compensate the attorney].

(Inclusion of this factor in the scheme will depend on whether the claimants or the agency pays the attorney's fees. This matter is distinct from the issue of whether the ceiling on fees should be raised, and it will be considered by the Committee in a subsequent report.)

A fundamental problem with any omnibus statute is that it ignores special problems in certain agencies. For example, veterans sometimes may be adequately represented before the Veterans Administration by service organizations; Congress may want to discourage attorneys from participating in the agency process and charging claimants for their participation when service organizations could adequately represent the claimant. Moreover, the omnibus statute ignores the situation where an aggrieved party brings a small claim before an agency and an attorney, representing the claimant invests considerable time in the matter at issue; it would be quite difficult to balance the interest in compensating the attorney for his time, since compensation to the attorney if deducted from the claimant's recovery could defeat the purpose of the claim. Also, the system may want to recognize the various degrees of sophistication among claimants in determining the relationship between attorney and client. The veteran with a limited education seeking disability benefits from the VA may be more vulnerable to possible abuses by some attorney than a corporate executive seeking redress before the SEC.

A parenthetical point which is essential to any statute regulating attorneys' fees is that the agency's award of fees must be subject to judicial review. ("In any . . . overhaul [of administrative agencies], specific attention should be paid to making the administrative process more open and simple, requiring that major administrative decisions be accompanied by an articulation of reasons, *subject to judicial review* of the fairness and reasonableness of the decision, and affording interested persons access to relevant information within the agency so that they may have an opportunity to develop an adequate record for agency decisions." [Emphasis added], *Law and a Changing Society*,

II, at pp. 8–9, American Bar Association, June, 1975.) If abuses do indeed exist in the process by which attorneys are compensated for services before federal agencies, such abuses will not be eliminated, even with adoption or reform statutes, unless the procedures adopted for implementing the provisions of the statute are reviewable by an independent judicial body.

An alternative to the omnibus statute approach is the adoption of a number of statutes tailored to each agency. In determining the role which attorneys should play in the various agencies, draftsmen of the fee compensation statutes should consider.

(1) The claimant's ability to represent himself before the agency;

(2) The extent of a service organization's ability to represent the claimant;

(3) The claimant's access to fair and equal representation by the service organization;

(4) Cases in which the special competence of attorneys can be of value, particularly where the perfection of an adequate record at the agency level may be essential to the claimant's rights;

(5) Whether certain statutory limitations on attorneys' fees effectively deny the claimant legal representation in agency matters.

In determining whether a service organization is competent in representing claimants before an agency, special attention must be given to the skills involved in successfully prosecuting a claim. For example, where cases involve substantial investigation of medical or public records, and preparation of countervailing proof, an attorney's training and skills can be expected to surpass the ability of a lay service representative to effectively represent claimants. Obviously, where claims involve complicated legal issues, service organizations often are not adequate substitutes for trained attorneys.

Perhaps, the agency on which the most attention has focused in recent years with respect to limitations on attorneys' fees is the Veterans Administration. The statute limiting compensation to attorneys representing claimants before the VA to $10.00 effectively removes the attorney from the decision-making process in VA matters. The following exposition reflects the various factors which must be considered in tailoring attorneys' compensation statutes to each federal agency.

The Veterans Administration has a $17,829,454,000 annual budget (P.L. 94–116, Oct. 1975). It ranks fifth in expenditures by federal agencies. (HEW—$118 billion; Defense—$93 billion; Treasure—$43.4 billion; Labor—$22.6 billion). The four major categories of programs administered by the Veterans Administration are: readjustment benefits, health services, compensation and pensions, and life insurance. The first three categories account for ninety-seven percent of the VA's budget (Veterans Administration, "Budget in Brief: Fiscal Year 1974, "page 21).

The VA's disability program has been a focal point of criticism in recent years. In November, 1972, the Armed Forces Journal obtained data on the percentage of retirements resulting from disability by rank and branch of service as of June 30, 1971 (Brook Nihart, "Disability Retirement: Some Facts," *Armed Forces Journal*, November, 1972). Data showed that in every branch of service, two to three times as many generals had been retired for disability (31% on the average) as had colonels and majors (14%), although generals were only slightly older at retirement than majors (Nihart, *supra*). Colonels and majors had higher rates of disability retirement than senior noncommissioned officers (12.5%) who retired at about the same age (Nihart, *supra*). The highest rate appropriately went to those who had the most exposure to combat [junior officers (60%), and lower-ranked enlisted men (41%)] (Nihart, *supra.*) Interestingly, more Air Force generals were retired for disability (45%) than lower-ranked enlisted men (Nihart, *supra*).

In 1972, Senator Proxmire asked the GAO to determine how many Air Force generals, retired for disability, had received flight pay. The GAO found that during the period from 1967 to 1972, 337 generals retired from the Air Force, and 130 of them (40%) retired on 30% or more disability. Of these, 97 (75%) received flight pay during the year immediately preceding their retirement. (Letter from Comptroller General of the United States to Senator William Proxmire, Aug. 23, 1972).

The various studies suggest that there may be some inequality in the VA's administration of its disability retirement program; there may be several rea-

sons for these inequities, including the inability of less sophisticated persons to present their case to the VA as compared with others. It therefore appears that attorneys could be useful and at times indispensable to the determination of disability claims in order to ensure equal treatment of claimants. The attorney can investigate the manner in which the VA handles his client's claim and, when appropriate, challenge the VA with respect to equal application of the laws and its regulations. Moreover, since disability benefits are granted only when the disability arises as a result of a service-connected impairment, the attorney can procure medical records to strengthen his client's case, a task which a service organization may be unable or unwilling to do.

Another pervasive problem in the Veterans Administration which attorneys could effectively monitor is the manner in which it determines who will and will not receive benefits. The problem is most critical in the exercise of the VA's discretion as to whether those with less than honorable discharges will receive veterans benefits. From 1964 to 1972, more than 175,000 servicemen were dismissed from the service with less than honorable discharges. Of the various discharges, bad conduct and dishonorable discharges were rare, accounting for no more than 1% of the total discharges. ("Types of Discharges Issued to Enlisted Personnel by Fiscal Year 1950–1972," Office of Assistant Secretary of Defense [Manpower and Reserve Affairs], Aug. 31, 1972.) Such discharges are imposed only by general or special courts-martial. The middle echelon of discharges is the undesirable discharge. Like the honorable and general discharges, it is administrative, but like bad conduct and dishonorable discharges, it may carry heavy penalties in civilian life. Undesirable discharges are given most often for drug use, homosexual acts, conviction by civilian authorities, and offenses involving "moral turpitude."

Contrary to widespread belief, federal law does not bar the Veterans Administration from dispensing benefits to veterans with less than honorable discharges. The VA is in a position, for example, to extend educational assistance to veterans who, because of a lack of education or training, are perpetually unemployed. But because of the way the VA has applied the law, and the way it interprets its social functions, the agency has not made such assistance available.

Benefits are available by federal law to all veterans who receive discharges "under conditions other than dishonorable." Anyone who receives an honorable or general discharge is unambiguously entitled to benefits. Anyone who receives a dishonorable discharge is unambiguously excluded from benefits, as is someone issued a bad conduct discharge by a general court-martial. Undesirable discharges and bad conduct discharges issued by special courts-martial constitute the "gray area." If a veteran has one of these—and more than six out of every seven Vietnam veterans with less than honorable discharges do (38 USC 101 (2))—the VA makes an independent determination of whether or not it was issued under dishonorable conditions. The agency has adopted its own rules on this question. A discharge issued for mutiny, spying, or homosexual acts is automatically considered to be under dishonorable conditions. In addition to the specific categories of discharges that the VA has determined to be under dishonorable conditions, the agency has adopted two rather broad and subjective criteria in its eligibility decisions. A discharge is considered to have been issued under dishonorable conditions if it stemmed from an offense involving "moral turpitude" or was the result of "persistent and willful misconduct." (Starr, *The Discarded Army*, at pp. 176–177). The determination is made on a case-by-case basis without the assistance of any published and definitive guidelines. The only guideline would appear to be an unwritten presumption that the service imposes less than honorable discharges only for acts of moral turpitude or persistent and willful misconduct, because the VA hardly ever comes to any other conclusion. For example, a recent study by the VA indicates that 93% of the veterans with less than honorable discharges who applied for educational benefits were denied them. (Letter from Mr. Stratton Appleman, Assistant Director, Public Information Office, Veterans Administration, to Raymond Bonner, dated January 18, 1973.)

Ordinarily, the VA keeps no statistical records on benefit applications from veterans with undesirable and bad conduct discharges. A study of a five month period in 1972, however, noted that only 1,305 applications for educational benefits were received from men with less than honorable discharges. Of these,

91 were approved. During this same period, more than 4,000 veterans with less than honorable discharges applied for unemployment compensation (although the benefits are dispensed by the Labor Department, eligibility decisions are made by the VA). Of the 4,000 men who applied, 3,400 were found ineligible. Ninety-seven of the cases involved veterans with drug-related discharges; six of these were approved. (Starr, *The Discarded Army*, at p. 179).

The per se rules which the VA has adopted with respect to servicemen with less than honorable discharges appear to be a violation of congressional intent. Some argue that service organizations can adequately protect and represent those allegedly unfairly denied benefits because of less than honorable discharges. It would appear from the statistics herein mentioned, however, that the American Legion, the VFW and other service organizations have not been particularly effective in prosecuting such claims. This is an area ripe for the watchful eye of the attorney in assuring that congressional intent is implemented and those entitled to benefits are treated equally.

The VA's disability program is another area in which the attorney could be quite useful, since the considerable discretion involved in processing disability claims makes the program susceptible to unequal treatment among veterans. For example, a regulation provides that a veteran can be classified as totally disabled if he is "unemployable" and he achieves a certain percentage rating under a rating schedule (38 C.F.C. 4.16–17). The concept of "unemployability," however, as described in the regulations, is rather imprecise, sometimes resulting in a lack of uniformity in practical application. (The regulations define unemployability as "unable to secure or follow a substantial gainful occupation." 38 C.F.R. 4.16.)

Similarly, in order for the veteran to participate in the disability compensation program, he must have at least a 60% disability on the rating schedule, to two disabilities totaling 70% with one equal to 40% (38 C.F.R. 4.16). A determination of disability under the rating schedule requires many subjective determinations, including the degree of social impairment due to psychoneurotic disorders. Even in the disability cases where medical disputes predominate, subjective determinations must be made in arriving at the percentage of disability pursuant to the rating schedule, and without the assistance of a trained attorney a veteran may not be able to effectively guard against unequal treatment.

The need for trained attorneys to represent veterans before the VA is highlighted by the complex procedure involved in processing claims, especially in the disability program. Over 350,000 disability claims are made each year to the 57 regional offices of the VA. (Popkin, *Study of Five Disability Programs*, at p. 6). The claims are heard in the first instance by rating boards comprised of three members with at least GS–12 status. One member is a doctor, one is a legal specialist, and the third an occupational specialist. The legal specialist need not be a lawyer and the occupational specialist need not have vocational expertise. Though hearings are permitted, they are rare. No cross-examination is permitted before the Rating Board. If the claimant is dissatisfied with the decision of the Rating Board, he files a Notice of Disagreement (NOD) which initiates an appeal to the Board of Veterans Appeals (BVA). (The BVA consists of three members, one doctor and two lawyers. The BVA has a staff of 18 doctors. It allows no cross-examination; rather the reviews are conducted like informal conferences.) Forty thousand NOD's are filed each year in disability cases, constituting 80% of all NOD's. One-sixth of the claims are approved by the Rating Board after the NOD is filed. Interestingly, one-third of the appeals are dropped by the claimant after filing his NOD; this suggests, perhaps, that many dissatisfied veterans are unable to cope with the complicated procedures involved in processing claims.

A legal representative can be especially helpful in prosecuting certain claims, as in service-connection claims where vocational evidence is important. Service-connection cases often involve past medical history which the veteran's record may not fully reveal. Since attorneys are trained in the art of investigation, their assistance could be quite valuable. Similarly, where vocational evidence is important, the veteran's records may not be helpful to the extent that they do not contain information with respect to his work history; again, a trained attorney can be useful in gathering evidence for presentation before the Board.

William Popkin, Professor of Law at the University of Indiana, prepared a

comprehensive report for the administrative conference in which he examined one year of BVA cases (fiscal 1972) which reviewed Rating Board decisions from the Indianapolis office of the VA. (Popkin, "A Statistical and Legal Analysis of the Role of Representatives in Administrative Decision-Making based on a Study of Five Disability Programs [Feb. 27, 1975]. The study contains the following disclaimer: "This report was prepared for the Committee on Grant and Benefit Programs of the Administrative Conference of the United States. It is one of three parts to be prepared for that Committee. It has not been reviewed or approved by the Committee or the Conference. It represents the views of the author only. It should not be used for quotation or attribution without this disclaimer.") Popkin's study supports the contention of this Committee that the effective marshalling and presentation of evidence can markedly improve a claimant's chances of success. His study demonstrates that a claimant has a significantly better chance of prevailing at the BVA level when new evidence is submitted to the Board. In service-connection cases, for example, when no additional evidence is submitted, claimants representing themselves were more effective than service representatives in prosecuting claims. When new evidence is presented to the BVA, the chances of a claimant prevailing jump in service-connection cases from 44% to 52%, and in rating scheduled cases from 32% to 48%. (Success rate with a service representative: 35%; Success rate without a representative: 57%. Popkin, at pp. 33, 34.)

These statistics suggest that new evidence has a significant effect on the outcome of cases at the BVA level. Moreover, it appears that service representatives have not availed themselves of the opportunity to present new evidence. In service-connection cases, for example, service representatives submitted new evidence in only 12% of the cases (Popkin, p. 35). Since attorneys are trained in the art of gathering and presenting evidence, it seems likely that their assistance would improve the veterans' chances of successfully prosecuting their claims, especially since service representatives often do not submit new evidence to the BVA. (In service-connection cases, service representatives submitted new evidence in only 12% of the cases. Popkin, p. 35.)

RECOMMENDATION

The claimant cannot always rely on the service organization to represent him before the Veterans Administration. It appears that service organizations may discourage claimants from bringing "harder" cases before the VA. Also, the service organizations may be unwilling to fully and fairly represent certain types of claimants such as those with less than honorable discharges. Therefore, to equalize the ability of a claimant to secure redress before the VA, attorneys can be valuable in some representative capacity. We must, therefore, determine the capacity in which attorneys can serve. In determining that, we must be sensitive to the claimant's desire to retain as much money as possible from the award which he receives from the VA. On the other hand, in order to secure the award, he may need the assistance of an attorney. Legal representatives can be helpful at different levels of the administrative proceedings where certain issues are involved. For example, representatives can be especially helpful when matters involving issues not contained in the veteran's service records are in dispute. Generally, when marshalling and presenting new evidence is necessary in the prosecution of a claim, it appears that the representatives can be most helpful. Moreover, legal representatives can be helpful in alerting the VA to unequal treatment of certain claimants.

As a means of balancing the claimant's desire to retain as much of the award as possible and the need for an attorney in successfully prosecuting a claim, the Committee recommends the following: The $10 fee limitation should be preserved at the Rating Board level. (The statute should maintain the $10.00 limitation for attorneys' fees at the Rating Board level because in some cases, a relative or friend of the claimant who is an attorney may offer gratuitous assistance. The goal of the statute is not to exclude attorneys at the Rating Board level. Rather, the statute seeks to preserve the claimant's award to the greatest extent possible. Where preservation of an award is possible with legal representation, the attorney should not be excluded from participation.) There is some evidence that the Rating Board will often give the veteran the benefit of the doubt in certain matters (Popkin, at p. 40). For those who fall in this

category, the services of an attorney would be unnecessary since claimants would have to pay attorneys' fees when representation would have been unnecessary. Therefore, in recognition of those who could successfully prosecute a claim either without legal representation or with representation by a service organization, on balance the system at the Rating Board level probably operates most effectively without the assistance of attorneys. A different story, however, exists at the BVA level. Those who are dissatisfied with the decision of the Rating Board may be unable to secure adequate representation from a service organization for various reasons. Moreover, statistics, such as the 7% success rate of those with less than honorable discharges who petition the VA for educational benefits (Popkin, supra, p. 9), indicate that the Rating Board has established certain unfair procedures; such procedures may go undetected by the BVA without the help of an attorney who can alert the BVA to specific procedural problems. Therefore, the Committee recommends that the guidelines set forth in the recommendations on pages 1 and 2 of this report be implemented at the BVA level so that claimants can secure legal counsel to represent them and to protect their interests.

This is the first of a series of reports by the Committee. This report focuses on the need for reform in the Veterans Administration with respect to federal limitations on attorneys' fees. The Committee will submit another report on the manner in which attorneys' fees will be paid. Also, the Committee will continue to examine other federal limitations on attorneys' fees * and submit future reports to the House of Delegates.

Respectfully submitted,

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FEBRUARY 1976.

LIMITATION ON ATTORNEYS' FEES UNDER FEDERAL STATUTES AND REGULATIONS

Statutory provisions		
Statute	Subject	Limitation
5 U.S.C. 8127	Government employees claims for injuries	Approval of Secretary of Labor.
7 U.S.C. 499g	Perishable agricultural commodities	Approval of Secretary of Agriculture.
11 U.S.C. 205(c) (2), (12).	Railroad reorganization	Approval of Interstate Commerce Commission.
14 U.S.C. 413(c)	Coast Guard lifesaving service claims	$10 maximum.
15 U.S.C. 79g(d) (4), 79j(b)(2).	Public utility holding companies, issues, and acquisitions.	Securities and Exchange Commission approval transaction conditioned on approval of fees.
18 U.S.C. 3006A	Counsel appointed in criminal cases	Maximum hourly rate and maximum total fee.
22 U.S.C. 277(d)-21	Reimbursement for appropriated land pursuant to 1964 United States-Mexican convention.	Up to 10 pct.
22 U.S.C. 1623(f) (Supp. IV, 1969).	Claim before Foreign Claims Settlement Commission.	Do.
25 U.S.C. 70n	Attorneys for Indian tribes	Absent approved contract, Indian Claims Commission may approve up to 10 pct.
25 U.S.C. 31	Certain contracts with Indians	Approval of Secretary of Interior and Commissioner of Indian Affairs.
25 U.S.C. § 81a	Cancellation of attorneys' contracts with Indians.	Approval of Secretary of Interior of attorneys' contracts predating § 81.
25 U.S.C. § 81b	Continuation of attorneys' contracts with Indians.	Contracts predating § 81 may be continued unless subsequently approved contracts on same matter.
25 U.S.C. § 82	Payment of attorneys for Indians	Approval of Secretary of Interior and Commissioner of Indian Affairs upon receipt of sworn statement, detailing services rendered.
25 U.S.C. § 82a	Payment of attorneys by tribes themselves (excepting claims against United States).	Approval of Secretary of Interior of payment of fees on certain claims of five named tribes.
25 U.S.C. § 85	Contracts respecting tribal funds or property in hands of United States.	Consent of United States.
25 U.S.C. § 476	Rights of tribes to employ legal counsel	Secretary of Interior must approve counsel and fee.
28 U.S.C. § 2678 (Supp. IV, 1969).	Federal tort claims	For claims accruing after Jan. 17, 1967, 25 pct of judgment or settlement after commencement of court action; 20 pct of administrative award, compromise, or settlement.

* Attached hereto is a compilation of Limitations on Attorneys' Fees under various federal statutes and regulations as of March 11, 1974.

LIMITATION ON ATTORNEYS' FEES UNDER FEDERAL STATUTES AND REGULATIONS—Continued

Statute	Subject	Limitation
30 U.S.C. § 938	Prohibition of discrimination against miners suffering from pneumoconiosis.	Determined by Secretary of Labor.
31 U.SC. § 243 (Supp. IV, 1969).	Military Personnel and Civilian Employees Claims Act of 1964.	10 pct of award.
33 U.S.C. § 928	Longshoremen and harbor workers' claims	Labor Department or court approval required.
38 U.S.C. § 784(g)	Veterans' insurance claims	Court may allow up to 10 pct of award or a reasonable fee.
38 U.S.C. § 3404(c)	All veterans' claims	Up to $10 per claim allowable by Veterans Administrator.
42 U.S.C. § 406(a) (Supp. IV, 1969).	Social Security Act	Secretary of Health, Education, and Welfare prescribes maximum fee.
42 U.S.C. § 406(b) (Supp. IV 1969).	do	Court rendering judgment favorable to client may allow up to 25 pct of the amount of the past due benefits as fee.
42 U.S.C. § 1714	Claims of U.S. employees outside the United States.	Approval of Secretary of Labor.
43 U.S.C. § 1619	Alaska Native Fund Disbursements	Approval of Chief Commissioner of Court of Claims. Up to $2,000.
45 U.S.C. § 355i	Railroad unemployment insurance claims	Approval of Railroad Retirement Board or court.
46 U.S.C. § 1225	Contracts under the Merchant Marine Act	Filing of retainers and expenses with Secretary of Commerce according to rules of the Secretary.
50 U.S.C. App. § 20	Trading With Enemy Act	Up to 10 pct if approved by President or his agent or court; appealable to district court in cases of unusual hardship.
50 U.S.C. App. § 1985	American-Japanese evacuation claims	Up to 10 pct allowable by Attorney General.

Administrative Regulations

Source	Subject	Limitation	Statutory basis
8 CFR § 2923(a)(1) (1973).	Immigration proceedings	Disbarment for grossly excessive fees	8 U.S.C. §§ 1103, 1362.
12 CFR § 4013 (1973)	Import-Export Bank	Bank approval as condition of loan	12 U.S.C. § 635.
13 CFR §§ 103.13-5(c), 103.13-6 (1973).	Small Business Administration.	Contingent fee only if in reasonable relationship to services; SBA may require agreement permitting SBA to reduce fees it deems unreasonable.	15 U.S.C. § 634.
20 CFR 404.973-404.975 (1973).	Old-age and survivors insurance.	Approval by Secretary for representation before Social Security Administration.	42 U.S.C. 406, 1302.
25 CFR §§ 71.1(a), 72.5, 72.24 (1973).	Indian's attorneys and their fees.	Approval of Bureau of Indian Affairs; payment out of award, or under certain conditions from tribal funds in U.S. Treasury.	25 U.S.C. §§ 81.476.
31 CFR § 10.28 (1973)	Internal Revenue Service.	No unconscionable fees	5 U.S.C. §§ 301, 551-558 (Supp. IV, 1969).
32 CFR §§ 1.500-1.509, 7.103-20 (1973).	Armed Services procurement contracts.	Fees must be reasonable not contingent; covenant against contingent fees applies to securing of contracts.	5 U.S.C. § 301 (Supp. IV, 1969), 10 U.S.C. § 3012.
38 CFR §§ 14.638, 14.639, 14.650-59 (1973).	Claims before Veterans' Administration.	With VA approval, $2 to $10 per claim; possible appeal; no fee for unrecognized attorney; automatic nonrecognition of attorney charging illegal fees.	38 U.S.C. §§ 210 (b), (c), 3401-3404.
38 CFR §§ 36.4312 (1A), 4313(b)(v) (1973).	Veterans' loans	Reasonable and customary fees allowed; 10 pct or up to $250 is permitted for liquidation of loans after default.	38 U.S.C. §§ 212(a), 1804.
41 CFR § 1-1.503 (1973)	Government contracts	Covenant of no contingent fees, with stated exceptions.	40 U.S.C. § 486(c).
R.E.A. Bulletin 400-4 (1959).	Telephone loans	R.E.A. approval; up to $17.75 per hour for appearances.	7 U.S.C. § 901 et seq.
R.E.A. Form 739 (1957)	Electrification loans	R.E.A. approval of fees out of loan funds	7 U.S.C. § 901 et seq.
45 CFR 500.3 (1972)	Foreign Claims Settlement Commission.	Maximum percentages	50 U.S.C. App. 2001, 22 U.S.C. 1622.

ITEM 10. STATEMENT OF THE LEGAL SERVICES SECTION OF THE STATE BAR OF CALIFORNIA; SUBMITTED BY PAUL NATHANSON[1]

The Legal Services Section of the State Bar of California consists of 550 attorneys and judges committed to "innovation, development, and improvement of systems to provide access to and delivery of legal services to the people of California in adequate quantity, of superior quality, and at a reasonable cost."

[1] See statement, p. 286.

The section commends the Senate Special Committee on Aging for holding oversight hearings on the issue of legal services for older Americans. The elderly have legal problems and concerns that are quite different from those of other age groups. Older citizens are more often the victims of consumer and administrative abuses calling for legal remedies and generally do not have the resources to be able to afford legal representation. We are sure that your hearings will develop increased evidence of the serious need that our older citizens have for legal services.

In June of 1974, we told Senator Tunney's Subcommittee on Representation of Citizens' Interests that:

"The private bar and law schools must assume greater responsibility for helping to improve the availability of legal service for our elderly citizens. Every local bar association should consider establishing a standing committee which will investigate and periodically review the problems of the elderly citizens in their area and then make recommendations as to how these problems can be resolved. Law schools in California should also be encouraged to design courses that deal with the particular problem of our elderly citizens and reassess all of their courses to insure that the problems of our elderly are covered in courses other than 'estates, probate, and taxation.'"

Since that time, the State bar has developed its own 5-point program for meeting legal problems of the aging. The 5-point program includes: (1) Project Outreach—a series of programs focused on meeting the legal needs of the elderly; (2) methods for financing and implementing these legal services; (3) educating attorneys to handle the legal problems of the aging; (4) educating the elderly about their legal rights and the legal services available to them; and (5) legislative action to remedy certain inequities facing the senior citizens. As part of the program, the bar has asked every local bar association in the State to become actively involved in developing or working with local programs for the elderly.

The legal services section was created to provide a mechanism for California attorneys and judges to focus their energy on this and other problems. Twenty-five percent of the section members already have expressed interest in the legal problems of aging. The section's executive committee has successfully lobbied the State Legislature to pass a bill that grants significant new rights to individuals who are subject to conservatorship and guardianship proceedings. Finally, the section's committee on the legal problems of aging already has united judges, professors, private practitioners, and legal services attorneys in developing a statewide program to deal with the legal problems of senior citizens.

We are keenly aware, however, that the legal services section can do only so much without creative legislative leadership in the U.S. Congress. We are highly appreciative of the efforts of Senators Church, Kennedy, Williams, and Tunney to educate their fellow Senators regarding the legal problems faced by our older citizens. We also wish to express our gratitude to Representative Brademas of Indiana for his work in assuring that the Older Americans Act would be amended to make legal services a priority. Much more needs to be done, however, if our older citizens are to receive the quality of legal care that they need. Only so much can be done by volunteer attorneys or by our underfunded legal service and legal aid programs. More money must be made available for the provision of legal services to seniors. We hope that as a result of these hearings you will draft new legislation which will provide more funds and resources in this important area. For as we said in 1974, the problems of the elderly are, in the final analysis, our problems.

NATIONAL SENIOR CITIZENS LAW CENTER PUBLICATIONS

Catalog No.	Title	Price
18.193	Handbook Directory of Federal Headquarters Sources	$2.00
18.194	Manual of Funding Sources and Models for Delivering Legal Services to the Elderly	7.00
18.320	Nursing Home Law Handbook	1.25
18.453	Age Discrimination	.50
18.454	Mandatory Retirement	.50
18.455	Consumer Problems	.50
18.456	Housing	1.25
18.457	Legislative Information	1.00
18.458	A Short Summary of Title II of the Social Security Act	1.00
18.459	Veteran's Benefits and the Elderly Veteran	1.25
18.460	Legal Issues Affecting the Older Woman in America Today	1.25
	Materials on SSI and Social Security Disability	(1)
	Legal Services Guidebook on California Estate Planning	(1)

[1] To be advised.

Source: Available through National Clearinghouse for Legal Services, Order Department, 500 North Michigan Ave., suite 2220, Chicago, Ill.

Appendix 2

LETTERS FROM INDIVIDUALS

ITEM 1. LETTER AND ENCLOSURES FROM JAMES B. CARDWELL, COMMISSIONER OF SOCIAL SECURITY; TO SENATOR EDWARD M. KENNEDY, DATED NOVEMBER 24, 1976

DEAR SENATOR KENNEDY: Your letter of October 19 requests information regarding our plans for implementation of the SSI study group recommendation for establishment of an ongoing interrelationship with advocacy and legal aid groups.

We are committed to the idea of furthering our ongoing interrelationships with the consuming public and had no reservation about moving ahead to establishing such relationship with advocacy and legal aid groups. As a first step we invited representatives of a number of legal aid organizations to Baltimore. Our objective was to get their input into the development of the most effective mechanism for an interchange process.

At the first meeting this group indicated that they were not sufficiently representative of the universe we were trying to reach and asked for additional time to consider the problem. At our second meeting the group reaffirmed the fact that they were not representative of the legal aid communities but suggested that they nevertheless serve as the advisory group to SSA. We agreed that the meeting participants were not sufficiently representative of the groups involved, e.g., there were no black attorneys. We advised that the entire issue of how and with whom the study group recommendation would be implemented would be given further consideration. This was reflected in our reports of the meetings, copies of which were sent to each participant. Copies are also enclosed for your information.

The kind of relationships and activities which need to be established are, of course, affected somewhat by the recent changes in the handling of regulations which are designed to promote broad public input into that process as well as the proposals of the HEW Task Force on Citizen Participation relating to decisionmaking. These were published in the *Federal Register* on November 10.

We have now decided that we will not establish a small advisory group representing the legal aid and advocacy communities but rather will establish a roster of individuals and organizations representing these groups and others particularly interested in the problems of the disadvantaged. We will, from time to time, invite representatives from this roster for the discussion of specific problems or areas of interest. The invitations will be issued on the basis of the particular interest and expertise of the members. The matter of compensation for those who participate in such meetings will be determined under a general policy of payment for expenses where there is a need for such payment.

We will be communicating this decision to the legal aid representatives who have previously met with us. These representatives will, of course, be included on our roster.

Sincerely yours,

JAMES B. CARDWELL.

[Enclosures]

REPORT OF MEETING, MAY 26, 1976, SOCIAL SECURITY ADMINISTRATION

INTRODUCTION

Convened by the Social Security Administration (SSA) and chaired by Thomas C. Parrott, Associate Commissioner for External Affairs, this meeting

was held to explore approaches which should be considered to establish and to maintain an effective system of two-way communications between SSA and the Nation's legal aid programs.

The meeting agenda and a list of meeting participants are attached.

Mr. Parrott and Mrs. Juni welcomed the seven legal aid attorneys and explained that the impetus for inviting them to meet with SSA came from a recommendation of the supplemental security income study group that SSA establish an ongoing relationship with legal aid and advocacy groups.

SSA recognizes that the development of a network of legal aid groups through which SSA and the legal aid community can interact has the potential for achieving specific goals. It can provide a means by which reliable information may be exchanged concerning laws, policies, and procedures, as well as information about consumer reactions and concerns so that misunderstandings can be avoided and program operations refined. It was emphasized that SSA's intent is to set up a mechanism that would not be a token venture but that would result in an effective, productive working relationship.

Mrs. Juni reviewed plans complementary to the proposed network of legal aid groups which are designed to take readings on trends and policies that might cause problems and which would provide for representation and input from the total SSA interested populations. Representatives of legal aid programs could participate in those activities. Included are plans to have a broad range of "weathervane" groups throughout the country for general consumer reaction to all aspects of the social security programs. Additionally, meetings in the field with organizations and individuals representative of the public will provide a forum for the discussion of issues involving SSA administered programs. (The first of these meetings will be held in the Denver region in October.)

THE LEGAL AID COMMUNITY

The legal aid attorneys were asked to clarify the legal aid community, what it is now and how it works.

There are approximately 800 legal aid offices providing direct service to clients. The Legal Services Corporation is providing financial support to 250 or 260 programs but any program may have more than one office. In addition, the Administration on Aging and the Office on Developmental Disabilities—in HEW's Office for Human Development—are supporting legal assistance provided special populations in their areas of concern. It was pointed out that there is nothing in the legal services resembling a network except very loose, informal communications.

The legal aid attorneys discussed the difficulties of achieving "representativeness" in the makeup of a network of legal aid groups for the proposed interaction with SSA. The interests of most legal aid offices lay in the supplemental security income (SSI) program: about one-third see SSI clients, title II is more "hit or miss," and very few medicare problems are taken to legal aid offices. With regard to title II, however, the attorneys agreed that probably 95 percent of the SSI problems overlap the title II disability program and that SSI and disability insurance are almost the entire SSA related workload of legal aid offices.

ESTABLISHING THE NETWORK

Most of the discussion dealt with how to organize a network of legal aid groups, both regionally and nationally. It was agreed that a start should be made with a national group, although there was considerable interest in first holding regional meetings to choose a national group and to deal with local operating problems.

The selection of legal aid representatives should largely be the responsibility of the legal aid community. Since paralegal personnel perform most of the direct work with clients they are an important consideration in achieving "representativeness."

This group of seven legal aid attorneys agreed to supply SSA with the names of people to makeup the next group for a meeting in late July.

Key words in discussing the procedures through which the network would operate were openness, flexibility, and responsiveness. Stressed was the importance to legal aid people that when particular items are brought out they receive "real consideration."

This discussion indicated that there are definitely other important areas of concern besides SSI and disability insurance which should be considered in the formal meetings, and the network should have the flexibility to bring in different people when considering specialized problems.

The topic of financing for the meetings was mentioned but was not explored in any detail.

FEDERAL ADVISORY COMMITTEE ACT

The question was raised as to whether the operation of the proposed legal aid network will be an activity covered by the Federal Advisory Committee Act. SSA agreed to have the matter explored thoroughly and an opinion of the Office of General Counsel will be obtained.

THE COMMISSIONER'S OFFICE

The meeting closed after a brief talk by the Deputy Commissioner, Jarold Kieffer, who emphasized SSA's and his own commitment to establishing a continuing interchange with groups representing consumers. Mr. Kieffer indicated his interest in participating at greater length in the next meeting.

REPORT OF MEETING WITH LEGAL AID ATTORNEYS, JULY 27–28, 1976

The second meeting with the legal aid attorneys was opened by Associate Commissioner Parrott. The associate commissioner welcomed the group, reiterated SSA's interest and commitment in working with the legal aid community, and outlined the purposes of the meeting of assisting in the formulation of procedures needed to establish effective working relationships of SSA and legal aid programs. Mr. Parrott indicated that, from SSA's view, there were three purposes to the proposed network: (a) To provide a means by which information may be exchanged; (b) to provide a structure through which the legal aid community may identify problems and channel suggestions; and (c) to provide a means by which SSA can consult with legal aid lawyers on proposed changes.

Mrs. Juni then opened the substantive discussion. She stated that the purpose of the meeting was to develop a "mechanism that would work," to exchange information and provide structures for input. She noted that the legal aid representatives had not met their commitment in supplying SSA with names of additional persons to be included in the network and timely suggestions for an agenda. She stated that SSA was seeking identifiable gains from the operation of the network, and that this would require commitment, time, and effort from all parties concerned. Mrs. Juni stated that, although some small time was allotted in the agenda for a consideration of program problems, the first priority of this planning meeting was to outline in some detail the structure and functions of the legal aid network. Ms. Bader emphasized that, although the "ground rules" for the operation of the network should be clearly established, a certain flexibility would need to be built into network representation and operation.

Joel Cohen outlined the possible impacts of the Federal Advisory Committee Act on the operation of the network, and this discussion led into a consideration of other problems surrounding network representation and operation. Several legal aid representatives again pointed out that the small group in the room did not and could not "represent" the legal aid community as a whole, since there was no overriding "organization" among the legal aid lawyers. Thus, the criteria for selection of legal aid attorneys to participate in the network were difficult to determine. Mr. Kimbell felt that representation in the network was really a secondary problem; the key issue was what role would the network play. Ms. Blong stated this same concern and asked whether the network would play a role in policy development. Mrs. Juni responded by saying that part of the operation of the network would include an opportunity to make timely input and comment to the agency and to present the legal aid perception of problems of program operation. Mrs. Juni distinguished between an adversary and an advocate role for the network, saying that SSA did not want network meetings to become an adversarial free-for-all, but did expect the legal aid attorneys to be strong advocates for the positions they considered correct. Mutual respect should prevail.

Mr. Goar indicated that all questions about role or representativeness would be moot without a consideration of travel funds. Mrs. Juni responded by saying that SSA was not planning to provide reimbursement for additional meetings, but that SSA would assist in locating other sources of funding. Mr. Miller noted that the legal aid backup centers could pick up the travel cost for their staff who were part of the network, but the local legal aid offices would need outside assistance, at least for the travel costs, if not the per diem. Mr. Miller asked at what level the decision was made, and was told that it was an OEA decision consistent with other policies laid down by the commissioner. Mr. Miller indicated that the attorneys would probably appeal this decision.

Mrs. Juni asked whether the legal aid groups should be kept separate from other structures of consumer input. The general consensus was that the legal aid network should be a separate structure, although this structure would not preclude other persons or organizations from participating in network meetings if the need arose. There also seemed to be general feeling that network meetings should take place in Baltimore, to allow for ready access to SBA technical personnel, but this also did not preclude some meetings being held in other parts of the country if a specific and limited agenda is worked out in advance.

The session on Tuesday afternoon opened with a discussion by Dick Brown of OPO concerning claims manual distribution and availability of other SSA documents. At the present time, legal aid attorneys may receive claims manual chapters 12 and 13, "A" supplements, and disability insurance letters. Mr. Brown briefly outlined the present arrangements for claims manual distribution to legal aid attorneys, some problems, and possible plans for the future. Mr. Brown indicated that the agency was developing a unified system for issuing field instructions in addition to the policy and procedural information contained in the claims manual which would help relieve the problem of multiple instructions to the field. Mr. Goad asked about the role of regional program circulars and the distribution of central office responses to policy inquiries from a region. Ms. LePore described regional procedures to assure that the circulars do not decide national policy questions. Barry Powell further answered that all ten regions receive answers to any regional inquiry, to assure national uniformity of interpretation. Mr. Miller seemed to sum up the feeling of the legal aid lawyers by saying that there seemed to be too many sources of "law" in the field, and the local legal aid attorneys had access to too few of these.

Ms. Blong asked Mr. Brown why only claims manual chapters 12 and 13 were distributed to legal aid attorneys, when many topics of importance to SSI were contained in other claims manual chapters. Mr. Brown indicated that the claims manual should be reexamined to see what other sections might be needed, but that there were problems in distribution which also needed to be resolved. Mr. Miller then indicated that the National Senior Citizens Law Center (NSCLC) would probably find it difficult in the future to continue the role it has played in claims manual distribution. Finally, Mr. Brown indicated that the agency was attempting to place more claims manual information in the program regulations themselves. Concerning the regulations, Mr. Brown indicated that there was a "law and regulations" section of the claims manual, and indicated that work was needed to determine the volume and exact cost of making this available to legal aid attorneys.

After Mr. Brown concluded, discussion concerning network organization and operation was resumed. The legal aid attorneys proposed a network structure which would include: (a) A core group of legal aid representatives who would attend quarterly meetings. This core group was proposed to consist of four "national" legal aid representatives: National Senior Citizens Law Center (Miller); California Rural Legal Assistance (Abascal); National Health Law Program (Mullen); Center on Social Welfare Policy and Law (Blong); and four local legal aid representatives: James Weill (Legal Assistance Foundation of Chicago); Doris Falkenheiner (Legal Aid Society of Baton Rouge); Linda Bernstein (Community Legal Services, Philadelphia); and Steve Kimbell (Vermont Legal Aid). (b) The core group would develop and submit to SSA a list of 30 to 50 names of other legal aid attorneys with significant experience in SSA programs. This larger group could be called upon by the core group and by SSA to provide input and expertise. Discussion for the remainder of the afternoon revolved about issues associated with this proposal. Mrs. Juni noted that blacks and other minority groups were not represented on the proposed

network, and that this could be a significant problem. Mrs. Juni also indicated that such an arrangement would have to be approved by the Commissioner and the Department, and that the Federal Advisory Committee Act (FACA) might limit this arrangement or impose additional requirements. Thus, no final answer would now be possible. Other items to be researched were suggested, including the content of a "charter" under the FACA, the possibility of "subcommittees" or "workgroups" for analysis of specific problems, and alternate sources for funding the network.

The first presentation on Wednesday morning was made by Rose LePore concerning the SSA organization. Ms. LePore outlined the role and relationship of the central and regional offices, and the various bureaus and offices. This discussion proved to be the jump-off point for a rather complex discussion concerning the role of BHA vis-a-vis the rest of SSA, the precedential weight of appeals council and ALJ decisions, the relationship of such decisions to policy formulation, and allegedly inconsistent decisions on disability cases applying for title II and title XVI. Paul Muller of BHA responded generally to a number of these questions, and Mrs. Juni indicated that substantive questions of this type should be left to later meetings when there could be thorough preparation. The legal aid representatives seemed to agree that a discussion of issues surrounding BHA would be a priority for subsequent meetings.

The remainder of the morning session was devoted to a discussion of the mechanics of the communications process between SSA and the legal aid community and a listing of priority problems for subsequent meetings. The advantages and disadvantages of various existing publications were discussed, including the *Clearinghouse Review*, the *Poverty Law Reporter*, newsletters from NSCLC, and the Center on Social Welfare Policy and Law. Other potential mechanisms were outlined, such as letters or memoranda from SSA to network representatives on significant matters.

In addition to questions concerning the role and relationship of BHA to the rest of SSA, the legal aid attorneys listed a number of other priorities which they desired to be considered in network meetings: input on contemplated policy changes; the notice and reconsideration process; the application process; overpayment policy and procedures; representative payees; and outreach. Mrs. Juni emphasized the need for an organized system to identify agenda items and to distinguish between routine and special concerns representative of consumer interests. It will be particularly important to assure that "business as usual" is supported, that normal communications and day to day work continue between the various SSA and legal aid offices. However, for items that will be explored in depth at network meetings, the group indicated that the network representatives should raise and document the question in advance. SSA should furnish a response with pertinent materials, and then the matter would usefully be discussed at a meeting.

Wednesday afternoon was devoted to a presentation of two substantive areas, the Privacy Act and check replacement. Concerning the former, Dick Brown of OPO discussed SSA's present posture concerning the act, and along with Gerry Altman of OCC answered a number of technical questions regarding the act and the access it gives to legal aid personnel to the records of a beneficiary. Mr. Brown indicated that the agency would be clarifying the requirement of consent for receiving information.

Mr. Bert Rouse of OPO discussed the title II critical case processing and check replacement procedures, and Mike Johnson of OPO outlined the system and procedures for replacing SSI checks. There were a number of questions regarding the feasibility of using prepositioned checks in the district offices to replace missing checks, and Ralph Abascal was also interested in an evaluation of provision in H.R. 8911 for States to provide interim assistance in the case of lost, stolen, or missing checks. Mr. Abascal asked whether the department had any formal position on H.R. 8911. Ms. Blong commented that the handouts of the type distributed by OPO to summarize and explain check replacement would not be sufficient for subjects to be discussed at future meetings. She asked that for future meetings such summaries should be cited throughout to applicable SSA policy and procedures manuals. Mr. Trazzi pointed out that such "citation" to sources was possible in some cases, but not in others.

At various times throughout the 2-day meetings, the legal aid attorneys asked that all formal decisions and announcements for the network be made in writing to minimize the chances for misunderstanding and to insure that all were adequately informed. They asked that minutes be kept of future network meetings, and that formal reports be filed. SSA staff emphasized their

own desire to keep a formal record of network activities and information, and indicated at the end of the second day that a report of this planning meeting would be distributed.

ITEM 2. LETTER AND ENCLOSURE FROM WILLIAM O. GREEN, MABLETON, GA.; TO SENATOR EDWARD M. KENNEDY, DATED OCTOBER 1, 1976

DEAR SENATOR KENNEDY: I just had occasion to run across your article entitled "Care for the Aged: Our Last Minority" that appeared in the May-June, 1974 issue of *Case and Comment* [see enclosure]. Quite recently we had a very difficult experience in my office that is prompting this letter to you as a result of the expression of your concern in the article I just referred to.

Some few years ago a middle-aged gentleman suffered a heart attack and was confined to a nursing home. In the ensuing course of events this gentleman was confined for a brief period of time to one particular nursing home in Cobb County, Ga. The lack of care and attention that this man got while there is simply appalling. We know for a fact that he suffered a fall and a resulting fracture though nobody at the home knows about it even though he was confined to his bed and could not move himself at all. We know one instance where he was left propped up in a chair for about 24 hours. We know of many instances of physicians' instructions not being carried out. We have photographs of the most horrible ulcerations of the man's skin caused by lack of attention to his needs in the nursing home. This tale of horrors goes on and on.

He died.

To make a long story short, we advised the grieved widow of the difficulties in pursuing litigation like this (an administrator's suit as well as the death action against the nursing home) and she wanted it pursued anyway, not for the money that she might or might not get, but because of a very honest desire to have such an impact on that home and others like it that others could not be victims of this sort of maltreatment. I don't have the slightest question in my mind but that this was the sole motive that this lady had in pursuing this case.

The original tragedy notwithstanding, the thing I want to communicate with you about is this: After we got suit filed and we really began to get into the case, we uncovered the most bizarre charade of ownership and responsibility that I have ever heard of. Some con artist or artists somehow set up a series of corporate shells and, to again make a long story short, I will simply say there was nothing and no one to get at in this case. The nursing home is still operating under the protection of some sort of receivership and it is abundantly clear that the people primarily responsible for this situation are long gone and there are not any assets from which judgment could be satisfied even if it were ultimately obtained.

I think what I am trying to say is that I certainly would be in favor of some sort of registration requirement for these homes and some sort of mandatory financial responsibility requirement. I realize that a lot of our medical friends are highly critical of malpractice claims, but I do not think that any responsible person in or out of the medical field would deny that the assertion of malpractice claims is certainly a primary factor in bringing about a lot of safety features that we now have in the hospitals.

I realize full well that the present mood of the country is antiregulation, but it does seem to me that the deplorable state of nursing care facilities for the aged in this country cries out loud and clear for some kind of help.

Cordially,

WILLIAM O. GREEN.

[Enclosure]

[From *Case & Comment*, May–June 1974]

CARE FOR THE AGED: OUR LAST MINORITY

(By Senator Edward M. Kennedy)

In the mid-nineteenth century, the missionary James Moffat recorded in his diary his conversation with an old Hottentot woman whom he had found

abandoned in a desert: "Yes," she said, "my own children, three sons and two daughters have left me here . . . to die . . . . I am very old, you see, and am not able to serve them. When they kill game, I am too feeble to help with carrying home the flesh. I am not able to gather wood and make a fire, and I cannot carry their children on my back as I used to do."[1]

THE NADER REPORT

This scene unfortunately has its modern counterpart, as revealed in Ralph Nader's *Task Force Report on Nursing Homes.* Seeing old age as the "last segregation," the Nader group, led by six seniors and an instructor at Miss Porter's School in Farmington, Connecticut, has documented the tragedy of many of the one million elderly citizens institutionalized in the 24,000 nursing homes across the country.

Nursing homes represent only a part of the over-65 subculture, affecting five percent of the 20 million elderly Americans. The federal government pays 40 percent of a $2.5 billion a year nursing home industry. Fifty chains of nursing homes now have their stock listed on Wall Street, and the elderly are treated in too many instances as digits in a profit and loss statement rather than as human beings.

The study group's main conclusion is that neither the government nor the nursing home industry nor the medical profession accepts responsibility for the quality of elderly health care. This disinterest is aggravated by a decentralized bureaucratic maze which ranges through a half dozen federal agencies, through multiple agencies in each of the states, and through local licensing and inspecting boards.

The bedsores and boredom of the aged can be traced through inadequate government programs and through the failure of national leaders to make a firm commitment to decent care for the aged. The medical profession appears to abdicate professional responsibility, and a profit-oriented nursing home industry appears willing to cut costs at the expense of its patients. Finally, our youth-oriented society is insensitive to the plight of elder Americans, rushing them to nursing homes regardless of the homes' quality.

The *Nader Report* first reveals the national disgrace of our treatment of the aged by tracing the history of efforts to enact legislation providing health insurance for all citizens, a struggle whose fate is still before the Congress. Attention is focused on the ebb and flow of support for national health insurance, the opposition being crystallized at various points by the American Medical Association, the American Hospital Association, and the American Nursing Home Association. Even partial victories in behalf of the aged have been hard-fought and few—the Social Security Act of 1935, the Hill-Burton Hospital Survey and Construction Act of 1946, Old Age Assistance in 1950, Social Security benefits for the disabled over age fifty in 1956, the Kerr-Mills bill in 1960—the forerunner of Medicaid—and Medicare and Medicaid in 1965. But no national policy was defined to offer strict enforceable standards and close inspection of the nation's nursing homes.

STANDARDS

A single nursing home, for example, may be inspected under three sets of standards—state licensing codes, Medicare standards, and Medicaid standards. The consequences of bureaucratic fragmentation are made clear: "in the absence of one agency clearly designated as responsible, and capable of assuming that responsibility, the public interest in insuring high-quality care in nursing homes has been frustrated."[2]

It should come as no surprise that 80 percent of the nursing homes that receive public tax dollars do not meet minimal federal standards. The reaction of a sympathetic Medicare inspector in Maryland is indicative of the attitude which persists at the state and local—as well as national—level: "the ultimate step of closing nursing homes is avoided because neither the homes nor the states has an alternative to offer the patients."[3]

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[1] The Matabele Journals of Robert Moffat (J. Wallis ed. 1945).
[2] C. Townsend, Old Age: The Last Segregation 39 (1971).
[3] *Id.* at 48.

This points again to the helplessness of the elderly patient who may be forced to choose between an inferior home or no home at all.

SUPERVISION AND INSPECTION

Nursing home inspections are often less revealing than they might be because of the almost universal practice of notifying homes well in advance of the inspection. The *Nader Report* found it not uncommon for homes to hire additional personnel for the inspection day in order to qualify under the staffing requirements, or to move staff members from floor to floor as the inspector made his tour. Deficiencies and poor conditions, whether camouflaged or not, are usually exacerbated by exorbitant costs, especially since older persons have less than one-half the income of younger people, while their medical expenses are three times as great.

Although doctors may attend individual patients, they neglect the home itself. With no medical supervision at all in many homes, the aged must fend for themselves. Female patients in urine-soaked nightgowns a week old, catheter tubes without urinal bags, bleeding from unattended wounds, call buzzers put deliberately out of reach, baths given but once a month, bedsores and urine burns, stale and even spoiled food are but a few of the agonies found by the Nader investigators.

Whether or not the many nursing home organizations deny that these horrors are widespread, the fact that they exist at all requires national attention and action, and their existence libels those institutions and administrations dedicated to the quality of care of their patients.

Most tragic of all have been the fatal consequences of the prevailing attitude of disinterest in and neglect of the health of our elderly citizens. On January 9, 1970, 32 patients died of smoke asphyxiation at Harmar House Convalescent Home in Marietta, Ohio. The scenario of death should not have been an unexpected one—deficient alarm signals, no fire evacuation procedures, doors too narrow to admit hospital beds, no water sprinklers or fire extinguishers, flammable and smoke-producing carpet.

Similar conditions in the enforcement of sanitation standards last year made Gould Convalesarium in Baltimore, Maryland, the scene of twenty-five deaths due to salmonella poisoning. Hearings later revealed that the home did not meet state requirements for kitchen hygiene or food handling. Disaster recently struck again, this time in a Homesdale, Pennsylvania nursing home, where in the words of Arkansas Congressman David Pryor "fifteen people met unforgivable deaths in a night of horror."[4] The fire which extinguished those lives came just a few weeks after the Pennsylvania Association of Nursing and Convalescent Homes had strongly, and successfully, opposed a regulation tightening state regulations governing fire procedures.

ADMINISTRATION AND ENFORCEMENT

An important aspect of the nursing home scandal revealed by the Nader inquiry is the role of the administrator in maintaining high standards of care. Educational credentials or experience in the field have been virtually nonexistent among a large percentage of nursing home administrators. For that reason, this writer sponsored an amendment to require educational standards for nursing home administrators. Yet, as the study points out, it would be wholly consistent with current regulations to have "an eighteen-year-old high school dropout running a house for the elderly, with sole responsibility for hiring and directing personnel, managing food services, coordinating patient care activities, as well as handling business and financial arrangements and community relations."[5]

Another major problem is holding owners accountable for homes they operate. Ninety percent of all nursing homes are privately owned, profit-making operations. There are strong indications that stricter regulations are

[4] Address by Congressman David Pryor, Women's National Democratic Club, Nov. 4, 1971.

[5] C. Townsend, Old Age: The Last Segregation 82 (1971).

needed to prevent abuse by owners, particularly in instances such as those found by the Nader study where entrance contracts require patients to sign over all of their possessions to the nursing home—often even including the deed to their burial plot.

Perhaps the most startling revelation of the task force study concerns drug abuse. Nursing home patients are at times "direct victims of the irresponsible administration of drugs, unchecked prescriptions, unauthorized drug experiments, and the widespread practice of administering tranquilizers to keep the patients quiet." [6] This situation requires immediate remedial action.

Both present and future members of the legal profession should by now be aware that they bear a significant responsibility to the elderly. The composition of local licensing boards may be in open violation of State licensing regulations. In Maryland, a nine-man board was at one time comprised of four owners of commercial nursing homes, plus a salesman of ambulance service and nursing home supplies. Yet, the study notes that Maryland law forbids board members to have any financial interest in nursing homes. As Nader and his associates report, "it was only when the family threatened to sue the home for negligence and the doctor for malpractice that the home released the woman from the contract and returned her property." [7] It can only be hoped that our lawyers take up the responsibility to bring dignity to the nation's elderly.

STUDY GROUP RECOMMENDATIONS

The study group concludes with a number of important recommendations to upgrade the quality of nursing homes and elderly health care in general. They include strict federal enforcement of nursing home standards and regulations; the publication of quality ratings for homes receiving federal money; medical review of homes to ensure adequate policies and practices; improved training of nursing home aides; higher standards in the licensing of administrators; better means of identifying nursing home owners and holding them accountable for deficient practices; stricter control over the use of experimental drugs on patients; and an active program of alternatives for elderly citizens outside the nursing home, including adequate community housing, employment opportunities, and home care programs.

The *Nader Report* has painfully reminded us that the elderly represent one of the most wasted human resources in this country. No truly great nation can afford to abandon a commitment to end the present demoralization of growing old—what one writer has described as the process of disengagement. The anguish of this national disgrace is perhaps best summed up in a recent letter to Congressman David Pryor from a young nursing home employee. She writes:

"I am sick of the smell of urine and feces and the silent eyes of old people who have no one left; forced to die in a place that has no regard for their dignity or worth as human beings. . . . What is going on today is bad enough and we can't sweep our old people under the rug and pretend they don't exist. If we have the means to keep them alive we have the means to allow them to live a meaningful old age." [8]

CONCLUSION

We have subjected a vast portion of our elderly population to an institution itself sick, feeble, and in need of care. We have consistently ignored the special needs of what is perhaps America's last minority, a status which our aged seem to escape only in the death to which we rush them. That this minority is an ever-increasing one may be seen in the trend toward earlier retirement at a time when the average life expectancy is rising. As the number of elderly citizens increases, their health care needs expand by an even greater proportion. So also does our moral responsibility to meet those needs. We must not allow one million of our fellow human beings to live out their golden years as victims of a bleak and tarnished tragedy. We must instead restore to old age the dignity envisioned by the Roman philosopher Cicero: "For herein is old

[6] *Id.* at 121–22.
[7] *Id.* at 93.
[8] *Id.* at 195–96.

age honest and honorable, in defending and maintaining itself, in saving itself free from bondage and servitude . . . even until the last hours of death."

ITEM 3. REPLY LETTER FROM SENATOR EDWARD M. KENNEDY TO WILLIAM O. GREEN, DATED NOVEMBER 19, 1976

DEAR MR. GREEN: Your description of the nursing home to which your client's husband was confined is deeply disturbing. Unfortunately, similar tragedies are occurring in nursing homes throughout this country. As Chairman of the Health Subcommittee, I am giving serious consideration to the problems of licensure of nursing homes and strict federal regulation of their operations.

I have taken the liberty of bringing your letter to the attention of my Subcommittee and to the Special Committee on Aging.

Thanks for taking the time to write.

Sincerely,

EDWARD M. KENNEDY.

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IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 3—WASHINGTON, D.C.

SEPTEMBER 28, 1976

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Part 2. Boston, Mass., August 30, 1976.
Part 3. Washington, D.C., September 28, 1976.
Part 4. Washington, D.C., September 29, 1976.

CONTENTS

IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

TUESDAY, SEPTEMBER 28, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:45 a.m., in room 4232, Dirksen Senate Office Building, Hon. Harrison A. Williams, Jr., presiding.

Present: Senators Williams, Hartke, and Clark.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Deborah K. Kilmer, professional staff member; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; Eugene R. Cummings, printing assistant; and Donna M. Gluck, resource assistant.

OPENING STATEMENT BY SENATOR HARRISON A. WILLIAMS, JR., PRESIDING

Senator WILLIAMS. We will come to order.

Today, the Special Committee on Aging will continue its hearings on "Improving Legal Representation for Older Americans."

Our agenda is long and our list of witnesses is impressive this morning. So I shall be brief and make three major points in my opening remarks.

First, the committee has a longstanding interest in making legal representation more readily available for the elderly.

As chairman of this committee in 1970, I initiated hearings 6 years ago in St. Louis at the American Bar Association conference on the legal problems of the elderly.

This hearing made it abundantly clear that older Americans had major legal problems which were receiving far too little attention. Since then, the Congress has enacted a number of measures to focus greater attention on the legal needs of the aged—from the private bar, law schools, the legal services program, and at the community level.

One example is the Older Americans Amendments of 1975, which include potentially far-reaching provisions to improve legal representation for the elderly. In addition, the Congress approved increased funding for model projects to develop innovative solutions for the aged's legal problems. Three of our witnesses today operate programs under the model projects section of the Older Americans Act.

Second, older Americans should be served by Government and not thwarted by it. Effective service is vital for the elderly because they rely on many Federal programs: social security, medicare, medicaid, supplemental security income, railroad retirement, veterans' pensions, food stamps, and others. But if my mail is an accurate indicator—and I think it is—many older Americans are baffled and confused when they deal with the Government. Of course, they are not alone in this.

Many Elderly Are Confused

An elderly widow may wonder why her SSI check is suddenly reduced when social security benefits are increased.

A 75-year-old man who is homebound may be understandably upset because of the redtape and bureaucratic lethargy at the local department of social services. Yet, he may be forced unnecessarily into an institution, at a much higher public cost, if he is denied homemarker services.

A retired worker may also throw up his hands in utter disbelief when he tries to wade through the retirement income credit schedule of form 1040.

Every Senator, I am sure, has heard identical or similar accounts. We try to help those who write and tell us about their problems. Caseworkers in our offices are kept busy working on behalf of these individuals to assure that they are treated equitably, fairly and courteously, by administrators of Federal programs.

We also know that there are many more out there who do not write, who do not complain, and who do not know just what to do. Oftentimes they accept wrong-headed decisions or injustice simply because they do not know what recourse is available.

Third, a society based on law should take steps to assure that its citizens—whether they be rich, poor, young or old—have equal access to the law. However, perhaps two out of every three Americans, according to some estimates, do not have access to legal services.

Reasonable persons may differ about the actual number of Americans who cannot obtain legal help when a problem arises, whatever the reasons may be. But, there is no doubt that a substantial number must look out for their own interests when a legal dispute occurs. And this is especially true for older Americans, whether their problems require the attention of an attorney or a person whose profession is described as paralegal.

Fortunately, some steps are being taken now to make legal representation more readily available for the elderly. Our leadoff panel, from Camden, N.J., will provide us with some examples of positive actions at the grassroots level on behalf of aged clients.

We at the Committee on Aging have always encouraged firsthand testimony because we want "to hear it like it really is" from the real experts—the people affected by Government programs. In the final analysis it is the people who will ultimately decide whether Government efforts are worthy, effective, and helpful. With this in mind, I welcome our panel from Camden.

Before we turn to our first panel, Senator Clark of Iowa is here. Senator Clark, do you have an opening greeting?

Senator CLARK. No opening statement. Thank you.

Senator WILLIAMS. We will proceed with Ms. Lessie Hill, attorney, Senior Citizens Advocate Center, Camden Regional Legal Services, Camden, N.J.; Rev. R. Alvin Wilson, chairman, Advocate Center Executive Committee, Camden, N.J.; and Mrs. Katherine Ashton, Gloucester, N.J. We welcome you and are grateful to you.

STATEMENT OF REV. R. ALVIN WILSON, CHAIRMAN, ADVOCATE CENTER EXECUTIVE COMMITTEE, CAMDEN, N.J.

Reverend WILSON. Senator Williams, we are very happy to be here and we appreciate your concern. Also, often we feel like we are voices crying in the wilderness and now that we have this kind of recognition it is very helpful.

It has been my privilege to be chairperson of the Citizens Advisory Committee. When Father Don Griesman of the Camden Regional Legal Services asked me to become involved in the forming of a citizens advisory committee for an advocate center for legal services for senior citizens, I was happy to respond. Because I had worked closely with the Camden Region Legal Services for a number of years, I had the highest respect for their work and felt honored to be asked to participate.

The function of the advocate center committee is to help choose the lawyers for the center and to help set policy. Therefore, I am happy and proud to present one of our lawyers, Ms. Lessie Hill, who directs the center. She represents the caliber of our staff.

We started out on a shoestring and with 70,000 potential clients that we have in five counties. It seemed sort of ridiculous to have just two lawyers take care of all these cases. However, our program is expanding, and with your blessing we trust that the Government will give title III more money so we can expand our program to get back into the boondocks, rural slums, and places where we need special kinds of transportation to go out and meet the low-income people who have real problems.

So now it is my privilege to introduce to you Ms. Lessie Hill, who will give you the specifics of what we are doing in Camden.

Senator WILLIAMS. Thank you very much, Reverend Wilson. We will come back to you after we hear from Ms. Hill.

STATEMENT OF LESSIE HILL, ATTORNEY, SENIOR CITIZENS ADVOCATE CENTER, CAMDEN REGIONAL LEGAL SERVICES, CAMDEN, N.J.; ACCOMPANIED BY KATHERINE ASHTON, GLOUCESTER, N.J.

Ms. HILL. The Senior Citizens Advocate Center was established in March of 1974. The initial funding for the center was divided by a grant from the New Jersey Division on Aging. The initial grant was $27.375 and Camden Legal Services provided a contribution of $9,125. The moneys from the division on aging were title III moneys. That is a brief introduction of the center.

Now I would like to ask Mrs. Katherine Ashton some questions. Mrs. Ashton is a former client of mine and of the center.

Mrs. Ashton, how old are you?

Mrs. ASHTON. I am 69 years old.

Ms. HILL. What is the source of your income and how much do you receive?

Mrs. ASHTON. I get social security, $149.70, and then I get SSI, medicare, and medicaid.

Ms. HILL. Have you any problems with receiving your SSI benefits?

Mrs. ASHTON. No; I have not.

Ms. HILL. What is your present housing situation?

Mrs. ASHTON. Well, my home is too big and I cannot stay in it at the present time because I cannot afford to heat it. I cannot afford the gas and electric. I stay with an elderly lady across the street and I get my housing from her.

Ms. HILL. How did you learn about the Senior Citizens Advocate Center?

LEGAL AID OBTAINED

Mrs. ASHTON. My husband was suing me for a divorce and I didn't know which way to turn. I had no money to get legal aid. My son found out through someone in a New Jersey bank that I could get legal aid from the Camden Regional Legal Services at Front and Point Streets, so he took me there and I got Ms. Hill to take my case and see, I got my divorce.

Ms. HILL. How was the center helpful to you, if it was?

Mrs. ASHTON. The center was very helpful to me, it saved me a lot of money. I didn't have the money in the first place and Ms. Hill got the divorce without any trouble and it didn't cost me a cent.

Ms. HILL. Would you use the services of the center again?

Mrs. ASHTON. I sure would; in any way, shape, or form.

Ms. HILL. Why would you agree to come here today?

Mrs. ASHTON. I agreed to come here because I figured the older people need more help and they need more money to get along on because the cost of living, health care, and other things are getting so high it is hard for people to live off of social security in the ways that we require.

Ms. HILL. Do you think that projects such as the Camden Senior Citizens Advocate Center are necessary for low-income elderly persons?

Mrs. ASHTON. Yes; it is, very much so.

Ms. HILL. Why do you think it is necessary?

Mrs. ASHTON. Because the way things are, people can't afford to pay the high prices for food, housing, electricity, oil, and other necessities.

Ms. HILL. So you think that there are ways in which legal services can help older people?

Mrs. ASHTON. Positively.

Ms. HILL. I thank you.

Senator WILLIAMS. Thank you very much.

Ms. HILL. I just would like to talk a little further about the center and perhaps later somebody might have some questions of Mrs. Ashton.

The mandate of the center was to provide free legal services to low-income persons—low income being described as income of $3,000 or less and elderly persons being defined as anyone 60 years of age or older. A center to especially deal with the legal problems of the elderly was thought of because the number of elderly persons being represented by legal services was extremely low when compared to the numbers in the area served by the project.

Many Problems Require Professional Services

Often senior citizens failed to realize that a lot of their problems were legal in nature and that legal services was there to serve them. Even those that knew that the problems could be solved by an attorney hesitated to contact an attorney because they could not afford one or they felt they couldn't contact legal services because lawyers, just like doctors nowadays, don't make house calls. The center was to provide services to seniors in a five-county area of South Jersey—more specifically Camden County, Gloucester County, Salem County, Burlington County, and Cumberland County.

As Al mentioned earlier, the number of low-income seniors in these five-county areas—he said 70,000 but I think it is closer to 100,000. In order to be brief I will not go into a detailed breakdown on the age and income distribution for each county.

Rather, I will just use Camden County as an example. Camden County has 41,161 residents who are 65 years of age or over. Of these residents, 19 percent, or 7,884 people, are living on fixed incomes below the poverty level. This income level ranges from about $1,400 to about $2,200. It is estimated that another 39 percent are living on incomes of between $3,000 to $7,000. In Camden County alone, the elderly population make up the highest percentage of the total population in the urbanized core. The elderly population group is increasing at a faster rate than any other group in the county of main population.

With one attorney initially, the center had represented over 140 clients in a 1-year period and the pressing caseload demanded expansion of the center. In December 1974, an additional attorney was hired. Shortly thereafter the area plan concept was instituted and through some type of administrative mixup the center was without funds for approximately 2 months. For the first time since its inception, the center had to notify persons that the services were not available.

The elderly community pressed their local elected officials and sent numerous letters to the Government requesting funding for the center. The State Department of Community Affairs fortunately had some discretionary funds which they gave to the center and we were back in business again.

The following year the center appealed to the county office on aging for funding. These efforts to achieve funding necessitated so much politicking and meeting with different freeholders that services to clients had to be curtailed and one attorney had to devote a major amount of his time on simply obtaining funds. Even after all of the center's efforts, funding was obtained from only four of the five coun-

ties which would have been served. That meant the service of one of the counties had to be discontinued.

In 1977, it was anticipated that the center would receive title III funds from all five counties and that the center can hire an additional paralegal to adequately serve the clients in the counties. In order to avoid the pitfalls of the county office on aging, vis-a-vis, the free-holders approach to funding, we strongly urged that title III moneys be allocated to projects in some type of flat grant so that at least we would know the specific limitation on the number of years that the project may apply for and receive funds.

Attorneys Must Budget Time

With an open caseload of approximately 300 clients, the center's attorneys cannot afford time to spend on funding problems. Presently the staff of the center consists of two attorneys, two paralegals, senior volunteers, law students, college students, one VISTA paralegal, and one VISTA attorney.

Now, I just would like to give you some idea of the types of cases that I and the other attorney in my office are dealing with on a daily basis.

The case that I will use is the JFK Towers Tenants Association. Approximately a year ago, a number of the elderly residents, in fact all of them in this public housing project in Camden City, were having numerous problems. The biggest complaint of the more than 100 tenants was the elevators. They said the elevators didn't come and they didn't go. In recent months, they had been taking their complaints to the project's manager and the results were just totally unsatisfactory—in fact, there were no results at all.

I think one statement of Mr. Frank Gibson, who was then president of the tenants association, just about summed up the feelings of the tenants. In speaking to the housing authority, he said: "Three of us have died in the past 2 months, 12 in the past year, 5 of us are now in the hospital. We cannot wait forever and you have done nothing for us so far."

Another glaring example, an aged tenant broke her wrist in the elevator when the elevator jerked and knocked her off her feet.

On July 24, an elderly woman had to wait 15 minutes on the stretcher before the elevator arrived to take her to the ambulance.

Another example of what is going on in the projects, when one 75-year-old woman moved into the project her apartment was extremely dirty and she requested that it be painted. She was simply given 3 gallons of paint and told, "Here, paint it yourself."

With these types of problems, these persons very effectively organized themselves a tenant association and came to the Senior Citizens Advocate Center for representation. Through the combined efforts of the staff of the center, we were able to obtain for these persons new stoves and new sinks. One man, who is 51 years old, lived in the project. He was a diabetic and had to have broiled foods. His oven had not worked in a number of months. We were able to get a stove for him; we were able to get stoves for some other people and refrigerators. We got repair and overhauling of the elevators. We got bars on the doors and we got the apartments painted.

I would not say all the problems in that project have been resolved, but the major problems were resolved. The office is still open so we are still working with those tenants.

Eviction Terms Opposed

I will conclude with just one more example of the types of problems that were encountered. Another was the senior citizens who lived in the mobile home park. Camden has three mobile home parks and the majority of these people are senior citizens. One of the parks would not let them stay. The owner of the park had a lease and he was leasing some ground. On that ground were approximately 40 mobile homes. There was a clause in the lease providing that it could be canceled on 6 months notice. The notice was given to the owner of the park and he in turn passed the news on to the tenants.

According to New Jersey law, there is nothing wrong with that if you want to retire the housing from the market or give 6 months notice, but these persons were just totally upset. They didn't know where to turn. Fortunately, some of them had been individual clients of the center and they came to us as a group. We were not able to do anything about the lease situation, but we were able to negotiate with the parties involved.

We got an additional 6-months extension that enabled a number of the people to gain time to sell their mobile homes or to get apartments. For a number of people, we were able to get them into apartments without having to pay the month or month-and-a-half security deposit. A number of persons had to sell their mobile homes. One lady I know just about gave hers away and moved in with her children.

So I think that is one good example of what we were able to do for the seniors even though, to put it quite frankly, we didn't have any law on our side. It was just other things that we were able to do before that. The center handles housing cases, the traditional cases of senior citizens such as social security and SSI problems. Surprisingly enough, we handled a lot of domestic relations cases, those obtaining divorces, even some child custody cases, that type of thing.

I just would like to make one suggestion and that is that some type of funds be allocated for the establishment of a mobile unit. We need transportation to go to the clients. We serve a five-county area spread out over a large proportion of South Jersey.

Advocacy Role Described

We cannot reach these people. We have been knocking on doors, but we still have not reached a number of people who we know are there and who we know need our services. If we had a small bus, we could outfit it with a desk, a typewriter, and a paralegal. We could be at senior citizens projects, we could be at nursing homes, we could be where the people are, and we could more effectively deliver our services to people.

That is all. Thank you.

Senator Williams. Thank you very much, Ms. Hill. It impresses me that you have most accurately described your center as an advocate

center. This was your designation of title to describe your activity, am I right?

Ms. HILL. Yes.

Senator WILLIAMS. And it impresses me from all you have said here that while it was created for basically legal services, situations develop that go beyond the narrower confines of legal questions that are really a response to social needs. So, yours is an advocacy and in the social service sense. For example, those mobile homes, while the lease was unbreakable, I suppose, and they were living up to the provisions of the lease, you, as an advocate, got an extension of time and then made other living arrangements possible.

Ms. HILL. Yes.

Senator WILLIAMS. Excellent. How large is your staff, Ms. Hill? Do you have a staff of 15 or so?

Ms. HILL. I guess all told it is about 15. We have only six paid full-time workers.

Senator WILLIAMS. Two lawyers and you are one of the lawyers.

Ms. HILL. Yes; that is right, and two paralegals.

Senator WILLIAMS. What training is needed for a paralegal?

Ms. HILL. Well, there are certain colleges that offer a paralegal course. I think it is approximately 2 years in terms of recruiting paralegals. We don't specifically require that. The only thing that we require is that the person have a high school diploma. We spend from 6 months to 1 year training these people. It is mostly on-the-job training. These people are not attorneys, they do not go into court, but they are of tremendous assistance to attorneys. They can go in and represent persons in administrative hearings such as social security, welfare, unemployment, those types of hearings. So they really are the backbone of attorneys and legal services, and I think the legal services uses paralegals more than traditional law firms.

Senator WILLIAMS. Who is the other attorney who works with you?

Ms. HILL. His name is John Poindexter. He is a young man who graduated from law school about a year ago, and he has been working quite effectively with the center.

Senator WILLIAMS. Have you thought of supplementing or expanding your staff to include, perhaps, lawyers who have retired from active practice?

Ms. HILL. We were thinking of some type of joint program with the bar association to use retired attorneys. That program has been talked about for 1 year now, but we just have not been able to get it off the ground for a number of reasons, but hopefully we will be able to come up with some type of program. Presently, we have one retired attorney who works for the volunteers and his services to the center amounts to 20 hours a week.

Senator WILLIAMS. I missed that.

Ms. HILL. One senior, 67 years old, a retired attorney, volunteers his services to the center for 20 hours a week.

Senator WILLIAMS. What is his name?

Ms. HILL. Sam Smith.

Senator WILLIAMS. Excellent. We wanted to get him in the record and to applaud Sam Smith for his volunteer work in this connection.

Reverend Wilson, did you have something to add at this point?

Some Volunteers Work Full Time

Reverend Wilson. Yes. This is my concern on the advisory committee. Mr. Smith is an excellent example of an RSVP volunteer. We work closely with the RSVP and they were able to send him our way. He had been to law school but had not practiced law; however, his first love was law. Now, after he has made his pile as a successful businessman, he is free to volunteer his services. He is very happy to come and, actually, spends full time at the center.

We are also working closely with the RSVP directors in each county, to provide us with senior volunteers to be trained as paralegals. To extend the services of the advocate center, we need paralegals in each county. Mr. Smith is our prime example.

Then again we are projecting a course for another category of volunteer who may be called "legal aid." Legal aids to the paralegals can enable the center to extend its services to a larger constituency. If we can have a legal aid volunteer in each club in each county, then we can begin to reach many seniors who as yet have not heard of our center. With this multiplication of our services, we could also begin to reach out to the isolated poor in the rural slum pockets we have in South Jersey. Lack of transportation isolates many poor senior citizens who are unable to get to the centers where the senior clubs meet.

Senator Williams. I think maybe for the listening audience—and this is being recorded and taped for CAP, I believe—RSVP is the retired seniors volunteer program. That is a creation of the Senate Special Committee on Aging, and it has really brought out the vitality of older people into service of others and in a magnificent way.

I am delighted to hear that Mr. Smith is part of that effort, RSVP. Very good.

Now, Rutgers Law School at Camden is a dynamic place. I have been there many times. You mentioned the relationship with the Camden Senior Citizens Advocate Center, Ms. Hill. Have they worked into any part of the curriculum anything concerning job familiarity and practicing with people on legal questions?

Ms. Hill. No. I hesitate to say too much because the building that we are presently housed in is being leased to us by Rutgers University for a dollar a year, and prior to that, they let us use two of their offices for legal services.

Senator Williams. Where is the advocate center?

Limited Transportation Hampers Access

Ms. Hill. The advocate center is about two blocks from what is Camden Law School at 12th and Front Streets in Camden. It is inaccessible to a number of senior citizens because the bus stop is about four blocks away from the center. Oftentimes we have persons who get off at the bus stop and call up on the phone and an attorney or a paralegal stops what he is doing, jumps in the car and goes over to pick up the person. So the transportation is a major problem simply because of the location of the center. We had hoped to consolidate a number of the offices in Camden and move closer to the bus stops, and so forth, but we didn't have enough funds to do that.

Senator WILLIAMS. Even with a relocation within the city of Camden, accessibility to the other counties is most difficult, I would think, unless an individual had an automobile.

Ms. HILL. Oh, yes.

Senator WILLIAMS. No bus routes would lead conveniently from Deptford to your advocate center, for example?

Ms. HILL. No; not from the rural areas to Salem.

Senator WILLIAMS. That is why the point is being made about transportation. A budget for transportation is so important if your service and availability is to be made real for people beyond Camden City.

Ms. HILL. Yes. Proportionately we would be serving more clients in Camden City than we do in the other countries and that is mainly because of the transportation problem. Now we have made some meager efforts to solve that problem. We have a paralegal who goes to Salem County 1 day a week. She simply goes down there and sits for about 8 hours and when a person comes in she takes the basic information and then she brings that case back to the center and consults with an attorney and we take it from there. But even with one person going to the counties 1 day a week, we are not reaching the vast number of people that we should because even in terms of the paralegal going to, say, Salem County 1 day a week, that person sits there and people still have to come to him.

I think the statistics indicate that the elderly do not have money for automobiles and if they have the money for the car, they don't have the money for the upkeep, or if they have an automobile, for a number of reasons they choose not to drive it. So simply because of the transportation problem, we are not reaching a number of the people that we feel we should be reaching and the statistics that we have accumulated indicate that very clearly.

We are not just coming here today and advising you of this problem, but we want you to know that we have made certain efforts on our own to resolve the problem. We have applied for foundation grants, and so forth, but for some reason this type of program is not all that glamorous and we just have not been able to get funding for it. Our estimates indicate that it would not cost that much to outfit some type of minibus.

We have even got Legal Services to agree to keep up the maintenance and insurance on the bus and we anticipate that we can get some types of contributions from seniors, and so forth, but the bulk of the moneys we just have not been able to obtain.

Senator WILLIAMS. If you were equipped to be mobile, you could go to the outlying counties. You could visit senior citizen clubs, for example, and describe the help that you can bring to people.

Ms. HILL. Yes.

Senator WILLIAMS. And that knowledge of the club could radiate out into even more remote areas—to others, I would imagine, including friends of those who come to the center.

HOME VISITS UNECONOMICAL

Ms. HILL. Yes. I have been with the project a little over 2 years and in my estimation transportation is the major problem of the center.

We simply need to go to the people. We do home visits but our caseload is about 300 now. To have an attorney go out of the office for an hour to do a home visit just simply is not economical, although we do it. That type of an effort is not reaching people.

If someone absolutely cannot come in and they call the office, and so forth, someone will go out, a paralegal, and get the information and bring it back. But even doing that—and that is very inefficient—we still don't reach the number of people that we should or the number of people who we know are eligible for the service and who need the service.

The most rural areas are in Cumberland County and Salem County and those counties are furthest away from the center. The center is at Camden and those are the areas which are being served the least by the center simply because of location.

Senator WILLIAMS. Yes.

Reverend Wilson.

Reverend WILSON. I think this is our main interest in the advisory committee and why it is important to cooperate with the RSVP. The idea would be that we would have a volunteer in every club who would represent us and be the outreach person to bring in the people, tell the news that there is help for them. This is what we are working for.

Senator WILLIAMS. Excellent. I wish I had had this hearing a few weeks ago. I have been in all these counties a great deal recently. I would like to be an advocate for the advocate center. I will be hereafter, because your service is so needed and being done so sensitively and so remarkably.

You spoke of the rural slums—meaning, of course, really the rural people living in great poverty. Have problems reached you from these areas? What is the nature of the problems?

Ms. HILL. A number of those problems are in Salem County and Cumberland County. I guess the greatest problems we see are in terms of housing.

We had one elderly woman come in. She was 67 years old. She lived in a house that didn't have plumbing and she didn't have toilet facilities in the house. She was having problems with the heat in the house. I think she had a spaceheater in the house. I guess that was the most extreme problem that I saw that came from the rural area, and she contacted us. She had initially contacted the Office on Aging and they referred her to the center and we in turn went to her. We were able to help her. Fortunately, we got her out of the house. We got her into low-income senior housing and I believe at some time the matching was instituted against the landlord also, although I cannot recall now how it terminated.

Cumberland County has a large number of elderly farmers. We see a large number of those problems also. Then, too, we have a large number of requests from seniors for wills, a large number of social security and SSI problems. A large number of the elderly say they cannot get through the application process for SSI or they don't understand, as you had mentioned earlier, when one program is increased or knocked off another program. Last year a number of them were lost in medicaid coverage. We were able to help a large number of those persons.

ATTORNEYS UNFAMILIAR WITH PROBLEMS

The average attorney knows very little about the problems of senior citizens. They have no idea what SSI means, so the attorneys and staff of the center are very effective in dealing with those types of problems simply because these attorneys have developed quite a bit of expertise in dealing with problems of older Americans.

Reverend WILSON. Senator, one thing I would like to have on the record is the interlock we have with the county directors of the offices on aging and the directors of the RSVP programs. The directors often attend our executive committee meetings and help us in the planning of our program. They also help us select the county representatives on our executive committee. They are the top leaders of the senior citizen club programs on aging.

Ms. HILL. I just would like to say one other thing. I have been talking a lot about individual clients. I would like to say also that the center is involved in a large number of law reform cases. We tried to help seniors individually as well as to alleviate the plight of senior citizens as a group and we do this through instituting major actions. We are involved with efforts to reduce utility costs for seniors, we are involved in the food stamp program, we have been involved with trying to obtain model leases. We are involved with rent control statutes. We tried to get those types of things for seniors.

Transportation is a major problem of the seniors. We find out what these problems are from questionnaires that we submit from time to time. When we see that a number of seniors are encountering a problem over and over, we try to institute major actions that will alleviate these problems of senior citizens, and this is one thing we have been doing throughout South Jersey.

Senator WILLIAMS. Where do you send these questionnaires?

Ms. HILL. In local newspapers, and so forth. They were published and then we sent them out in the mail to senior citizens groups and so forth. We wanted to find out from the seniors what they wanted from the center, what they expected from us and what they perceived to be the major problems. From these questionnaires we institute suits.

Senator WILLIAMS. Mrs. Ashton, we have not been questioning you enough. You described your housing situation. Your home is a large home in Camden?

Mrs. ASHTON. In Gloucester.

Senator WILLIAMS. And this has been your home for a long time?

Mrs. ASHTON. Well, since 1916 we have lived there. It was my mother's homestead and when she died she left it to me as long as I lived. It is my home but it is entirely too big for me to take care of. It has 19 rooms in it and I cannot afford to keep it up. I go across the street and stay with an elderly lady. She is 97 years old and I stay with her in order to have heat. I feel like a companion to her because she has nobody else.

Senator WILLIAMS. Has this large home of yours been put on the market to sell?

Mrs. ASHTON. No.

Senator WILLIAMS. Do you own it yourself?

Mrs. ASHTON. Well, it is an estate between three of us, a sister and a brother. In other words, whichever one dies, the other one gets it.

Senator WILLIAMS. I see. Have you had any legal problems with the center that arose out of your residence situation?

Mrs. ASHTON. No, none whatsoever.

Senator WILLIAMS. This is in Gloucester City?

Mrs. ASHTON. Gloucester City, N.J.

CENTER AIDED BY TITLE III MONEYS

Senator WILLIAMS. This has been very, very helpful. As I see the picture, title III money from the national program goes to the States, from the States to the county offices on aging, and all five counties have contributed part of their money under title III to the center.

Reverend WILSON. Yes.

Ms. HILL. Yes. It goes to the corporation, that is true, and then it is used for the maintenance of the center.

Senator WILLIAMS. First, it goes really into the hands of the Legal Services Corporation?

Reverend WILSON. Yes.

Ms. HILL. Yes.

Senator WILLIAMS. And then they distribute the money to you?

Ms. HILL. Yes.

Reverend WILSON. Yes.

Senator WILLIAMS. There is another route of money. The taxpayers money that comes out of Federal programs does reach your communities, and this is being renewed now. That is the revenue sharing money. I know that some of the counties in your area have been very responsive, using revenue sharing money in service to older people in Gloucester, for example.

Gloucester County has an excellent transportation program paid for in part by revenue sharing money. Are you familiar with that?

Ms. HILL. Yes, I am. I know some of those moneys with revenue sharing were specifically earmarked for and were used for seniors basically on transportation problems. I think dollarwise that is where a senior needs a ride to a doctor or a hospital and he calls up and the bus comes and gets the person at a prearranged time, picks him up and takes him back home. That does exist in Gloucester. There was a similar program but it does not exist any longer. There is no such program in Salem County nor in Camden County.

Senator WILLIAMS. Reverend Wilson.

FUNDING POSSIBILITY FROM REVENUE SHARING

Reverend WILSON. One source of funding legal services is title XX moneys at the State level. However, since this is the prime source of funding for our parent organization, namely, the Camden Regional Legal Services, we do not compete for these funds. Now that we have better public relations with the county offices, I think we may have a better chance of approaching the freeholders and investigating the possibilities of funding from the revenue sharing moneys. We are making a little progress.

Senator WILLIAMS. Excellent. Well, it has been very exciting, very revealing, and certainly I applaud all you are doing.

Where did you graduate, Ms. Hill, from law school? Wherever it was, I bet you were the top of the class.

Ms. HILL. Oh, I don't know. That depends on how you define the top.

Reverend WILSON. She made a record at the college and we hired her. She will be a tremendous person to develop a community development program out at the college.

Ms. HILL. Thank you.

Senator WILLIAMS. I believe it. She has shown that. Thank you very, very much.

Now we are going to combine the panels here. Margaret Stone Brodsky, project director, legal counsel for the elderly, American Association of Retired Persons; Eric S. Sirulnik, associate professor of law; codirector, Institute of Law and Aging; director, Community Legal Clinic, National Law Center, George Washington University; and William Fry, director, National Paralegal Institute.

Will those persons named come forward.

That one light means a vote in the Senate. So maybe I will go over and take care of that. If you could relax for a few minutes rather than starting and interrupting, we can proceed shortly. I will vote and return.

[Whereupon, a short recess was taken.]

AFTER RECESS

Senator WILLIAMS. We shall reconvene and come to order again.

STATEMENT OF MARGARET STONE BRODSKY, PROJECT DIRECTOR, LEGAL COUNSEL FOR THE ELDERLY, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C.

Ms. BRODSKY. Thank you. My name is Margaret S. Brodsky. I am project director of Legal Counsel for the Elderly, a model project located here in Washington, D.C., providing legal services to the elderly.

The project is funded by the Administration on Aging of HEW through a grant to the National Retired Teachers Association/American Association of Retired Persons. I appreciate this opportunity to testify before you on the need for improved legal services for the elderly.

You have already heard testimony from another representative of the NRTA/AARP, Dr. James Peace, at your hearings in Boston on August 30. Dr. Peace's testimony addressed generally the special needs of the elderly and the efforts to meet these needs which have been made to date by the Administration on Aging and through other channels. My testimony today will concentrate on what has been learned about providing legal services to the elderly by the first year of operation of Legal Counsel for the Elderly and on what we feel can be done in the future to encourage expanded legal services for the elderly and—perhaps more importantly—to encourage the elderly to utilize the legal services which are available to them.

Legal Counsel for the Elderly was established in June 1975. The purpose of the project was to test the hypothesis that retired persons would be willing to volunteer their time and could be trained by full-time staff lawyers to act as paralegals in an operating law office serving the elderly.

The staff spent the first months of the grant year laying the groundwork for screening potential volunteers from the Washington area, preparing the forms and substantive materials the volunteers would use in their work and training the first group of volunteers. Twenty-five volunteers were chosen from over 70 applicants. Each volunteer agreed to work 1 day a week and to participate in a 3-day training program.

Public Benefit "Checkup"

The office opened to clients in December 1975. During its first 8 months of operation the model office, staffed by 2 full-time attorneys and 25 part-time volunteers, has offered 3 services: (1) A public benefit "checkup" for each new client to determine if the client is currently receiving all benefits to which he is entitled; (2) legal representation for clients whose problem involves entitlement to a public benefit such as title II social security, supplemental security income, medicare or medicaid; and (3) an information and referral service for all callers whose problem cannot be handled directly by the model office.

The model office has been able to take on at least 60 new clients each month and to provide information and referral services to an additional 100 persons each month. A good deal of the work of the office, at all levels, is done by the retired volunteers, working under the supervision of staff attorneys. The volunteers conduct client interviews—which include giving the new client a benefit "checkup"—negotiate with government agencies on behalf of clients, draft correspondence and help prepare for hearings. The volunteers have performed so well in handling public benefit problems that, starting this month, the pilot office has begun handling cases in a second major area of importance to the elderly. The service of the office has now been expanded to include assistance with wills and with protective arrangements such as powers of attorney and conservatorships.

In our first months of operation the project staff has learned that the benefits of using senior volunteers—aside from the obvious one that their services are free—are manifold. Retired people bring to a job a range and depth of experience from their own worklife which makes them exceptionally competent. The volunteers are both dependable and enthusiastic about their work. Perhaps the greatest advantage of using senior volunteers, though, is that older clients are more willing to use, and more pleased with, a service which is offered by their peers.

NRTA/AARP believes that Legal Counsel for the Elderly serves as a good example of how the quality and quantity of legal assistance to the elderly can be enhanced, without large additional expenditures, through the use of a slightly imaginative approach. Volunteer retirees, in addition to increasing the capability of paid professional

staff by at least 50 percent, make it possible to give each client a kind and degree of personal attention which would not otherwise be possible.

The associations are pleased that the project will be able to continue for another year under a combination of renewed funding from the Administration on Aging and a grant from the District of Columbia Office on Aging. In the coming year the project will continue to run the District of Columbia pilot office and, in addition, will be helping to set up similar offices using senior volunteers in other jurisdictions.

"Volunteer Retirees as Paralegals"

Use of volunteer retirees as paralegals is obviously only one of a myriad of good ideas which can help in the eventual development of comprehensive legal services for older Americans. Many of these ideas have been presented to this committee during these hearings, and I have included some additional suggestions later in my statement. For the moment though, I would like to concentrate not on ways of fostering better service but rather on important threshold barriers in the profession of legal services to the elderly. The problem is that the elderly, ignorant both of their legal rights and of the counsel available to them to enforce their rights, do not fully utilize the legal services which are available to them.

To a large extent it is the very nature of the predominant legal problems of the elderly which breeds their ignorance of their rights. Generally, over half the legal problems of an elderly client group concern entitlements to various public benefits. The elderly person whose benefits have been denied or terminated by a government agency probably does not regard that agency as an adversary which can be challenged. Rather, the agency is perceived as infallible, or at least all powerful, with the absolute right to grant and deny benefits. Of course, this is an untrue perception but a strongly felt one nevertheless.

Older persons' ignorance about the legal services available to them is less explicable than their ignorance of their rights, but equally evident, as the recent experience of Legal Counsel for the Elderly attests. In May of this year, a small article about Legal Counsel's pilot office in the District of Columbia appeared in one of the NRTA/AARP's membership publications. This article elicited some 1,200 letters in a 3-month period from older persons in all parts of the country who had legal problems and did not know where to turn.

Obviously, the answer to the problem is to provide the elderly with information about their rights and about the help available to them in enforcing those rights. Specifically, to suggest some possible solutions, it would be helpful if Legal Services Corporation grantee projects were to provide senior citizen groups with speakers on topics of special interest to them, such as social security rights; if every agency administering a benefit program—and perhaps every pension fund administrator as well—were required to enclose a list of available legal services with every notice of adverse action; and if bar associations were encouraged to compile listings giving the specialties and qualifications of attorneys within their jurisdiction.

The need for education, however, is only a threshold problem. The fact remains that there must be increased and improved legal representation for the elderly to meet even current demand.

Policy Proposals Considered

Many innovative approaches to the problem of providing improved legal representation for the elderly are currently being tested; and I am certain that many other ideas have been and will be presented to this committee during these hearings. To all these I add the following suggestions. Although the NRTA/AARP has not taken a policy position on any of these proposals, we believe they are worthy of your consideration:

(1) That the Legal Services Corporation be directed to develop substantive and training materials dealing with areas of particular concern to the elderly. These materials would serve as an encouragement to legal services staff—both attorneys and paralegals—to handle client problems in these areas.

(2) That capacity to increase legal services to the elderly in the public sector be increased by requiring a year of service to the elderly following graduation from law school as a condition for receiving a Federal loan for legal education.

(3) That consideration be given to providing a tax benefit to attorneys in the private sector who provide free or low-cost services to clients over a certain age and under a certain income level.

In conclusion, NRTA/AARP is gratified that this committee has directed its attention to this area of great concern for the elderly and hopeful that the work which has been begun in providing adequate legal assistance for the elderly will be continued and expanded.

I hope that my remarks today will be of help to you in your consideration of this important problem. Thank you.

Senator Williams. Thank you very much.

Let's continue with the panel members. In that way we question you all at once.

Mr. Sirulnik.

STATEMENT OF ERIC S. SIRULNIK, ASSOCIATE PROFESSOR OF LAW; CODIRECTOR, INSTITUTE OF LAW AND AGING; DIRECTOR, COMMUNITY LEGAL CLINIC, NATIONAL LAW CENTER, GEORGE WASHINGTON UNIVERSITY, WASHINGTON, D.C.

Mr. Sirulnik. Thank you.

Good morning. My name is Eric Sirulnik. I am the codirector of the Institute of Law and Aging at the National Law Center of George Washington University. I am also the director of the Community Legal Clinic which is the litigation component of the institute.

On my left is Ms. Robinwyn Lewis, one of the four supervising attorneys at the clinic and also its associate director. On her left is Attorney Raymond Natter, the director of the institute's research component. It is with great pleasure that we appear before you this morning.

I speak to you today as someone who has been heavily involved in clinical legal education for the past 8 years, 4½ of them as the director of my own program at George Washington University and before that as the assistant director of the Urban Law Institute, the forerunner to the Antioch School of Law.

It is no secret that there is a crisis in the delivery of legal services to the Nation's aged and aging poor. Problems such as agency advocacy, will writing, estate planning, and tax counseling are so time consuming that general legal services agencies such as our own neighborhood legal services programs (NLSP) in Washington, which are funded by the Legal Services Corporation and overwhelmed by their present caseloads have deemed this service a second priority. In fact, such services are often not available at all. Although there is some basis for these agencies setting legal priorities, that justification is less than persuasive to a 74-year-old widow whose social security check has stopped coming in.

Even when a general legal services agency does have the time and resources to represent the extremely large number of special cases generated by the process of growing old, it rarely, if ever, has the expertise to do it effectively and efficiently. Social security practice, for example, is a form of administrative advocacy which is *sui generis* and capable of frustrating even the most experienced legal practitioner who has not previously faced the problem.

Private Bar Reluctant

The private bar is likewise of little or no help in providing services to the elderly poor, and lawyers are seldom willing even to maintain minimal numbers of paying elderly clients because of the time demands required to deal with the total lifestyle problems of older Americans.

Further, and perhaps in conclusion, it is our observation that a large portion of the blame for this lack of legal services can be lodged squarely with the country's law schools. Not only are the law students who represent the future membership of our bar not given anything resembling the requisite preparation for adequately representing the elderly, they are given even less of an incentive to do so. Predictably, will writing and trusts and estates are offered universally, but ask a graduating law student a question about medicaid or supplemental security income and his or her response will likely be one of ignorance.

As for interest in representing the elderly, and especially the elderly poor, the problem comes full circle. Since there is little or no classroom material dealing with that area of elderly concerns, a future lawyer's likelihood of becoming interested in the field is less than encouraging.

For the past 4 years the Community Legal Clinic, and more recently the Institute on Law and Aging, have been intensely engaged in a relatively unique experience in clinical and legal education. That experience has been the representation and legal education of older Americans as part of the law school curriculum. To date, the positive results of our experiment have been quite substantial and even more promising. I wish to share those results with you this morning.

Beginning with the fall of 1975, through moneys made available by HEW's Administration on Aging and the District of Columbia Commission on Higher Education, the Institute on Law and Aging initiated a program composed of three separate but coordinated components: (1) A clinical legal education program in the field of law and aging aimed at traditional law students; (2) a paralegal training program in the field of law and aging directed at a group of 60 retired or semiretired persons; and (3) a research effort in the same field with the object of producing and distributing written materials for use in this and other law schools throughout the country.

The clinical program, known as the Community Legal Clinic, operates under the fundamental proposition that second- and third-year law students can gain invaluable practical legal experience while helping provide badly needed civil representation to substantial numbers of the area's aging who are otherwise incapable of retaining counsel. Last year, some 1,300 District of Columbia, Maryland, and Virginia residents were assisted by our law students in everything from estate planning to civil litigation in the city's landlord-tenant and small claims branches of the District of Columbia Superior Court.

In so doing, these students became skilled in such substantive areas of aging law as social security representation and medicare-medicaid procedures which would otherwise be unavailable in the law school curriculum. Perhaps more importantly they have also become exposed to, and sensitized by, the problems and needs of the elderly client.

Their training includes work with students and faculty from other disciplines related to serving the aging, such as the medical school and the departments of sociology and psychology. Over the past year, approximately 90 second- and third-year law students enrolled in this aspect of the institute's program.

Tapping the "Untapped Source"

Our paralegal training for seniors program is another partial solution to the gross inadequacy of legal services currently available to the Nation's aged and aging poor. By training older Americans who are retired or approaching retirement to become legal resources with specific skills in assisting the elderly, an intriguing and virtually untapped source of legal aid is being explored for the benefit of the aging community. The obvious understanding these paralegal students have for the problems of their fellow seniors is only one of several dividends their selection as future legal assistants has provided. The wealth of experience many of them have derived from years of government and industry service, and in fact from just plain living, makes them particularly effective as both advocates and counselors for other older Americans.

For last year's class of 20 such older paralegals and this year's class of 40, the program has been a significant contribution to ending the personal waste of retirement while providing badly needed legal services to the elderly.

It is our hope to interest government agencies as well as private law firms in the employment of these legal resources for the aging; for instance, their benefit to a local social security office in helping applicants proceed in the benefits process would be substantial.

We discovered in setting up our project that not only was there a paucity of clinical materials in the field of law and aging but that a similar shortage existed in traditional classroom materials. Under the direction of our research staff we have for the past 2 years been hard at work in the production of new and particularized materials for use in the classroom and the clinic. Seven completed volumes of substantive materials exploring the age-related issues of such traditionally taught law school courses as taxation and housing law as well as literally hundreds of pages of clinical forms related to representing the aging are now available for public use as a result of our efforts.

Finally, perhaps the aspect of the project with the most far-ranging potential is our design to make our own model, complete with textbooks, research materials, and clinical forms, and procedures, available to law schools throughout the country. Through a grant from the Administration on Aging we intend this year to experiment with such a program exportation at three yet to be selected law schools in representative areas of the Nation. By effecting the use of State and area agencies as the storefront office, as we use it, these programs can become an inexpensive and mutually beneficial working program for the chosen law schools and the States and local agencies.

Thank you.

[The prepared statement of Mr. Sirulnik follows:]

PREPARED STATEMENT OF ERIC S. SIRULNIK

THE INSTITUTE OF LAW AND AGING

I. THE PROBLEM

In the United States today, there are over 21 million people 65 and older, and an additional 19 million people between the ages of 55 and 64.[1] These individuals are faced with increasingly serious legal, socio-legal, and economic problems. For example, one-quarter of all elderly families have annual incomes of less than $3,000, and one-half of all elderly people living alone have annual incomes of less than $2,000.[2]

Thirty percent of all elderly are living in substandard housing,[3] and it is estimated that between 25 and 50 percent of all elderly individuals presently confined in institutions have no medical reason for being placed there.[4] Governmental assistance is extremely important for the elderly as a group, statistics indicating that almost 80 percent of all individuals aged 75 or older are relying on social security or supplemental security income for at least a portion of

[1] U.S. Bureau of the Census, *Statistical Abstract of the United States: 1975* (96th ed. 1975).

[2] Fry, "The Senior Citizen Paralegal: An Advocate for the Elderly Poor," Department of Health, Education, and Welfare, Administration on Aging. *Aging*, 10 (January–February 1974). Although the problem of poverty affects all categories of the aged, perhaps the most severely disadvantaged are the nonwhite elderly and elderly widows. See, e.g., hearings on "Future Directions in Social Security" before the Senate Special Committee on Aging, 94th Cong., 1st sess., pt. 10 (1975).

[3] Senate Special Committee on Aging, *Developments in Aging: 1970*, S. Rept. No. 92–46, 92nd Cong., 1st sess., 27 (1971).

[4] *Aging*, supra note 2. While thousands of elderly individuals are confined to institutions without proper cause, others face the situation in which they will need some form of institutional care and not be able to receive it, due to either lack of funds or the critical shortage of space available. See, Subcommittee on Long-Term Care, Senate Special Committee on Aging, 93rd Cong., 2d sess., *Introductory Report: Nursing Home Care in the United States: Failure in Public Policy* (committee print, 1974).

their monthly income.[5] Unfortunately, many Federal, State, and local programs make it almost impossible for most persons to understand let alone negotiate the bureaucratic procedures required to obtain benefits without the assistance of a trained professional.[6]

These statistics demonstrate the dramatic need of our Nation's elderly for competent and readily available legal assistance. The elderly need advocates for better housing conditions, for more stringent competency procedures, for fair and realistic welfare benefits, for protection of pension benefits, for representation before Federal and State agencies, and for assistance in disputes involving all forms of age discrimination and mandatory retirement practices. Yet, the sad truth is that our present legal community is unable to provide adequate legal assistance to the vast portion of elderly Americans who are unable to afford the fees of the private bar. In the field of social security, for example, the shortage of qualified attorneys is especially acute, and one prominent administrative law judge has stated:

". . . [I]t is paradoxical that in this area of administrative law [social security], where the claimant is most in need of an attorney's legal counsel and expertise, it is so noticeably lacking. To a great extent . . . the bar has shown indifference toward becoming involved in social security matters. I am also firmly convinced that attorneys' involvement would speed up the hearing process."[7]

Problems such as agency advocacy, will writing, estate planning, and tax counseling are so time-consuming that general legal services agencies such as neighborhood legal services programs (NLSP) which are funded by the Legal Services Corporation and overwhelmed by their present caseloads, have deemed this service a secondary priority; and in fact such services are not provided. Although there is some basis for these agencies setting legal priorities, their justification is less than persuasive to a 74-year-old widow whose social security check has stopped coming.

Even when a general legal services agency does have the time and resources to represent the extremely large number of special cases generated by the process of growing old, it rarely, if ever, has the expertise to do it effectively and efficiently. Social security practice, for example, is a form of administrative advocacy which is *sui generis* and capable of frustrating even the most experienced legal practitioner who has not previously faced the problem.

The private bar is likewise of little or no help in providing services to the elderly poor, and lawyers are seldom willing even to maintain minimal paying elderly clients because of the time demands required to deal with the total life style problems of older Americans.

Further, it is our observation that a large portion of the blame for this lack of legal services can be lodged squarely with the country's law schools. Not only are the law students who represent the future membership of our bar not given anything resembling the requisite preparation for adequately representing the elderly, they are given even less of an incentive to do so. Predictably, will writing and trusts and estates are offered universally, but ask a graduating law student a question about medicaid or supplemental security income and his or her response will likely to be one of ignorance.

As for interest in representing the elderly, and especially the elderly poor, the problem comes full circle. Since there is little or no classroom material dealing with the area of elderly concerns, a future lawyer's likelihood of becoming interested in the field is less than encouraging.

II. SOLUTIONS PROPOSED BY THE INSTITUTE OF LAW AND AGING

The Institute of Law and Aging has developed a unique and innovative program designed to meet this challenge. This prototype utilizes the resources of a major law school—the National Law Center of the George Washington University—and the skills provided by a small staff of professionals trained

[5] K. Davis, "The Paradox of Poverty in America," 56 (1969).

[6] E.g., disputes, frequently arise as the more than 150,000 requests for administrative hearings received by the Social Security Administration in 1975 indicate. Hearings before the Subcommittee on Social Security of the House Committee on Ways and Means, 94th Cong., 1st sess., 29 (1975).

[7] Hanrahan, "Social Security—Another Area for Specialization," 49 Fla. B.J. 294, 297 (197).

in the problems of the elderly, to provide training for lawyers, law students and paralegals in the area of "elderly law," while at the same time providing immediate and direct legal assistance to the elderly community. The program is composed of four interrelated components: (1) Training for senior citizen paraprofessionals or paralegals in the legal problems of the elderly; (2) training of law students in the area of elderly law; (3) development of materials that can be used by both the senior citizen trainees and law students; and (4) exportation of the program to other universities throughout the country. Each of these four phases of the institute relies heavily on outside assistance as well as support of the law school community, and each phase complements the other to form a cohesive and cost-efficient operation.

A. Paraprofessional Training

At the core of the Institute of Law and Aging's structure is the paralegal training for seniors' program (PTS). The goal of this program is to train older persons in the skills necessary to offer competent paralegal and social service assistance to other senior citizens. The effectiveness of using paraprofessionals in this capacity is very promising. For example, statistics from the Social Security Administration indicate that claimants who appear *pro se* at social security administrative hearings are successful approximately 38 percent of the time. However, claimants who have been represented by a nonattorney, such as paralegal or lay advocate, have won 48.5 percent of their cases.[8] The obvious conclusion is that paraprofessional assistance, especially at administrative hearings, is an effective tool for assisting the older social security claimant.[9]

The PTS program itself consists of two components—traditional classroom instruction and clinical experience. The first part of the program, the classroom instruction, began in the Fall of 1975 with an initial class of 20 paralegal students aged 55 or older. Selection of these students was based on their prior education, work experience, communications skills, community involvement, motivation, and, most important, their desire to work with and for the elderly. The student body was composed of individuals from every part of the city and surrounding suburbs and represented varying income levels from the elderly poor to the upper middle class, and equally heterogeneous educational backgrounds.

Instructors for the program were recruited from the faculty of the law school, the graduate law department (LLM candidates), and from the professional staff of the institute. Various speakers were invited to address the class from one of the governmental agencies being studied by the class at that time.

Classroom instruction began with an introduction to the art of interviewing the older client including the psychological and emotional problems the interviewer might encounter. This was followed by substantive course work in the areas of landlord and tenant law, social security, supplemental security income, medicare, medicaid, consumer law, probate and will writing, and legal research.[10] All para-legals were required to pass written examinations in these subjects before being permitted to participate in the clinical phase of the program.

The clinical portion of the PTS program began by placing the paralegal students under the direct supervision of attorneys and advanced law students. The paralegal students were then assigned to clinical sites located throughout the community. The primary clinical placement was at our storefront office, located in the Adams-Morgan section of Washington, D.C., and known to the community as "Operation PEP," protection for elderly people. Other clinical placements included seven National Capital Housing (public housing) projects designed for elderly tenants, a nutrition site for the elderly located in southeast Washington, and the George Washington University Legal Aid Bureau. One paralegal, with a particular interest in legislation pertaining to the elderly, was assigned a clinical placement at the National Council of Senior Citizens' research arm—Legal Research and Services for the Elderly.

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[8] Collins, "Supplemental Security Income: An Advocate's Handbook," 161 (1975). Claimants represented by attorneys are successful 54 percent of the time, *id.*

[9] An important dividend of such assistance is the reduction of costs of administering the social security appeals process. The improperly executed application, the ill-prepared hearing exhibition on the self constructed appeal, all take their toll on the Social Security Administration's ability to discharge its statutory role at a reasonable cost to the taxpayer (institute staff).

[10] See p. 229 for the complete curriculum.

At these clinical placements, the paralegal students received "on-the-job" type training, while at the same time providing, under the supervision of attorneys, direct assistance to the elderly community. The students gained practical experience in such procedures as initial intake, legal interviewing, legal research and writing, and advocacy at the administrative level. Paralegals were also given the opportunity to assist in the preparation of cases going to trial in various branches of the D.C. Superior Court.[11]

In February of 1976, every paralegal student participated in a special day-long seminar conducted by the Internal Revenue Service arranged by our project and held at the university. Following this seminar, which stressed the problems of the low-income and elderly taxpayer, law and paralegal students began providing free income tax assistance to those requesting such aid at our various service sites. This program is especially significant in light of the fact that many elderly individuals pay more taxes than they owe because of their failure to take advantage of many of the special tax benefits that are available to them.[12]

B. Training of Law Students

Equally important in our program is the training of future attorneys to be qualified and competent to deal with the legal problems of the elderly. Recognizing this fact, the Institute of Law and Aging is integrating the legal problems of the elderly into the regular curriculum. All of the clinical sites used in the training of senior citizen paralegals are used for clinical placement of law students. By the end of the academic year 1975–76, over 90 second- and third-year law students had participated in these clinics, including 10 students who were authorized to represent clients before the courts under the local student practice rules. To satisfy course requirements, law students were required to participate in these clinics, learning first-hand about the problems of the elderly, as coworkers with senior citizen paralegals placed at the same clinic. In this manner, law students gained valuable experience working with older people as both clients and as peers. Further, law students and paralegals in the clinic were required to attend a weekly seminar devoted to a lecture or discussion of some particular aspect of law and aging.

Law students also gained knowledge of the technical aspects of "elderly law" by participating in the research and development of the materials prepared by the Institute. These students were assigned various research topics in an area of the law in which they expressed an interest, and asked to prepare memoranda on these subjects. Memoranda which were of acceptable quality were then incorporated into the materials used in the training of the paralegals and law students.

C. Materials Development

The success of every training program is dependent upon the quality of the training materials used in that program. Because PTS is a completely unique program, no existing materials would have completely served our needs. Therefore, prior to the beginning of the PTS program, the institute began to develop its own materials, especially suited for the older paralegal student and law student. The result of this effort has been the creation of a textbook length training manual, entitled "Paralegal Training Materials on the Legal Problems of the Elderly." This book introduces the lay student to the concept of paralegal advocacy for the elderly, legal ethics, the unauthorized practice of law, and the psychology of aging. This is followed by an in-depth discussion of the art of legal research. Special emphasis is placed on the function of the paralegal in administrative proceedings, especially those involving social security, medicare, and supplemental security income.

The project also developed a "Law School Supplementary Materials Series" to be used in traditional law school classes supplementing administrative, welfare, tax, probate, consumer, and property law courses for the purpose of studying the legal problems of the elderly in each of these fields.

The institute is investigating the most cost-effective method of distributing these materials.

[11] NOTE: The paralegals are not themselves permitted to represent clients in these courts.

[12] See hearings before the Senate Special Committee on Aging on "Income Tax Overpayments by the Elderly," 91st Cong., 2d sess. (1970).

D. Expanding the Program

Our strategy for exporting this program throughout the country is three-part: (1) Teaching material development; (2) interfacing paralegal and law student education; and (3) clinical training through offering free legal services to the elderly.

Our teaching materials have been and are being developed to fit into traditional law school courses, because our strategy is to supplement existing courses rather than develop an entirely new curriculum. We are recommending specialized paralegal training for seniors to complement law student training for a number of reasons. First, older Americans need advocates to perform quasi-legal functions. Second, the law student can contribute knowledge about traditional legal approaches while the senior contributes specialized expertise about the problems encountered. Third, paralegal training is self-supporting because it is job-oriented and directed and can be tuition based. Fourth, specialized senior paralegals add the dimension of concern, sensitivity and appreciation for and about the legal problems of the elderly so lacking in legal education at present.

Finally, our program is based on the joint objectives of providing both short- and long-range solutions for the dearth of legal services available to older Americans. Our export program anticipates utilizing the over 300 State and local Administration on Aging offices already providing social services to the elderly. This resource provides a built-in office with clientele that is available for law schools needing clinics that can reach the elderly population.

This export prototype will enable law schools to pick up the educational model under existing classroom and clinical programs. It will also multiply legal services available to the elderly poor as adopted.

III. SERVICE TO THE ELDERLY

An immediate concern to the institute is the need for direct legal, social, and medical services to be provided to the elderly community. Recognizing that many of the problems faced by the elderly are not purely legal, but a combination of legal and emotional, the institute decided to use a multidisciplinary approach at its primary community center—the Operation PEP storefront. Arrangements were therefore made to place graduate counseling students at the PEP center to work with those elderly individuals who had either emotional difficulties or a combination of legal and emotional problems. These students worked under the supervision of a professional mental health counselor on the staff of the storefront office. This operation proved to be especially effective in the situation where an individual's legal problems were causing additional emotional problems such as depression or anxiety. An individual in this position would then be able to receive both legal and supportive emotional assistance in one coordinated approach. The following case history is illustrative:

Mrs. R., an elderly black widow, first contacted our PEP office in an obvious state of emotional distress. After an initial interview, she was invited to speak with one of the mental health counselors on duty at the center. The counselor soon learned that Mrs. R.'s emotional difficulties had been precipitated by the decision of the Department of Human Resources to terminate her eligibility for medicaid due to over-income status. The counselor made arrangements for Mrs. R. to meet with a law student working at the PEP office, who would be assigned as an advocate in her medicaid termination. The law student immediately requested Mrs. R. be given a full and fair hearing on the question of her continued eligibility for the medicaid program, and began to prepare for that hearing. During the weeks that followed, both the law student and the mental health counselor kept in close contact with Mrs. R.; the law student, in order to gain more information needed for the hearing, and the counselor, in order to prepare Mrs. R. for the possibility of losing her medicaid benefits. As the date of the hearing approached, alternatives to medicaid were discussed, as well as ways in which Mrs. R. could save money for medical expenses through simple changes in her budget. She was also given constant reassurance that she would be able to overcome the loss of the benefit, and learn to manage without it if necessary. By the date of the hearing, Mrs. R. was able to face this prospect with a minimum of anxiety and with a great deal of composure. The hearing was held, a decision was made in her favor, and the entire case was closed.

Arrangements are now being made with the George Washington University Medical School to institute a multidisciplinary, multifaceted service center, in conjunction with the school of medicine and health sciences gerontology program, where clients could be provided with interview, diagnostic and evaluative treatment for legal, mental and physical health, and other life style problems with a view toward immediate "treatment."

In addition to the legal and psychological services provided by the Operation PEP center, a wide range of other social services are available on an emergency basis. For example, emergency transportation, storage of household goods while locating housing, and assistance in finding housing are all provided or have been provided by the office whenever possible.

During the period from September 1975 through September 1976, the PEP center handled over 1,021 cases, for an average of 85 cases per month. Cases from all clinical locations, including the National Capital Housing sites as well as the PEP office totalled over 1,380 for the one year period. The highest percentage of cases requiring legal or paralegal assistance were in the areas of social security, medicare, medicaid, supplemental security income, wills and probate, and income taxes. Other legal problems that were presented frequently included consumer problems, Veteran's benefits, and landlord and tenant cases. But, whether the problem presented was designated legal or "nonlegal" (emotional and psychological), service to the elderly client was made available by a university based team of faculty, practicing professionals, paraprofessionals, and law students who had one thing in common—a desire to translate concern into service and learning.

Curriculum, Paralegal Training for Seniors, 1975–76

1. THE ROLE OF THE PARALEGAL (4 WEEKS)

This first segment contains an introduction into the function and role of the paralegal assistant in helping to solve the problems of the elderly. Special emphasis is placed on counseling techniques with the older client, psychological and emotional problems of the elderly, legal interviewing, and the prohibition against the unauthorized practice of law.

2. LEGAL RESEARCH AND WRITING (4 WEEKS)

Paralegal students are taught the fundamentals of legal research and writing including the National Reporter System, statutes and codes, legislative histories, Federal regulations, and the use of citators.

3. ADMINISTRATIVE LAW AND THE ELDERLY (10 WEEKS)

Paralegal advocacy before Federal and local administrative agencies is examined in detail. Topics covered include social security retirement, survivors' and disability benefits, medicare, medicaid, food stamps, and supplemental security income. The effect of the Administrative Procedure Act upon agency adjudications is stressed.

4. PRIVATE LAW (8 WEEKS)

The role of the paralegal as an adjunct to the licensed attorney is examined. Class work covers the areas of landlord and tenant law, rent control, the problems of condominium conversion of rental units, public housing, nursing home law, the problems of the elderly consumer, and will writing and probate law.

5. TAX (2 WEEKS)

Paralegals are taught the correct preparation of Federal and local income tax forms with emphasis placed on those provisions which are designed to aid the elderly taxpayer. Also discussed are property tax rules designed to benefit the older landowner.

6. CLINICAL PLACEMENT (8 WEEKS)

Practical experience is gained through placement at one of the seven clinical sites operated by or associated with the training program. This experience includes intake, legal interviewing, representation before administrative agencies and assisting law students with court cases. All clinical work is supervised by licensed attorneys.

Senator WILLIAMS. Thank you very much. Mr. Fry.

STATEMENT OF WILLIAM FRY, DIRECTOR, NATIONAL PARALEGAL INSTITUTE, WASHINGTON, D.C.

Mr. FRY. My name is William Fry. I am the executive director of the National Paralegal Institute. I thank you very much for the opportunity to speak here this morning.

I have submitted written testimony [1] which I am not going to read from or necessarily follow. I would like to summarize some of the main points in that testimony and raise some concerns about development of the new legal services program for older Americans.

I think this is a crucial time in the development of this national program. The program has now been running effectively for about a year and has gotten off the ground like a rocket. The need was so enormous and the interest so great that down at the State and area agency levels there is a great deal of activity and things are moving very quickly. I think within the next year the program will have developed a clear profile, so the questions that I would like to raise today are what that profile should look like.

First, let me say, what the National Paralegal Institute is. We have been in existence about 4 years. We focus on the promotion of the paralegal concept. We have a national scope and jurisdiction. We have been funded by OEO and the Legal Services Corporation and are now funded by HEW. Our focus is on promoting the utilization of nonlawyers in delivering legal services.

A great deal of our emphasis is on the preparation and delivery of training because training is what makes a paralegal. In addition, we spend a lot of time talking to agencies and legal services projects on how to recruit paralegals and how to train and utilize them.

"LACK OF CONCEPTUAL FRAMEWORK"

I have noticed that while the new legal services program for senior citizens has generated a great deal of interest and excitement there seems to be a lack of conceptual framework around which it can be built. I think that lack is causing trouble in the field, essentially because the personnel in the senior networks are not familiar with legal services. They know the need, they know about lawyers, and they know that there is a tremendous desire on the part of the senior community to have access to legal assistance, but they are not from the legal services network, they are from the senior network. As a result, they lack basic concepts in trying to design a new legal services delivery system.

Let me suggest an image which may explain our view of a legal services delivery system for older citizens. It consists of a pyramid. The apex of the pyramid represents law reform and test cases—the kinds of things that were mentioned by Mr. Sirulnik. It is the kind of thing that has gone on historically in the OEO legal services program through the national backup centers and through some of the active test case litigation of the OEO projects. It is lawyer work.

[1] See p. 234.

The second level of the pyramid is the kind of work that lawyers and legal services projects have traditionally done which we think of as crisis intervention. This involves situations in which people have reached a crisis in their affairs; they have been sued, they are being kicked out of their building, their welfare grants are being terminated; they are desperate. In a situation like that they think of getting an attorney.

It is situations like these which cause middle class and well-to-do citizens to pay substantial sums of money to attorneys. They are in real trouble. It is often what stimulates poor people to go to a legal services program. They wait until they are in real trouble.

The third layer of the pyramid we think of as work for nonlawyers and to us it represents the greatest need, the greatest number of problems. Many of these problems were described early this morning by the representatives from the Camden project. They talked about such things as people coming into their office with a lease problem where there was not a need for an attorney. They talked about the application process for public benefits. We know that there are millions of citizens who need assistance in the public benefit area. The application process itself is moderately complicated, people often don't know how to fill out applications for public benefits. It takes a knowledgeable person to counsel an applicant on how to make themselves eligible for public benefits. It takes a knowledgeable person to assert a disability claim. These are all things that nonlawyers can do.

We have received a grant from HEW to work on the delivery of services to this third layer of the pyramid. We have given a label to the person who functions in that category and it is not a paralegal.

The paralegal is a nonlawyer working with and under the supervision of an attorney. We call the third layer personnel community service advisors and we expect that these will be the information and referral people, the counselors, all the people that work out of the senior agencies who constantly run into low-level, law-related problems, who need training in handling these problems and who if trained can represent millions of citizens in this third layer of legal problems.

Problems in Program Evolution

Let me turn to a couple of the concerns that we have about the way the AOA national legal services program has been evolving. I should say that by emphasizing concerns I do not mean to suggest that I have any profound inhibitions about the program. It is an excellent program, it has been launched quickly and effectively, and it has a very important mission but in its evolution I think there are some problems emerging.

One of the problems that we see is that the third layer of our pyramid where we think the need is the greatest, the need below law reform and below crisis intervention, we are fearful that that third layer will not be supported, will not receive enough attention, will not be developed. It is going to require a great deal of training to give older people the knowledge and the skills needed to handle these third-level cases. I am not sure that the concept is sufficiently well understood and I am fearful that among other things senior administrators will believe that

legal services is synonymous with lawyer services because that is a traditional concept in this country.

In fact, the AOA and Legal Services Corporation programs have worked hard to establish the idea that poor people have a right to an attorney, which I believe is correct—but it is not the only thing that they have a right to. I think it would be too easy to automatically convert the senior citizen legal services campaign into a campaign to provide lawyers for older people. I think they need much more than that. I think they need trained nonlawyers to help them, and, indeed, I think that the number of their problems is so enormous that it is not conceivable that there will ever be enough lawyers to handle these problems.

The second concern we have is around training and the absence of training. The AAA structure under the Older Americans Act relies heavily on the processing of money through the States to the AAA. There are close to 500 AAA's in the country. It is a system to promote the grassroots participation and involvement of senior citizens. I think the problem is that some delivery services cannot run effectively at the AAA level.

When we travel around the country performing our mandate under our grant, we go into communities and we describe the paralegal concept and we urge them to develop their own training. Most people turn to us and say: "We would like you to do the training, we don't know how. We don't have the people, and we only have five paralegals in our community, and that is not enough to justify launching a whole training program."

So at the AAA level there is not enough money, not enough knowledge, and there is not a critical mass of people to be trained. You really can't expect an AAA to launch a whole training program to train 5 or 10 people. What is needed is some kind of national or regional training and I think it would be very important for the Congress to express that view to AOA. I think the concept of national and regional training is now viewed as a deviation from the Older Americans Act. I don't think the training of senior citizens as paralegals or CSA's is going to happen unless there is some national or regional training capacity.

Questions on Jurisdiction

The third concern which I will just touch on is unauthorized practice and I do it simply to remind you that what we are talking about in expanding legal services to older citizens is nonlawyers handling legal and law-related problems. I believe everyone, including Congress, will have to watch closely to see that the bar associations don't close down on all this. I don't want to go into detail at this time, but we are currently involved in three or four situations around the country in which bar associations are promulgating rules on unauthorized practice or ethical rules governing lawyer conduct which would preclude nonlawyers from doing many of the things that we are talking about paralegals and CSA's doing for senior citizens.

A number of State bars are moving in the direction of forbidding nonlawyers from doing administrative representation. If that were to

happen, it would mean that senior citizens would be deprived of the main resource that they have for help in social security, disability cases, food stamp cases, and supplemental security income cases. There are not enough lawyers to handle those matters.

Another concern that we have developed recently around the so-called sprinkle grants is the question of what the States should do under the recent directive from AOA to establish a statewide developer and coordinator of the legal services.

Senator WILLIAMS. What kind of grants did you say?

Mr. FRY. Well, they are referred to as sprinkle grants. This is a program recently launched by AOA in which each State is given a sum of money, most States approximately $20,000, with the directive that they should create State legal services developers, some of whom would promote, coordinate, and stimulate the development of legal services. The AOA directive was that that person should be a State employee unless there were exceptional reasons for his not being a State employee. A number of States are, as we understand it, planning to subcontract that function. It is a very important function, and a question that has been coming up frequently is whether or not it is a good and proper thing for the States to subcontract that money with another agency rather than to use it to employ someone on their State staff.

I would simply like to call attention to a couple of problems with this subcontracting process. One of them is that if these functions are to be subcontracted, I believe it is important that they go to an agency that has substantial roots in the senior community.

CONFLICT OF INTEREST SHUNNED

Second, I think there is a potential problem in the subcontracting of this function which is that the legal services developer in each State will have a great deal to say about what happens to funds within that State—title III and title IV funds—to develop legal services. I think it is important that the development function not be given to an agency that might have a conflict of interest over applying for those funds. If an agency has the developer function and also is applying for title III funds to operate a program, there is a potential conflict of interest.

The final point I would like to raise is the need for a new title in the Act for legal services. You may recall that the nutrition program started as a model project and grew into having its own title. I believe that that is the direction that legal services expansion should take and I can provide at least one reason. The national support projects funded by AOA to promote legal services are model projects now funded under section 308. As I understand it, there comes a time when a model project has to be terminated, when it has fulfilled its model project purpose. I further understand that there is, under the law, no simple way that these national backup and support programs can be continued indefinitely. I think they should be. It was the experience of the OEO legal services program in this network of national backup programs, and I think AOA will reach the same conclusion.

Senator WILLIAMS. There is new legislation now under study which would automatically terminate programs unless they are renewed.

Every idea, every program, and every effort has a sunset. Then it must justify itself to see a sunrise. You are familiar with the processes we are going through now to insure that, are you not, Mr. Fry? Are you familiar with the sunset legislation.

Mr. FRY. I am not.

Senator WILLIAMS. My friend, when this breaks, you will consider it a disaster that is about to descend upon this Nation, as some of us have. But we have adjusted to the idea that the Nation is in the mood to see all programs zero based within 5 years, and therefore they must rise again and be reborn so to speak.

Mr. FRY. I really don't have any great problem with that concept.

Senator WILLIAMS. I had a big problem, but I am getting adjusted to it and I am beginning to rather like it, as a matter of fact.

Mr. FRY. What I am really referring to is in the future when AOA may lack the legal capacity to continue national support projects even if the decision was made that they ought to be continued.

Thank you.

[The prepared statement of Mr. Fry follows:]

PREPARED STATEMENT OF WILLIAM R. FRY

I. INTRODUCTION

I am grateful for the opportunity to address the Special Committee on Aging at this important stage in the development of legal services for senior citizens. The Congress, through amendments to the Older Americans Act, and the Administration on Aging, through its grant decisions and policy statements, have launched a campaign to expand and improve the legal help available to older Americans. This new direction, if executed effectively, can attack many of the root causes of deprivation, injustice, and misery experienced by older Americans.

At this stage in the evolution of the program, many fundamental decisions are being made about the directions that the program will take, the choice of vehicles for delivery, and the relation of the new program to existing efforts in the field. In this presentation I would like to address some of the choices on structure and direction which are now being made or soon will be made by the Administration on Aging and the State commissions on aging. I will propose a point of view which will suggest a logical structure and manner of proceeding with the program.

To summarize some of the main points I will put before you: The new program should avoid departing from the philosophy of the Older Americans Act which emphasizes strengthening and coordination of existing services by State and area agencies on aging; the new program should utilize senior citizens in the planning and in the actual delivery of services, avoiding too much reliance on lawyers and lawyer-controlled programs; the particular role lawyers should play in the overall delivery system should be clearly defined; and the new program should develop a national training strategy which transcends reliance on State and area agencies to each develop their own training capacities.

II. THE PHILOSOPHY OF LEGAL SERVICES UNDER THE OLDER AMERICANS ACT

The major impetus for a national legal services effort for older Americans is frequently attributed to this committee. Until 1975, the Older Americans Act had no provision which required legal services as a priority under the broadly defined social services activities found in title III. This committee urged a willing Administration on Aging to launch a national effort to promote the extension of legal services to senior citizens. As a first step in this direction, AOA funded 11 model projects which were to provide technical assistance to State and area agencies on aging on identifying legal problems of the elderly, on designing strategies to meet these needs, and on developing a capacity to train those who would deliver the new services.

In 1975, the Older Americans Act was amended to emphasize new categories of social services. Legal assistance and legal counseling were specifically included under title III (section 302(1)(F)). In an effort to affect implementation of these amendments. AOA has now offered to provide each State with funds to employ a statewide legal services developer to promote and coordinate legal services.

It is important to emphasize that the new program direction outlined by AOA builds on and does not modify the underlying philosophy of the Older Americans Act. The act emphasizes the coordination of existing services; the strengthening of State agencies and area agencies on aging; the utilization of senior citizens in the delivery of services; the expansion of power, authority and control of senior citizen agencies over their own affairs; and the development of local multipurpose centers so that as many services as possible can be provided under one roof. I emphasize these underlying philosophies because, as will appear below, I fear that in too many cases new legal programs are being established in or through agencies and programs in which senior citizens are the least involved—and that this development is contrary to the philosophy of the Older Americans Act.

Before discussing the possible structures of delivery, it may be useful to summarize the kinds of legal problems which older citizens experience.

III. The Range of Legal and Law-Related Services Needed for Older Americans

During the last few years, there has been extensive analysis of the legal needs of older citizens. Much of this has been produced by the model project grantees of AOA whose function it was to explain to State commissions and AAA's what services ought to be provided. These services may be classified into seven categories:

1. ASSISTANCE IN OBTAINING PUBLIC BENEFITS

Millions of senior citizens are receiving or are eligible to receive the benefits of social security, supplemental security income, food stamps, veterans benefits, homemaker services, medicare and other public benefits. Despite extensive efforts to bring these programs to the attention of those who may utilize them, there are still many who are not aware of them. Moreover, the eligibility qualifications for these programs are in some cases quite complex. Assistance in filling out applications, understanding eligibility factors, and in taking steps to become eligible (such as disposing of certain assets) are matters on which skilled assistance is often required.

Those who are receiving public assistance are by no means beyond the need of help. Eligibility factors constantly change; Congress frequently amends the law or administrative changes are made. Thus, in any given year public benefit recipients may be subjected to reduction or termination of their benefits, often based on complex adjustments to the Federal statutory scheme (or on administrative error). For example, it has been estimated that during the coming year 800,000 recipients of SSI will be subjected to a reduction of their benefits because of alleged overpayments to them.

2. INCOME MAINTENANCE

Perhaps the biggest threat to older Americans, aside from severe illness, is the falling off of income which accompanies age. Thus the maintenance of the highest possible level of income for each individual is crucial. Public benefit programs may provide part of this need, but senior citizens need assistance in reviewing their entire financial status, including matters of insurance, pensions, tax, purchase of medicine and health benefits, transportation, mortgage financing, debt and credit, and other factors bearing on the maintenance of their income level. Access to such advice should be consolidated in one place so that an informed overview of the individual's income maintenance situation can be made.

3. PREVENTIVE LAW AND EDUCATION

All citizens suffer from lack of knowledge about the consequences of legal commitments they make or about the remedies available to them under the law.

This lack is particularly damaging for senior citizens who are functioning on fixed incomes where a bad financial bargain can mean the loss of essential resources. In the areas of consumer law, landlord tenant, real property, and debtor-creditor law, there is a need for both general education, and basic counseling prior to entering into bargains and legal commitments.

4. PROTECTIVE SERVICES

This subject encompasses the range of legal rights and remedies available to assist senior citizens in preserving their health, assets, independence, and well-being. It includes guardianship, commitment, third-party payees, powers of attorney, and health-homemaking services. There is an extensive need for counseling, assistance, and advocacy, on behalf of senior citizens in this area. In the absence of such assistance, millions of seniors may be stripped of their rights, their resources, and their liberty.

5. NURSING HOME ADVOCACY

While the subject of protective services deals with preventing commitment, this area focuses on those 1.2 million older citizens who are placed voluntarily or involuntarily in nursing homes. The Administration on Aging has recognized this area of need by funding State developmental programs to promote and develop ombudsman programs which will coordinate and provide advocacy, representation and law reform on behalf of residents of nursing homes.

6. CRISIS INTERVENTION

This is the area traditionally served by legal services programs and private attorneys. It cuts across many of the problem areas mentioned above, and involves intervention at a time when preventive law, education, counseling, assistance, and protective services programs have either failed or led to a confrontation. Traditionally, people seek assistance from attorneys when their affairs reached a crisis state, and litigation or representation by an attorney (or an attorney's assistant, the paralegal) is needed. It might be added that because of the structure of the legal services delivery system in the United States, and the limited resources available to the federally supported Legal Services Corporation program, the intervention of the lawyer or legal services project must, in the nature of things, be reserved for a crisis.

7. TEST CASES AND LAW REFORM

In addition to providing people with assistance to obtain their legal rights, benefits and remedies already available to them, there is a need for changes in the law through selective litigation calculated to correct injustice and promote more favorable legal interpretations.

IV. CONCEPTS FOR THE FUNDING AND DELIVERY OF LEGAL SERVICES

It seems clear that there will be insufficient funding under title III of the Older Americans Act to provide the foregoing broad range of services needed to meet the needs I have described. Competition for title III funding is severe and legal services is only one of many program priorities under the Older Americans Act.

Title IV training moneys can be used to supply an essential element to expanded delivery of legal services. The greatest potential for dramatic expansion of service is to draw upon the energies, common knowledge, and experiences of senior citizens themselves. The National Paralegal Institute and other entities with the support of the AoA have been experimenting with the training and utilization of senior citizens to deliver legal services. There are now tested training materials and techniques designed specifically for senior citizens which can be used to create an entirely new work force of advocates, counselors, and administrative representatives. The funding of training under title IV–A is essential to achieve this expansion.

Although moneys now being made available under the Older Americans Act are critical to the initiation of new programs, these moneys are minimal in relation to the needs in the field.

Effective implementation of the legal services mandate will require a merging of a variety of programs and resources.

Title XX of the Social Security Act establishes social services to prevent or remedy abuse, neglect, or exploitation of adults as well as children. Legal services have been established in several States as one of the major social services. In fact, title XX moneys have been used to create statewide legal services for older people in States such as Pennsylvania and West Virginia. The potential of using this program and funding resource to meet the legal needs of older Americans is clear.

The funding available from the Legal Services Corporation for its projects also can play an essential role in strengthening legal services for senior citizens. For many years, it has been recognized that while older Americans comprise approximately 20 percent of those in need of legal assistance, only 6 percent of the caseload of legal services projects has been older clients. Without changing their funding structure, Legal Services Corporation projects can be encouraged to provide more adequate representation of this class of clients. Moreover, as will be discussed in more detail below, Legal Services Corporation projects are frequently the best source for crisis intervention, test case and law reform activities. Thus they may supply a crucial element in the total picture of legal services delivery.

There are other sources of funding which can be tapped for expanding legal services for senior citizens. Programs enhanced by moneys from ACTION, the Comprehensive Employment Act and from other manpower programs such as the senior community services employment program will be described by others at these hearings.

Since none of these programs alone can provide the funding necessary to establish and maintain the comprehensive legal services network needed to meet the needs of older people, it is crucial that the promotion and eventual use of such funds is coordinated through the network established to serve people under the Older Americans Act.

The expansion of legal services is not to be achieved by the wholesale creation of the new delivery network, nor by creating or funding entities outside of the existing network of senior citizen programs. The thrust of the Older Americans Act is to strengthen state agencies and AAA's, so that they may effectively build and coordinate a coherent and interrelated delivery system of all services. An underlying theme of this strategy is that senior citizens must be given greater responsibility and authority in their own affairs. Thus, wherever possible delivery mechanisms ought to be directed and coordinated by senior agencies. Above all, the program should be designed so that senior citizens themselves are involved in the direction and control of the programs, as well as the direct delivery.

It follows from this that legal services needs cannot be met consistent with the Older Americans Act by turning over the responsibility to bar associations, law schools, private law firms, or Legal Services Corporation projects. Instead the special talents and skills of those groups are to be coordinated into the overall system, with direction and control being provided by a strengthened senior network.

Thus, through the creative combination of funding resources, and creation of new relations of cooperation with existing legal services delivery systems and the expansion of capacities of senior citizens and their agencies, a full range of legal services delivery may be achieved.

V. Suggested Framework for Legal Services Delivery System

The legal services delivery system needed for senior citizens can be viewed as a pyramid, with the width of any cross section representing the numbers of people needing direct assistance.

At the apex of the pyramid would be law reform, test case litigation and handling of complex legal matters including design and analysis of legislation. This is an area in which Legal Services Corporation projects have been most active through the aggressive litigation of individual projects, and the backup of national support centers. In addition, considerable work has been done through law schools and in cooperation with bar associations (particularly those with special committees or panels dealing with senior citizen matters).

A second level of the pyramid is crisis intervention and handling matters where a legal confrontation has occurred or is imminent. These are the kinds of

matters for which citizens seek out attorneys, and conversely, which attorneys are trained to handle. Within the Legal Services Corporation projects, attorneys with the support of paralegals provide this service as do some bar association referral programs, law school clinical programs, and specially funded senior citizen legal services projects. (For example, those located in Santa Cruz, Dallas, Tex., and St. Paul, Minn.).

The third level representing the widest need and, unfortunately, the least available service are those matters discussed earlier under the heading of public benefits, income maintenance, preventive law, education, protective services, and nursing home advocacy. For the top two layers of the pyramid, some available services exist, presenting problems of coordination and strengthening. This third level of need is one which has yet to be fully defined, although AOA has undertaken a number of important experiments to explore this area. It has funded the National Paralegal Institute to create training materials and give technical assistance in this area. Under a current grant, NPI is designing, and will test in three separate training programs around the country, the concept of the nonlawyer community service advisor. This person will generally be a senior citizen employed by a senior agency, and trained to give assistance to older Americans. Emphasis will be on public benefit eligibility assistance, income maintenance, preventive law, community education, and protective services. Related experiments have been conducted by the American Association of Retired Persons under an AOA grant in which a training program for volunteers has been designed; and in California where an intensive statewide training program was conducted by the western subsidiary of NPI. Under that California program, area agencies on aging and senior projects within the State were given technical assistance in designing a legal services delivery system, training materials were prepared, and during 1976, 60 paralegals and CSA's were trained. Another 60 will be trained in the next 12 months. Careful monitoring of the work of these trained senior citizens indicates that they have caused a dramatic and rapid expansion of available legal and law-related assistance, and have established an extraordinary record of success in gaining benefits and remedies for senior citizens.

The services that are needed under this third layer of the pyramid may be provided out of multipurpose centers, nutrition sites, senior citizen housing developments, health care centers, home care agencies, and other social services agencies. The expansion of this third level promises a massive involvement of senior citizens in the policymaking and actual delivery of services.

This concept of legal services needs suggests a framework which can be developed within each State. The "sprinkle grant" policy of AOA (which creates a legal services developer for each State) can provide the impetus for the creation of an efficient statewide network. The developer may find it useful to analyze needs in terms of the suggested three-level pyramid. At the first level some entity within the State should be focusing on selected test case and law reform activity, as well as legislative and regulatory agency monitoring. Whether this should be a legal services project, a bar association committee, or a law school based project will depend on which of those entities is available and able to undertake the function. In some States, it may be necessary to create a statewide unit to perform this function.

At the second level, the crisis intervention and more traditional legal representation, it will be possible in many areas to build upon existing legal services delivery systems. Legal Services Corporation projects are traditionally underfunded and stretched to the limits of their capacity. Moreover, Federal funding has been insufficient to provide total coverage, and vast geographic areas in the country have no effective legal services projects available. Accordingly, even where Legal Services Corporation projects can be involved, there may be a need for supplemental assistance. An alternative to utilizing Legal Services Corporation projects is to provide senior citizen programs with their own attorneys.

I believe that one of the most serious pitfalls facing the development of senior citizen legal services is the failure to stress the third level of need, and the error of believing that the provision of services at the second level is sufficient. Achievement of a full range of legal services for senior citizens may require coordination and utilization of existing systems for law reform and crisis intervention, but for broadening the base of delivery it will require expansion of current senior citizen agencies capacity by creating a new person, trained to supply the assistance which no other entity is now equipped to deliver.

VI. Potential Errors in Selecting the Wrong Structure for Legal Services Delivery

The concept of legal services delivery is generally new to the senior citizen network. AOA has funded NPI and several other national organizations to provide technical assistance to State commissions and AAA's on various aspects of legal services delivery. NPI concentrates on providing technical assistance regarding paralegal CSA's, and on designing training techniques and materials.

Knowledge and understanding of legal services needs and delivery systems has risen dramatically as a result of the AOA funded technical assistance. Nonetheless, within the senior citizen network (State commissions, AAA's, and service delivery projects) there is even now a lack of indepth knowledge on many aspects of legal services.

One of the most common problems we have encountered in providing technical assistance is the question of which entity within the legal system can best provide a particular service.

For example, there are lawyers, paralegals, CSA's, and program supervisors who need training. As potential trainers there are colleges, law schools, on-the-job trainers, national and local training specialists, continuing education programs, and schools of gerontology. Which of these is best suited to train lawyers? Paralegals? CSA's?

There is a need for service delivery in the form of information and referral; nursing home advocacy; public benefit applications; test cases and law reform; income maintenance; and crisis intervention. Potential delivery resources are law school clinics, private attorneys, bar associations, Legal Services Corporation projects, senior citizen projects, or newly created agencies. How is a State or AAA to make a wise decision as to which of these many choices is best?

We have seen choices made which we believe were not for the best. Are law schools the best place to train paralegals? Are bar associations the best source of counseling on public benefits? Subject to some exceptions, the answer is probably not. Errors in such matters are, however, understandable. Do not law schools teach law? Are not bar associations made up of lawyers who know "the law"? The problem is that the decisionmakers within the senior network sometimes need guidance in asking more pointed questions. For example, should paralegals receive the same training as law students? Does the average lawyer know social security law?

These choices of the proper vehicle are often difficult.

A question currently being faced by AOA and the State agencies is the extent to which Legal Services Corporation projects should be utilized as the statewide legal services developer. Despite the strong language of the AOA technical assistance memorandum which specifies that the developer should be employed as part of the State agency on aging staff (unless there is some clear barrier to such employment) it appears that a number of States will propose to subcontract the statewide legal services development function to a Legal Services Corporation project.

NPI has no specific policy or recommendations as regarding such a decision. In some States, Legal Services Corporation projects have been involved in senior citizen matters to such an extent that subcontracting the function to them can result in highly effective developmental work. It has been the position of NPI that we should assist a State in making a careful and informed decision on whether to subcontract the developmental function and if so to whom.

The developmental function is essentially one of coordination, stimulation, program development, instigation of training, and leadership. It is not viewed by AOA as expansion of service delivery. Accordingly, consistent with AOA policy it will be important for any subcontract of the developmental function not to result merely in expansion of one service delivery program. Moreover, because of the nature of the developmental role, it should be given to a person familiar with the senior citizen community, and its structure, functioning and politics. It must also, in the nature of things, be someone with a history of involvement in the senior community. While some Legal Services Corporation projects fit this description, many do not. We are concerned that some States will contract away the important function of the statewide legal services developer without getting more for it than a slight increase in the level of service being delivered to older citizens through Legal Services Corporation projects.

One problem looms as a potential conflict of interest for a subcontracting statewide legal services developer. The person or organization occupying that position will have considerable influence over the granting of funds under title III, and perhaps over title IV–A training money, title XX social services, and nursing home ombudsman funding. If the developer function is subcontracted to an operating program which is also applying for program operation funds, there may be an actual or apparent conflict of interest over where the programmatic funding should go. There may also be an irresistible impulse for any service delivery program to utilize the position of the developer as a way to obtain funding for itself.

Once they are installed, perhaps the most difficult question facing State legal services developers is the question of the appropriate role for Legal Services Corporation projects in the overall expansion of legal services to older people.

To understand the potential role of such projects, it is necessary to understand their history, and their place in the legal delivery system.

The legal services program initiated by OEO in 1965 was unquestionably the most effective of all the war on poverty programs. Its ambition was to provide to the poor a form and quality of legal services similar to that which could be purchased by the well-to-do. Despite earlier efforts to establish considerable community control over legal services programs, they have evolved as essentially lawyer controlled and dominated instruments.

Legal Services Corporation projects are run by attorneys whose background and predisposition is toward the more technical aspects of legal practice. Thus, they are particularly competent at crisis intervention, law reform, test cases, litigation in general and the handling of complex legal disputes. Many Legal Services Corporation projects now employ paralegals to work in support of attorneys and also to extend the projects' range of services, particularly in the administrative law area.

In many parts of the country, Legal Services Corporation projects represent an important potential for supplying part of the overall functions of the legal services delivery system for older citizens. One mission of the State legal services developer will be to help the Legal Services Corporation projects focus more of their attention, and a greater proportion of their resources upon serving older citizens. According to the statistics cited earlier these projects could triple the time and energy devoted to older citizens, without additional funding.

Legal Services Corporation projects share with other lawyer-dominated entities such as bar associations and law schools certain deficiencies which militate against their being the principal resource for senior citizen legal services. They are not usually an integral part of the senior community. They are neither controlled by the senior citizens, nor do they employ substantial numbers of them for delivery of services. Moreover, they are generally not in close working relations with other elements of the senior citizen network, and this lack of familiarity may make cooperation difficult.

Most Legal Services Corporation projects are not geared to handle the broad array of income maintenance, public benefit, preventive law, education, protective services, and nursing home matters which senior citizens need. This is partly a result of lawyer education and professional attitudes, which focus on handling crisis rather than what lawyers may view as less difficult and sophisticated legal problems. There is also an extraordinary pressure on legal services offices to handle crisis cases, and most Legal Services Corporation projects make the perfectly rational choice to handle only those matters which are *in extremis* or close to it.

Under what circumstances, then, would it be appropriate as a general rule to involve Legal Services Corporation projects in the expansion of legal services for senior citizens? As described above, one element of such expansion is the increase of access by senior citizens to the kind of legal services in which these projects specialize (essentially law reform, test cases, and crisis intervention). It seems entirely appropriate that the title III service funds could be utilized to strengthen the involvement of Legal Services Corporation projects in the senior citizen community, particularly in a coordinated relationship with other service delivery instruments. It will, of course, be a difficult judgment in individual cases to determine whether such additional title III funding is necessary or whether an expansion of service can be achieved through better coordination, and by educating older citizens as to the services which are already available.

In those States where a statewide law reform unit is indicated, it may be wise to turn to existing Legal Services Corporation projects which already have the general expertise and staff capability to engage in such activity.

As to the expansion of the area we have called the third level of the pyramid, for all the reasons mentioned earlier, the State developer should create a strategy for training older citizens, for the expansion of the current service capacity of existing senior citizen agencies, and for employing older citizens to deliver the service. It is the perception of the National Paralegal Institute that the strength and effectiveness of the national program to extend legal services to older people will depend upon the success of the creation of this third level of the pyramid.

To achieve this, the developer should look to the senior agencies themselves rather than to a mere expansion of lawyer-services through bar associations, law schools, or Legal Services Corporation projects.

Partly it is a matter of geographic coverage. Older people have special difficulty in getting themselves physically to a service office. There are numerically perhaps 10 to 20 times as many senior agencies in communities as there are Legal Services Corporation projects. (For example, there are about 30 LSC projects in California compared with well over 1,200 senior agencies.)

There is also the question of strengthening the senior network, a goal of the Older Americans Act. Such strengthening cannot occur unless senior agencies have a substantial role in the delivery of services.

Finally, there is the nature of the service, and the need for locating it in the most appropriate entity. The greatest numerical need for services is on the lowest level of the pyramid; the kinds the problems CSA's can handle, but the kind of problems LSC projects and lawyers generally are not geared to handle and probably cannot handle given the pressure of crisis cases.

This strengthening of senior agencies and creation of a third level delivery mechanism, through CSA's, requires training.

VIII. The Need for Training

In order for any expansion of legal services to older citizens to occur, training is necessary. Many of the legal issues affecting senior citizens, such as protective services, disability, and SSI are not generally known or taught in law schools. Thus, training will be needed for lawyers as well as for paralegals and community service advisors.

The most compelling need for training, however, is to bring into the delivery system nonlawyers in the form of paralegals and CSA's, who ought to be the principal resource for the expansion. These people need fundamental training not only in the substantive areas mentioned above, but in the skills and techniques of rendering assistance, including the fairly sophisticated art of administrative representation (which is permitted to nonlawyers under Federal regulation).

I should hasten to add that the Administration on Aging has already recognized the foregoing proposition. In three separate fundings it has mandated the National Paralegal Institute in Washington, D.C., to develop national training materials for paralegals and senior citizens legal problems, and to provide technical assistance around the country to help states train and utilize paralegals. A separate grant to the State of California has enabled the western division of NPI in San Francisco to provide technical assistance to deliver training designed specifically for California.

These training materials and techniques should now be made available throughout the country. AOA has funded some efforts in this direction but success in expanding training has not been impressive. In delivering its technical assistance NPI has been made aware of a fundamental defect in the approach to training currently taken by AOA. Consistent with the Older Americans Act, AOA has sought to develop training through the network of State and area agencies on aging. NPI, while authorized to design training materials, has not been funded to deliver training on a national or regional basis (except for three demonstration and testing training events under its CSA grant). AOA has hoped that, through technical assistance and other forms of guidance including the provision of prepackaged training material, training would emerge on a local level, but unfortunately this has not happened, for a number of reasons.

The resource AOA looked to for legal services training for paralegals and CSA's was to be the network of community colleges, universities, and law schools. To date, very few of these entities have undertaken to provide the

needed training. Except for some law schools, the other educational entities have no one on their staff with a good comprehension of the substantive law and skills for which training is needed. Most of these educational entities serve a specific geographic area. There have not been sufficient numbers of people in such areas to justify an educational institution creating a specific training program for that audience. Perhaps the greatest numbers of paralegals and CSA's can be found in California, where NPI's western office received several hundred applications for places in their training program. These applicants came from all over the State. In any particular California town where universities and community colleges serve the population, the likelihood of finding more than a half dozen candidates for such training is slim. Given such a limited audience for one-time training only, there is little motivation for a college to undertake to create and produce a training program. Finally, there is always the risk of duplication of effort and inordinate expense associated with splitting training up into small local elements. If every community college in the country were to undertake to deliver training to its local paralegals, the administrative expense would be enormous. Even if the colleges were all to adopt the materials developed by NPI without modification (an unlikely event) the expense of operating the separate programs would be extremely inefficient.

Thus, while the structure and control of senior citizen programs is, under the Older Americans Act, given to the grassroots level of the senior network, it does not follow that the delivery of training should not be on a national or regional level. In providing its technical assistance to States for setting up training programs, NPI is constantly asked to provide training to the States or AAA's, since they do not believe they have the capacity to generate such training within their own areas. There is no efficient way for NPI to respond to such requests. The only way that NPI or any other organization can provide effective training to all the States is through a coordinated national level effort. This would permit the scheduling of regular training programs, the creation of an ongoing training capacity and the most efficient delivery of training to all those desiring it. In the absence of such a national or regional training capacity (which could be on a statewide basis in the base of a few large States) the training of older citizens to deliver legal assistance is likely to be sporadic, or mixed quality, and inordinately expensive.

Senator WILLIAMS. Thank you very much, Mr. Fry.

We could be well served with a long discussion here. You are in the center of what impresses me as vital, essential social activity, albeit legal service. Now I wonder, just to get a broad picture here of the resources that make your activity possible—each institution that you are associated with has Federal funding and I just wanted to see if I could understand so that we could rationalize the sources of the funding. We started with Ms. Brodsky. Could you go down the line again? You all gave that, now let us run through it again so I can see how funding sources relate one to another because you are all on a similar mission, basically.

Ms. BRODSKY. We currently have two sources of funding. We have a model project grant from the Administration on Aging. Those funds are used for our technical assistance project which provides help to State agencies and other jurisdictions to set up programs based on our District of Columbia model. We also have some funds from the District of Columbia Office on Aging, the State agency on aging. These funds are used to continue the operation of the model project office which offers services to citizens in the District of Columbia. Those are our two sources of funding.

Senator WILLIAMS. It is all Administration on Aging money at two levels, is that correct?

Ms. BRODSKY. Some of it is coming through the District of Columbia Office on Aging.

Senator WILLIAMS. But their resources depend upon the national AOA.

Ms. BRODSKY. That is right.

Senator WILLIAMS. It is all AOA, two levels.

Ms. BRODSKY. Yes.

Senator WILLIAMS. All right.

Mr. SIRULNIK. We have three basic sources of funding. One is a research, training, and continuing education grant from AOA. We call it the training grant to distinguish it from our earlier model projects grant.

The second source of income is from the District of Columbia Commission on Postsecondary Education through title I of the Higher Education Act.

The third is the contribution the law school itself makes to the clinical program.

Senator WILLIAMS. You are all within HEW except for the law center at George Washington University itself?

Mr. SIRULNIK. That is right.

Senator WILLIAMS The Commissioner of Education and the AOA is all within HEW.

Mr. SIRULNIK. Yes, sir.

GRANTS FROM AoA

Mr. FRY. We have two grants from the Administration on Aging, one under title III as a model project to do technical assistance around the country and another under title IV, a grant for training to develop and test the training concept for community service advisers. In addition, we have a series of contracts from various entities around the country: one from a division of the State of Texas, another from a legal services program, several from places in New York. All of these involve training or training related matters.

Senator WILLIAMS. Are these governmental programs that come to you from the States?

Mr. FRY. They all originate with the Government. In Texas, we work with a State agency, the department of public welfare, to train their staff in senior citizen problems relating to technical services. The arrangement with the legal services program involves manpower funds with a subcontract to us to develop training programs. There are several New York City smaller contracts which are using Legal Services Corporation funds.

Senator WILLIAMS. Let me ask you this. You are all, as individuals, Washington based?

Mr. SIRULNIK. Yes.

Mr. FRY. I might add that we have a west coast office in San Francisco, which is currently running on several grants and contracts in the State of California doing senior citizen training and technical assistance and is just for that State. So, while our main office is here, we also have another office.

Senator WILLIAMS. Do you see a thread of common purpose in all of your individual activities?

Mr. FRY. Yes, I think I do. I think we are all working at different aspects of the expansion of legal services through the use of nonlawyers.

Senator WILLIAMS. Under your title that is exclusively your mission because it is the Paralegal Institute.

Mr. FRY. Yes.

Senator WILLIAMS. But now the others are broader—legal services furnished by lawyers and paralegals.

Ms. BRODSKY. We also are using nonlawyers in that our volunteers are not lawyers.

Senator WILLIAMS. In addition, under this supervision.

Ms. BRODSKY. That is correct.

Senator WILLIAMS. Your program really does not get direction from the legal community.

Mr. FRY. Paralegals by definition are directly supervised by attorneys. The third group that we spoke of as community service advisers, would be linked to lawyer backup and referral but not directly under a lawyer controlled organization.

SHORTAGE OF "TRAINED" LAWYERS

Mr. SIRULNIK. I think the common thread is that this is the first time in recent memory that I have heard three people make the statement that there is a shortage of lawyers in this country. I think that perhaps the explanation is that there is a shortage of lawyers with the proper expertise to effectively serve the client community in which we are all interested. We are developing, all three of us, alternative means of providing legal services—some with nonlawyers, some by better trained lawyers, and also by certain law reform activities which might simplify the procedures and ameliorate the need for any lawyers.

Senator WILLIAMS. Let me ask you; do you all meet formally or informally and communicate your problems and your answers and the situations that you face in your prospective work?

Mr. FRY. Yes. As a matter of fact, we will have a meeting of all the national grantees of AOA next month in Philadelphia. We meet regularly three or four times a year to discuss what it is we are doing, how to cooperate, whether there is any overlap, and we will be doing that this year.

Mr. SIRULNIK. There is also, I would state, a good deal of informal communication on a weekly basis, referral of cases or consultation among problems especially between the three groups that are presently here in the same city.

Senator WILLIAMS. So you think if anyone should look at your activities, your organization, and your funding, you would successfully withstand an attack about wasteful, complex, and duplicative efforts and all of those other charges that we hear leveled at Government-sponsored activity?

Mr. FRY. I don't think it is any of those things, Senator. I think we are working in different areas for a common purpose. We are using some of the same conceptual bases. We all believe in training and we all believe in the expansion of services through training with the utilization of laymen but that is a very big universe. We, for example,

don't work with volunteers. AARP is an organization that works with millions of volunteers in the country. We don't work with them, and if we were the only one around, nobody would work with us. We work essentially with people employed in agencies.

Mr. SIRULNIK. I think our program is unique in two particular fashions. The first is that it is law school based and we are training not only the traditional young law student in the traditional way but also the paralegal trainees who are retired or semiretired along with the law students. The two groups work together in clinical programs. This is significant because there is a tremendous problem, as I am sure you know, with the sensitivities of many professionals in treating elderly people.

I am talking about medical treatment, as well as legal treatment. For instance, the term in many law offices for older clients is "crazies" because their problems are complicated and alien. There is a problem of attitude that I think programs such as ours at George Washington try to approach by putting younger persons alongside of older persons in a mutual attempt to solve some problems.

Senator WILLIAMS. I will come back in a moment.

Senator Hartke.

AVAILABILITY OF LAWYERS QUESTIONED

Senator HARTKE. Let me ask you about the one statement you made there. The last witness was talking about there not being enough lawyers around to handle the cases. Is that what you said?

Mr. FRY. Yes.

Senator HARTKE. Is that a situation which should be remedied? In other words, are you saying the lawyer should be supplemented or the lawyers should be increased?

Mr. FRY. I am not really saying that the lawyers should be increased. I think the number of members at the bar in the country may be increasing slowly. I don't see any possibility of an answer or a solution by increasing lawyers. The legal profession will always be limited in size, and, in addition, the structure of the legal profession—the price scale, for example—makes it virtually impossible to think of lawyers dealing with these problems. It costs too much money.

Third, these are not problems that require a lawyer. We have done a great deal of experimentation and analysis around that subject over the last 4 or 5 years and the majority of problems faced by poor people are problems that can be handled by a trained nonlawyer.

The public benefit area is one that is mentioned most. There are issues concerning eligibility for all of the public benefit programs. Those are questions which lawyers are not trained to handle and which many laymen are now handling, and I might say very successfully.

Probably it would help if I gave you a brief example. We trained, about 6 months ago, a group of 30 senior citizens. We trained them, among other things, in handling a current, very difficult problem for older people. A lot of SSI recipients have been told that they have been overpaid and they have to pay back to the Government. There are about 800,000 such cases.

These overpayment cases are coming up this year and, of course, for poor people that is a terrible blow. They are barely living on what they get and they are told they have to give some of it back. There are Federal regulations governing the overpayment demand and explaining what one has to do to get the overpayment waived. It is moderately technical, and it certainly takes someone who understands the overpayment situation to represent a client.

We trained paralegals in handling overpayment cases. In one case a paralegal trained by us came back a couple of months later and said he had six such cases and won every one of them. Now I would like to assume that those were six people who would have been under a severe hardship if they had not had the representation of this person. This was not a lawyer. There are not enough lawyers around to handle those cases.

Senator HARTKE. Are you really drawing a distinction between a legal and a nonlegal situation? I can see under section 3 that the priority for money to have people other than paralegals—volunteer or whatever you call them—is one of two things. Either you offer castoff second-class treatment to those cases not really justified as needing legal representation or you go ahead and give legal representation.

Mr. FRY. I certainly agree with you on the point that if, by definition, paralegal is one that can do these things, these are not legal problems.

Senator HARTKE. Would it not be better advised then to draw that distinction very clearly?

Mr. FRY. Yes. It is a matter of definition. I like to refer to these as law-related problems.

"BUREAUCRATIC MESS"

Senator HARTKE. I understand that. After all, what we are trying to do is deal with specific problems of individuals and I think this is where the Government gets itself into many traps and where you get this so-called bureaucratic mess accusation. I can see from what you have said and in Senator Williams' statement here that most people out in the public arena would say yes, that is a mess, that is a bureaucratic complicated mess; I don't understand it at all.

It looks to me like it is one agency trying to duplicate what another is doing without any clear-cut definitive arrangement. What I am saying is that you could do that very clearly if you would go ahead and deal with the situation. For instance, you would not have a nonlawyer doing a lawyer's work any more than you would have a paramedic performing major surgery on somebody.

Mr. FRY. These people are certainly not practicing law or doing the work a lawyer must do.

Senator HARTKE. Why not call it what it is in every senatorial office and congressional office; pure and simple casework. Isn't that right?

Mr. FRY. I think that is right. In fact, the category that I described earlier, the community service advisers, is an effort to do just what you suggested, to create a category of people who are clearly not related to practicing law.

Senator HARTKE. Would you not, in your funding efforts, be more apt to have a successful operation if you had that definition clearly recognized—naturally there are a lot of gray areas—so that you could have good, competent legal representation where you need it and competent caseworkers where you need it?

Mr. SIRULNIK. Senator, if I might. We are all dealing with the sort of problem which I don't think is fair to categorize as "legal" or "nonlegal." The two are not always mutually exclusive. A lot of the cases which we handle require an interface between a paralegal and a lawyer. Oftentimes a case which begins as a social service problem develops into a legal problem. The social security administrative procedure itself calls for an exhaustion of nonlegal remedies and then at some point one may turn to the courts. There is a need to provide people with training which enables them to recognize legal issues as well as provide nonlegal social services. I think only in this way can the individual who we are the most concerned with, the client, be prevented from falling through the cracks, or getting lost in the woodwork.

Senator HARTKE. The person may not fall through the crack if you get that type of theoretical discussion done but the fact is that the bureaucratic mess does fall through the crack.

You are describing exactly what the people out in the countryside in Indiana are complaining about Washington, D.C., which is that you want to take every single thing and hold it up into a situation where no one knows how it comes out.

DUPLICATION WITHIN THE SYSTEM

Mr. SIRULNIK. What they are saying is that the need for this type of duplication is because there is such duplication in the Federal bureaucracy. Some problems may be perceived by some people as being nonlegal and very simple until they try to extract themselves from the quagmire of the applicable program. It turns out what one day was an administrative problem the next day is a legal problem.

Senator HARTKE. A nurse says, "You have a high fever and a pain in your side and I am going to operate on you for appendicitis." What I am trying to say is that in the medical field you have this type of clearcut definition.

Now there is not any question that the nurse can give you a shot and a doctor can give you a shot. There are certain legal situations which could be defined and I can see where as long as you keep the situation sufficiently confused as to determining when you are telling me it is not legal, and doing social services and characterizing them as legal services, that the net result is you are going to have no one wanting to do anything, although that need may be there and certainly is there.

The purpose of the hearing is to find out how that need is being met, not whether the need is there. That already has been decided.

Why redecide that issue unless there is something that needs to be done. What you are trying to find out is how do you solve that problem? The problem has been identified and specified, an agency has been directed to do it. Now we are trying to find out what happened.

Mr. FRY. Senator, I think a great deal has been done to meet that problem and I, aside from any——

Senator WILLIAMS. We have the conference report on the bill involving toxic substances which will create a lot of work for you, I have a feeling.

We will go over and vote and pass another necessary measure.

This has been extremely helpful to the committee. We greatly appreciate your work. The fact you are doing this, it seems to me, shows that the national response to this need has been comprehensive. Much more, of course, remains to be done. But we have a beginning and something worthwhile to build upon. I like the idea concerning the title to deal on a comprehensive basis with the subject matter of legal services and the companion questions. It just impresses me. I think one of the missions of law is to define rights and duties precisely so an individual knows what his rights are and what his duties are. Any contract you read or insurance policy is a complicated business.

This may be especially true of older persons, many of whom have little experience with legal matters and some sense of reluctance to become involved in them. It is a very, very difficult mission that you are trying to work toward and equip people to handle in a social setting that certainly is greatly needed.

My congratulations.

We will recess at this point.

[Whereupon, at 12 noon, the committee recessed, to reconvene at 10 a.m., Wednesday, September 29, 1976.]

APPENDIX

LETTER FROM STANLEY DI ORIO, DIRECTING ATTORNEY, LEGAL AID FOUNDATION, LOS ANGELES, CALIF.; TO SENATOR FRANK CHURCH, DATED SEPTEMBER 17, 1976

DEAR SENATOR CHURCH: It has come to my attention that you will be holding, in the very near future, hearings on improving legal representation for older Americans. I would like to bring to your attention a disgraceful example of blatant discrimination in the ability to retain legal representation between two different groups of older Americans. Various proposed solutions to the problem will be mentioned in the hope your committee can promptly move to correct this problem.

Under the social security disability program Congress provided that attorney's fees "shall" be paid out of past-due benefits. [42 USC 406(a)—referred to as title II] Applicable regulations provide for direct payment from the Social Security Administration to the attorney.

Since attorneys are guaranteed they would receive the money awarded them if they win, Congress in effect established a contingency fee arrangement for title II cases and private attorneys are therefore practicing in the field and available for older claimants.

The supplement security income program (42 USC 1381 et seq.—title XVI) on the other hand makes no mention of a similar fee arrangement in the legislation. Regulations enacted by the Secretary of HEW however specifically state "the administration assumes no responsibility for payments" (20 CFR § 416.1510(c)). Title XVI was modeled in large part after the title II program and in effect either incorporates or copies the exact language of larger portions of the title II legislation. Older Americans and those fast approaching those years are potential and actual claimants under title XVI.

The effect of this arrangement on the availability of legal representation is precisely the opposite of title II. Because those applying for benefits under title XVI have usually little or no money or assets of their own, private attorneys not being guaranteed the ability to receive the money awarded them in a successful case, generally do not represent title XVI cases. The burden then falls to lay advocate groups and legal service attorneys. I personally know in the entire city of Los Angeles only a couple of private attorneys who just recently began to risk taking a few of these cases. If they do experience problems in collection of their fee, I am sure they will discontinue that practice.

Reliable sources have informed me this difference in the legislation resulted from Representative Wilbur Mills' feelings in 1971 that the war on poverty was over and that legal services to the poor had had its day. There is no fair rationale for making the distinction between the two groups. The old stand-by excuses that attorneys will cause a delay in the process of cases and will cost the government more money do not stand up under close examination. Social security has managed on its own to create a 6- to 12-month delay in setting an administrative hearing after a request has been filed. If, as a result of conducting a skilled, fully documented hearing, people become qualified who ordinarily would not have without an attorney, I suggest that it is only a just result and a reflection of the true intent of Congress.

This situation of legal representation becomes critical not only because people who apply for SSI are at the bottom step of the ladder, but from my information in California, approximately 40 percent to 60 percent of those cases initially denied are reversed at the administrative hearing level. This figure is even more significant when you consider at a maximum about 25 percent of those cases have any type of representation at these hearings.

Two obvious solutions are clear at this point: (1) either add specific authority for the withholding of payments in 42 USC 1383(d)(3), or (2) change the regulations to permit such a withholding since the statute itself does not specifically prohibit such a practice. The former would be preferable; the latter would be quicker (if possible).

Given the large numbers of people applying and potentially eligible for SSI, this is a problem of significant proportion. While I am not an advocate for increasing the business of the private bar, they would certainly support such a change. In addition, the limited resources of legal services could be more effectively utilized on cases where the ability to obtain attorney's fees and private attorneys is not available.

The above description is hopefully significant to illustrate this irrational distinction between the ability of senior citizens to obtain legal representation on social security disability versus supplemental security income.

Your prompt attention to this problem may give applicants for SSI a fair opportunity to present their case in a full and effective manner and achieve at least a minimal income to live on.

If I can be of further assistance, feel free to contact me.

Sincerely yours,

STANLEY DI ORIO, *Directing Attorney.*

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MEDICARE AND MEDICAID FRAUDS

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 6—WASHINGTON, D.C.

AUGUST 31, 1976

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Medicare and Medicaid Frauds:
Part 1. Washington, D.C., September 26, 1975.
Part 2. Washington, D.C., November 13, 1975.
Part 3. Washington, D.C., December 5, 1975.
Part 4. Washington, D.C., February 16, 1976.
Part 5. Washington, D.C., August 30, 1976.
Part 6. Washington, D.C., August 31, 1976.
Part 7. Washington, D.C., November 17, 1976.
Part 8. Washington, D.C., March 8, 1977.
Part 9. Washington, D.C., March 9, 1977.

(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

MEDICARE AND MEDICAID FRAUDS

TUESDAY, AUGUST 31, 1976

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

The subcommittee met, pursuant to recess, at 9:45 a.m., in room 318, Russell Senate Office Building, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss, Demenici, Clark, and Percy.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Margaret S. Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; Alison Case, assistant chief clerk; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

I welcome you all here this morning for the hearing by the Subcommittee on Long-Term Care to examine possible abuses of the medicaid program.

The ranking Republican member, Senator Percy, will be a little late in arriving this morning because of a family problem with his boy and taking him to the hospital. He told me yesterday afternoon that he might be late, but he will be here.

We also expect other members of the committee to come. It is a very busy time in the Senate and hard for all the members to attend. We do appreciate the attendance of those who are to be here this morning as well as those observing these hearings.

At yesterday's hearing, I summarized the more than 47 hearings we have held dealing with one or more aspects of the medicaid program in the past 7 years since 1969, and I have before me copies of all those hearings that have been held, printed, and published. This would indicate that this is an ongoing problem with which we have been concerned for a long time.

I mentioned briefly our investigation of fraud and abuse among clinical laboratories and of the growing trend to dump senior citizens out of mental hospitals into nursing homes and boarding homes. I mentioned briefly our look at for-profit home health agencies, factoring firms and nursing homes. We estimated that 10 percent of the $15 billion in medicaid funds is ripped off by the unscrupulous.

Five-State Audit Released

This morning we want to hear more about the operation of medicaid mills. However, I also want to take this occasion to release an audit [1] prepared at my request by the U.S. General Accounting Office. Although I received this report some time ago, it has not been released until this morning and I am releasing it today.

The audit concerns nursing homes in five States: New York, California, Missouri, Michigan, and Florida. At my request, GAO selected a valid sample of 30 nursing homes in these States and attempted to learn if the nursing homes provided appropriate safeguards for patients' funds. I am talking about the $25-a-month spending allowance to which patients in nursing homes supported by medicaid are entitled. GAO found that HEW and the States were not properly monitoring patients' funds. GAO found deficiencies in every one of the nursing homes they surveyed.

The kinds of deficiencies uncovered by GAO include: shortages in patients' funds; medical supplies and services were being charged to patients' funds—such supplies and services are included in the basic rate medicaid pays to nursing homes; funds of deceased and transferred patients were being kept by the facilities; interest earned on patients' funds was being kept by some nursing homes; and patients' funds, which should be kept inviolate, being commingled with general operating funds.

This problem is one of the most serious we have encountered in nursing homes. The fact that every home in GAO's sample had deficiencies of some kind speaks for itself. In fact, I know of only one criminal proceeding against a nursing home operator who absconded with the personal expense money which generally goes to buy extras: cigarettes, to pay for a hairdo, or the like. In that Seattle case, the defense attorney argued that the nursing home operator should not be convicted because stealing patients' funds was the common practice in the industry.

Although the dollars in this instance may not be large, I view this problem as a severe abuse. The misappropriation of these funds is almost like the final indignity. We are to the point of robbing patients of their very dignity. As we have said many times, the one million elderly in our 23,000 nursing homes deserve the very best quality of life that we can bring to them.

I would like to join with the General Accounting Office in asking HEW to take more direct action to safeguard patients' funds in nursing homes.

We will continue this morning with the hearings that we began yesterday when we heard various investigative personnel concerning medicaid mills, as they are called, operating in New York City. We heard from Dr. Bruce Reiter, an M.D. from New York City; and the New Jersey Commission of Investigation chairman, Joseph Rodriguez, told us about New Jersey's experience and released a report which we made part of our record.

This morning we will hear from Robert B. Fiske, Jr., who is the U.S. attorney for the southern district of New York, and George

[1] See appendix 1, p. 697.

Wilson, associate U.S. attorney. We will ask them if they will come to the table and present their statement at this point.

We welcome you gentlemen before the committee. I want to acknowledge the fine cooperation that our committee staff has had with the U.S. attorney for the southern district of New York. Without his assistance we could not have carried on the kind of investigation that we have had underway and which is the subject of these hearings.

Mr. Fiske.

STATEMENT OF ROBERT B. FISKE, JR., U.S. ATTORNEY, SOUTHERN DISTRICT OF NEW YORK; ACCOMPANIED BY GEORGE WILSON, ASSOCIATE U.S. ATTORNEY

Mr. FISKE. Thank you very much, Senator. I would like to start by expressing appreciation to you for the assistance that you have given us in our investigation and for the information that you have provided to us which we are pursuing as part of our continuing investigation of medicaid fraud.

I am very pleased to have this opportunity to appear before you today. I would like to introduce assistant U.S. attorney George E. Wilson who is sitting on my right. George has been primarily responsible for the medicaid investigations and criminal prosecutions conducted by our office, working with very able assistance from assistant U.S. attorneys Joel N. Rosenthal and Shirah Neiman. I would just like to say at this point that to the extent that our office is given credit for its successful criminal prosecutions in this area, George, Joel, and Shirah deserve that credit.

George worked untiringly on these cases for well over 1 year in spite of what I will later describe as some difficult procedural and investigatory obstacles, and I think we all owe him a great debt of gratitude for the work that he has done.

Senator MOSS. Thank you. We welcome you, Mr. Wilson. We are pleased that you are here with us.

Mr. FISKE. To date, which has continued for the past 3½ years, we have convicted a total of 22 medical doctors, podiatrists, and chiropractors—plus 3 nonprofessional defendants—on a total of 72 felony counts. They were found guilty of violating U.S. Criminal Code sections involving the crimes of conspiracy to defraud the United States, mail fraud, false statements to the United States, false claims against the United States, income tax evasion, and the filing of false tax returns. Additionally, two doctors, currently under indictment, are awaiting trial.

SETTLEMENT FEES IMPRESSIVE

In addition—I think this is an important adjunct to our criminal prosecutions—we have brought civil actions under the Federal False Claims Act against the defendants who have been convicted. To date, these have resulted in civil settlements totaling just under $600,000, which amounts to double the amount paid out by the Federal Government on the false medicaid claims for which these defendants were convicted, plus an additional amount which was sufficient to roughly cover the cost of our investigation to date.

I would emphasize at this point that the double remedy of criminal prosecutions plus civil actions to recover double the amount of the fraudulent Federal payments, as described by the False Claims Act, is an important part of our prosecutorial arsenal in this medicaid investigation.

We have currently underway a continuing and ever-expanding grand jury investigation into medicaid fraud in the Southern District of New York. While it is obviously inappropriate to comment specifically, it is fair to say that we expect a number of further indictments in the near future.

My office first became involved in the prosecution of medicaid fraud cases when the New York City Department of Investigations referred to us the results of a preliminary inquiry into several medicaid clinics which were owned and operated by two chiropractors, Joseph Ingber and Sheldon Styles. As a result of this investigation, we uncovered a conspiracy involving eight medicaid clinics situated in deprived neighborhoods, catering almost exclusively to medicaid recipients. The factual statements that Mr. Wilson and I are making today came from the public testimony at the trials of these cases, together with what was included in publicly filed sentencing memorandums.

The clinics involved secured various practitioners in medical and related professions—doctors, dentists, chiropractors, podiatrists—commonly known as medicaid providers. These providers agreed to pay a percentage of their medicaid earnings as rent for the use of the medical facilities. These rents varied according to the specialty of the provider. For example, a chiropractor would pay between 65 and 80 percent of his gross medicaid income in rents and other fees, retaining only 20 to 35 percent for himself. His medicaid billings would be divided with 12 percent going to a factor and, normally, one-quarter of the remaining 88 percent going to the clinic as rent. The remainder would be split sometimes equally and sometimes one-third/two-thirds between clinic operators and the chiropractor.

On the other hand, medical doctors were able to retain a much greater share of their income because they were the drawing card at these clinics. They generally could retain over 60 percent of their gross medicaid claims after paying the factor and their rent.

The Ingber-Styles clinics were set up for the purpose of making money. Providers at these clinics were required to pay their rentals to the clinic owners promptly. Thus, cash flow for them was always a problem. Since the New York City Department of Social Services took from 3 to 6 months to pay claims, providers were encouraged to go to factors in order to generate the cash needed to pay rents to the clinic.

Extrication Difficult

Once involved with a factor, it was frequently difficult for a provider to extricate himself because he could not cease doing business through the factor until all of his outstanding medicaid claims and disallowances were repaid. Since city disallowances sometimes ran as high as 30 percent, the provider had to have a substantial cash sum to buy himself out of his factoring agreement. The provider was prevented from terminating his relationship with the factor and dealing

directly with the city because the city would not resume direct payments to the provider until the factor consented.

Some of the practices engaged in at these clinics included activities which are known to the committee and its staff, as Senator Moss personally observed, as ping-ponging and family ganging. Ping-ponging involved the referral of a medicaid recipient to some, or all, of the other providers working at the clinic. For example, a woman visiting the clinic with a cold would also be sent to see the chiropractor, the optometrist, and the podiatrist—all of whom billed medicaid for separate visits.

In family ganging, a mother with a number of children, lacking a babysitter, might bring all of her children to the clinic even though only one member of the family was ill. The sick family member would be treated, but the woman would be encouraged to have the doctor examine all of the other children. Frequently the entire family would then be ping-ponged around the clinic to all the providers present.

Thus, in many cases, a simple examination involving one member of a family, which should have resulted in one provider receiving one fee for one service rendered, would be parlayed into many fees involving several family members by several different providers.

We recognized early in the investigation that despite the obviously undesirable experiences as ping-ponging and family ganging, as a matter of prosecution these matters of ping-ponging and family ganging involved questions which might turn on a provider's professional judgment as to the necessity for providing certain services and would result in battles of the experts at trial and would serve only to obscure the real issues. We felt that criminal prosecutions in the area of ping-ponging and family ganging might involve testimony in each case that is a matter of medical precaution—"We thought it desirable to have these extra examinations conducted" or he was "really only looking out for the welfare of the patients"—but may also involve Federal fraudulent practices. Therefore, our investigation and theory of prosecution focused on proving that certain claimed services by providers were never rendered at all.

Earlier, when we gave the figures what I was talking about, we were able to demonstrate that invoices had been submitted for alleged treatments of patients where the treatment prescribed in the invoice had never been rendered at all.

Kickbacks Arranged

Aside from income derived by directly billing medicaid, the clinics had an arrangement with a medical laboratory whereby, in return for referring all blood and other tests, the clinics received a percentage commission—or kickback—sometimes referred to as rents, which ranged from 20 to 50 percent. Thus, as the volume of laboratory tests from the clinics increased, the kickbacks from the laboratory rose in proportion.

Because of the volume of paper work required to process medicaid claims, local residents were hired as secretaries and receptionists to work at these clinics. In most cases they were young girls who possessed no medically related or secretarial skills—only the capability

to perform routine office procedures with a minimum of on-the-job training. The procedures followed were fairly uniform at all our clinics.

They would receive patients and record all pertinent information required to prepare a medicaid invoice. They would then prepare medicaid invoices in whole or in part, depending on the desires of the individual provider. In many cases they knowingly prepared false invoices.

Most of the female employees dressed in white, giving the appearance of being nurses. Many performed duties such as drawing blood, giving injections, and taking X-rays and electrocardiograms, even though they were not licensed to perform those duties.

As a result of our investigation we found approximately 170 providers associated with the clinics we investigated. The prosecution of many of these providers was impossible because of the statute of limitations or the lack of evidence to demonstrate criminal fraud. The remaining providers, totalling approximately 80, submitted over 200,000 medicaid invoices to New York City during the period 1971–72. The criminal prosecutions that I have described earlier resulted from a painstaking review and analysis of those 200,000 separate invoices and it is in this area particularly that we encountered substantial investigative difficulties.

First, we concluded that the only way to adequately conduct a review of the thousands of claims submitted was through computer profiling. Although the New York City Department of Social Services offered its cooperation, it stated that it did not have the manpower or computer resources to devote to our task. Therefore, to obtain our profiles, we had to find funds, a programer, and computer time. HEW provided the funds and a computer expert. Eventually, after a great deal of looking around, we secured access to a U.S. Army computer at Fort Monmouth, N.J. GSA and HEW furnished computer programing services. Working with the programer, we designed our own computer profiles. This process took us approximately 4 months just to locate these resources.

Trained Investigators Needed

The second problem is that we do not have a staff that can conduct investigations into medicaid fraud. Our office has 100 lawyers who serve as assistant U.S. attorneys, but we do not have a large staff of investigators who can go out into the field and make factual analyses. We have to rely on other agencies to supply us with that kind of manpower. HEW does not have a large staff of trained, competent investigators who are available for this kind of investigation.

We started the investigation with only one qualified criminal investigator, Postal Inspector John Ellis, who was assigned at the early stages because this was a mail fraud investigation. His efforts proved invaluable but, obviously, one investigator is totally inadequate to conduct an investigation.

We sought assistance from the Department of Health, Education, and Welfare, which we did obtain, but with great difficulty. A variety of different personnel from HEW were detailed to us who provided

different services and provided different functions. We also obtained, for a period of time, an HEW investigator. However, the basic problem there was that none of these people were full-time, trained, competent investigators. All of them were borrowed from some other program at HEW on sort of a short-term spot basis, and everybody knew that as soon as they finished what they were doing they were supposed to go back to their other program. It was a short-term, makeshift operation, but we had to make do with the best we had.

Our difficulty in obtaining skilled, experienced auditors was greatly alleviated when the General Accounting Office detailed two supervisory auditors to us. Their assistance was invaluable in organizing and conducting an audit of the massive volume of financial records which had been subpenaed. Subsequently, the HEW audit agency also provided an auditor. We were also able, with some difficulty, to obtain temporary help from the New York State Department of Social Services.

Finally, in recent weeks we have obtained a commitment from the Federal Bureau of Investigation in New York to provide assistance to us in designated cases.

Obviously just from that very recital it is apparent that what is missing here is a basic staff of competent trained investigators who can be available on a full-time basis doing nothing other than investigating this type of case, and I might say it is obvious to everybody that that kind of a full-time commitment would be very productive indeed in terms of producing prosecutory results. We think that as a long-term solution to investigatory problems, HEW itself should be given the funds from the trained staff of competent investigators.

The final problems we encountered in our investigation were long delays in obtaining the basic, paid medicaid invoices from New York City. The city, as everyone knows, was experiencing serious fiscal difficulties and did not have the staff required to locate and retrieve these thousands of invoices which, unfortunately, are stored only by payment date. The payment dates ranged from 3 to 6 months after the services were rendered. To meet the problem of retrieving these invoices we turned to still another source, utilizing the services of 11 enrollees in the President's draft amnesty program as well as several HEW staff members detailed to our investigation.

Evidence Presented

Finally in October of 1975 we reached the point in the analysis of our computer profiles where we could begin calling in providers. The plan was simple. We would disclose to each provider, in the presence of his attorney, the evidence we had. We then offered him, as an alternative to having his case presented to the grand jury, the opportunity to waive indictment and plead guilty to a criminal information containing charges in number and nature which matched his degree of culpability. As part of the agreement, each defendant would agree to cooperate fully with the investigation and settle all civil liability, including the double amount, prior to his sentencing. This program resulted in pleas of guilty from all but two of the providers who have been convicted to date.

Finally, we have certain recommendations which we developed from our experience of 2½ years. We make these recommendations from the point of view of law enforcement officials. They are designed to provide procedures and techniques which will make prosecution of these cases more effective.

First: Title 42 of the U.S. Code, sections 1395nn and 1396h, the penal statutes for medicare and medicaid, should be changed from 1-year misdemeanors to 5-year felonies. This would increase the deterrent effect of these statutes and would also make medicare and medicaid fraud prosecutions more attractive to Federal prosecutors, from the standpoint of committing their resources to lengthy investigations.

I would say parenthetically here that there are other Federal criminal statutes, including the ones we utilized. However, those are statutes which are not directed specifically at medicare and medicaid and, while they can be used and while they can be interpreted to cover the type of conduct that we have prosecuted, we think it would be important for Congress to make it known that Congress itself takes medicaid fraud seriously so that the specific criminal statutes designed to regulate the medicaid and medicare fraud themselves carry a 5-year penalty—and not simply a slap on the wrist of 1 year for a misdemeanor.

Second: We think existing regulations should be amended and enforced. Patients should be required to sign medicaid invoices at the time the service is rendered. The format of the invoice should be changed to clearly reflect the Federal presence and penalties for fraud. It should be clear to the patient signing the invoice as well as the doctor submitting it that a false statement means a jail sentence. If a number of providers practice together as a clinic or similar organization, the organization should also be licensed.

As noted earlier, there is a critical need for a professional criminal investigative staff within HEW to assist U.S. attorneys in developing criminal cases. We believe that such a staff should consist of a mix of auditors and criminal investigators who are conversant with medicaid regulations. There is no such organization presently within HEW that is capable of rendering the support necessary to encourage other U.S. attorneys to investigate and prosecute medicaid fraud.

Computer Technology Essential

Third: There is also, because of the sheer volume of claims submitted, an absolute need for use of computer technology. A management information system which would provide profiles of clinics, laboratories, providers, and patients should be required of each State participating in the medicaid program. It is only through computer technology that program abuse can be detected. I would say parenthetically, at one point in our investigation we had 2 people by hand going through these 200,000 invoices that I described earlier trying to sort them out by doctor, by patient, by clinic, and these 2 people spent almost 1 year on that type of an analysis. The Bureau of Health Insurance of the Social Security Administration already has such a system for medicare which we feel could be adapted to medicaid by the States.

Finally, I would like to say that anyone connected with law enforcement knows that the only effective deterrent in criminal conduct is a certainty—or at least a reasonable apprehension—of being caught. The basic problem with the medicaid program, as we see it as law enforcement officers, is that a system has been allowed to develop which is so loose and slipshod in its regulatory procedures that those operating within it have had virtually no fear of being caught, and until very recently—in the unlikely event that they are caught—no fear of any significant penalty. The committee report itself at page 50 refers to interviews with 2 of the doctors who we prosecuted who, in the language of the report at page 50, admitted they were spurred on by the knowledge that the worst that could happen would be nonpayment of their claims or a fine.

The recommendations that we have made in our opinion will go a long way toward making investigation and prosecution of these cases more efficient and effective. This in turn should serve as a major deterrent to those who for a long time have regarded medicaid ripoffs as no-risk propositions.

Thank you very much.

Senator Moss. Thank you very much, Mr. Fiske. That was a fine statement.

You have appended three pages here listing individuals who have been convicted and the sentences meted out in each of those cases, and I will order that they be placed in the record at this point to illustrate your testimony.

Mr. Fiske. Thank you.

[The material referred to follows:]

Name	Criminal docket No.	Convictions	Sentence
1. Leonard Briggs, D.C	75 Cr. 1025	False claims (sec. 287, title 18, U.S.C.)	6 mo confinement; 18 mo probation.
2. Peter J. Carnes, D.C	75 Cr. 1026	do	3 mo confinement; 21 mo probation.
3. Raymond Jawer, D.P.M	75 Cr. 1027	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Do.
4. Sidney Gerber, D.C	75 Cr. 1080	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 mo confinement; 1 yr probation.
5. Ira Feinberg, D.C	75 Cr. 1081	False claims (sec. 287, title 18, U.S.C.)	2 yr probation; $1,000 fine.
6. Elliot Martin, D.P.M	75 Cr. 1145	Fraud and false statements (sec. 1001, title 18, U.S.C.); filing false income tax return (sec. 7206, title 26, U.S.C.).	2 mo confinement.
7. Stanley Reichler, clinic administrator.	75 Cr. 1146	False claims (sec. 287, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 yr confinement; 2 yr probation.
8. Martin Levine, M.D	75 Cr. 1147	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 mo confinement.
9. Joseph Raguseo, D.C	75 Cr. 1148	Mail fraud (sec. 1341, title 18, U.S.C.)	1 mo confinement; 23 mo probation.
10. Ralph Sheldon Bell, M.D	75 Cr. 1192	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Not sentenced as yet.
11. Sheila Toby Styles, secretary.	75 Cr. 1201	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); failure to file an income tax return (sec. 7203, title 26, U.S.C.).	2 yr probation; $500 fine.
12. Joseph Howard Ingber, D.C.	75 Cr. 1221	False claims (sec. 287, title 18, U.S.C.—2 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.—2 counts); mail fraud (sec. 1341, title 18, U.S.C.).	5 yr confinement.

Name	Criminal docket No.	Convictions	Sentence
13. Sheldon Max Styles, D.C.	75 Cr. 1222	False claims (sec. 287, title 18, U.S.C.—2 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.—2 counts); mail fraud (sec. 1341, title 18, U.S.C.); filing a false income tax return (sec. 7201, title 26, U.S.C.).	5 yr confinemt.
14. Tyler Ira Freeman, M.D.	75 Cr. 1236	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 mo confinement; 2 yr probation.
15. Donald Trager, D.C.	75 Cr. 1237	do	1 mo confinement; 35 mo probation; $10,000 fine.
16. Marvin Mosner, D.C.	75 Cr. 1251	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 yr probation.
17. Edwin Kimmel, D.C.	75 Cr. 1258	do	2 mo confinement; 22 mo probation.
18. Arthur Krieger, D.C.	76 Cr. 57	do	3 mo confinement; 2 yr probation.
19. Rene Clark, secretary	76 Cr. 74	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	18 mo probation.
20. Morty Kazdin, D.C.	76 Cr. 98	do	1 mo confinement; 23 mo probation.
21. Arthur Paul Solomon, M.D.	76 Cr. 115	False claims (sec. 287, title 18, U.S.C.)	2 months confinement.
22. David Friedman, D.C.	76 Cr. 155	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 yr probation.
23. John Errol Asher, M.D.	76 Cr. 518	False claims (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.).	1 yr confinement; 18 mo probation.
24. Robert March, D.C.	76 Cr. 114	False statements (sec. 1001, title 18, U.S.C.—10 counts); mail fraud (sec. 1341, title 18, U.S.C.—3 counts).	3 mo confinement; 2 yr probation.
25. Max Kavaler, D.C.	76 Cr. 110	False claims (sec. 287, title 18, U.S.C.—13 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Not sentenced as yet.

Senator Moss. I do appreciate, as I say, the great amount of cooperation that we have had. In fact, I remember my visit in your office at the beginning of this investigation. Here is a photograph to remind you where it all started. The fellow without the necktie is me. That picture was taken in your office, before we went out to visit the medicaid mills.

Mr. FISKE. I remember that very well.

Senator Moss. Mr. Wilson is in there, too.

You have indicated some of the problems that you have been encountering in prosecuting offenses in this field. What is the size of your staff that is assigned to this kind of work?

Mr. FISKE. We have, as I said earlier, 100 assistant U.S. attorneys. They are divided roughly two-thirds and one-third between criminal prosecutions and civil cases. There are approximately 65 lawyers in our office who do criminal work and roughly 35 who do civil work. I would say at one time or another during the course of this investigation there have been anywhere between 5 and 10 assistant U.S. attorneys who have participated in the investigation and prosecution of these cases, both criminally and civilly, all under the direction, basically, of George Wilson.

I would like to say, Senator, that we would be prepared to commit many more assistant U.S. attorneys to this kind of prosecution if we had the investigative resources to develop the facts which make prosecution possible. I think our experience has been that the number of assistant U.S. attorneys that we have devoted to the cases up until now have been more than sufficient to deal with the facts that have

been able to be developed by the limited investigative help that we have had. If we had more investigative help, we could lend a lot more assistance to this kind of prosecution and we would be anxious to do so.

Senator Moss. Roughly, what is the size of your caseload in this field?

Mr. FISKE. In the field of medicaid?

Senator Moss. Yes, just totals, on an average.

Mr. FISKE. Well, I think there are three cases presently pending as part of the original investigation that are awaiting trial. All of the others have resulted in pleas of guilty or convictions. That is the caseload in terms of cases that have resulted in indictments or information. As I indicated earlier, we have a very extensive investigation continuing into all aspects of the medicaid program, including areas other than clinics and doctors. Obviously, I think it would be inappropriate to comment on that specifically, but that is where our major effort is being directed right now. The initial effort which resulted in the so-called Ingber-Styles prosecutions is virtually over except in two or three cases that remain to be tried. We are in the second wave, so to speak.

Senator Moss. What is your assessment of HEW's current capability to investigate medicaid fraud?

PERMANENT INVESTIGATIVE STAFF NEEDED

Mr. FISKE. I think that is one of the major problems that we encountered and that is one of our major recommendations. HEW should obtain, accrue, or be given the necessary funds to have a permanent staff of competent investigators much like Internal Revenue agents or FBI agents who can be available to the U.S. attorneys offices to conduct the kind of factual investigation that is essential if these kinds of prosecutions are going to result. I recognize that there may be a difference of opinion as to whether that kind of investigative responsibility should be in the Federal Government, in HEW, or rather with the States or the cities but, as Federal prosecutors, we like to work with Federal agencies and we would like to see HEW do it.

Senator Moss. Are you acquainted with the Talmadge fraud bill or my proposal to create an Office of Inspector General in HEW to concentrate on monitoring compliance with medicaid-medicare—all health services?

Mr. FISKE. I am aware of the concept of the bill, Senator. I cannot tell you I am familiar with every detail of it, but we certainly heartily endorse that concept.

Senator Moss. I think you touched upon it, but maybe Mr. Wilson could also comment upon it. How difficult is it to make a medicaid fraud case?

Mr. FISKE. You are talking to somebody that can give you firsthand knowledge.

Senator Moss. I know he has been in the midst of it.

Mr. WILSON. It is extremely difficult. Let's take, for example, a hypothetical case. We received a complaint from a citizen about a cer-

tain doctor. Now ideally we should be able to call the agency that pays that doctor's invoice and ask for a profile of what he does, either in a certain month, a 6-month period, or a 1-year period. We should be able to examine that profile and be able to pick patterns of inherent improbability of treatment of particular patients and then interview those patients and make a case.

I think it has to be understood that you just can't go into court charging the doctor with one isolated instance because the chance of not being successful is too great. You have to get a pattern of fraud. Now, the only way we can do this, with any particular doctor, is to design our own program, find our own computer time, get some money from some agency to pay for printout, and go out and have it done. This takes a couple of months. That is just one case.

If we get individual complaints, one every other week, then the same process has to be gone through each time. To answer your question, sir, it is extremely difficult. It takes a lot of work and some luck.

Recorder Used To Obtain Evidence

One of the doctors we convicted only because of sheer luck. We had already decided that there was insufficient evidence of fraud from our examining printouts when we found that another doctor knew him and had personal knowledge. He was sent in with a wire on, a recorder, and we obtained the evidence which we confronted him with to get a conviction. It is largely a catch-as-catch-can situation.

Senator Moss. So we must conclude that it is very easy to cheat at medicaid, but very difficult to prove a case against those who do cheat.

Mr. Wilson. Yes.

Mr. Fiske. Yes.

Senator Moss. What is the current process in New York City as far as recordkeeping? How are they doing it now?

Mr. Wilson. The invoices, which are the primary evidence both to show the claims made and, most importantly, to make handwriting exemplars, are kept in a warehouse. They are filed by order of payment which may range anywhere from 3 to 6 months after they are submitted. Those records are obtainable, after research, at one office of the department of social services. To obtain file numbers or box numbers, we must obtain a work-gang of people to crawl through mountains of invoices to physically find them. That is the recordkeeping system for the records that we are interested in. The records which are kept in the computer—what the computer does is act as an auditing tool to determine the amounts paid, so they can compare the monthly report to the State.

Senator Moss. On page 216 of our report [1] there is a photograph of a lot of boxes. I wonder if that was where the records were residing primarily?

[1] *Fraud and Abuse Among Practitioners Participating in the Medicaid Program*, staff report for the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

Mr. WILSON. If that is our warehouse in Brooklyn, sir, that is correct. I might add the city had made a commitment to find these 200,000 invoices for us and we are getting them in dribs and drabs—a few at a time. In September of last year they fired all the laborers they had hired for this task. We were not getting any more invoices, we were told, because of the fiscal crisis—that the laborers were let go. We were being forced around. At the same time the Selective Service was making their amnesty ruling, so it seemed an ideal marriage. Each agency is helping each other out.

INVOICES RETRIEVED FROM WAREHOUSE

At one point later on we had to get a supplementary group of invoices. I had to send for a group of investigators to work for me. Auditors, investigators, clerks, everybody came in one day with their old clothes on and actually spent a whole week in Brooklyn—male and female. The whole gang went into the warehouse and they spent a week retrieving invoices, and that is the most accurate way we could do it.

Senator Moss. Now looking ahead, has New York changed that? Have they started computerizing their filing of these invoices in any way?

Mr. WILSON. Not that we know of. We have not looked for invoices for the past 6 months. We understand that they have a little bit different field in their master tape but, insofar as the information, there are still no profiles of any type. According to my information they are still filing the invoices in the warehouse and I am not aware of any different way of filing other than this.

Mr. FISKE. I would like to emphasize at this point, Senator, the value of a good computer profile in terms of simplifying the investigation of these cases. If you can press a button and get out of a computer all of the invoices that a particular doctor has submitted in a particular year—let's say, itemized by patient—then you could very quickly see in the course of a day or two whether there appears to be a pattern where patients are being treated three times in the same week for the same ailment. This, then, could target for you a group of patients who you could call to the grand jury to find out whether or not they received those services or not. If they said they had not, you would have a fraud prosecution of that doctor developed right there within just a few days. That is just one example of the way a computer can be used.

Another way it could be used would be, for example, if you know a doctor himself. This is the actual procedure that George used with the Fort Monmouth computer. If you know the doctor is in the hospital, for example, for a period of time—for 3 weeks—or he is out in the country for a period of a month on vacation, then you just plug into the computer to see if there were any invoices submitted by that doctor during that period of time.

One of our prosecutions resulted from exactly that process where we were able to show that a doctor was submitting a substantial number of invoices for medicaid reimbursement for a period of time

when we knew that he himself was hospitalized and not even in his office.

Those are just two examples of the way that a computer can be used. Mr. Wilson has brought with him, and we would be happy to leave them as exhibits, three sample computer runs which we actually developed from this Fort Monmouth computer which has demonstrated those two methods, plus the third one where a computer can be very effectively and very quickly used to make criminal cases in this area. If you would like to have those, I would be glad to leave them. I think they are self-explanatory.

Senator Moss. I would like to have them and I appreciate that.

[The computer runs follow:]

LEVINE, MARTIN 10-086646-6

ANDERSON MABLE	2908567-2			
MABLE				
TENCRESS				
1 FAMILY VISITS BY DAY				
1 SINGLE INVOICES				
** ANDREWS CLAUDETTE	2643017-1			
CLAUDETTE		WED	01-27-71	048853
CLAUDETTE		SAT	01-30-71	732195
2 FAMILY VISITS BY DAY				
2 SINGLE INVOICES				
** ANDREWS ELIZABETH	3086711-1			
ELIZABETH		MON	01-18-71	011226
ELIZABETH		TUE	03-23-71	292477
ELIZABETH		FRI	05-21-71	670702
ELIZABETH				
ELIZABETH		THU	08-19-71	772981
4 FAMILY VISITS BY DAY				
4 SINGLE INVOICES				
** ANDUJAR	2732838-1			
LISA		TUE	04-20-71	533674
MARTH				
1 FAMILY VISITS BY DAY				
1 SINGLE INVOICES				
** AQUAFREDDA NEVIA	2363555-1			
NEVIA		MON	08-07-72	058819
NEVIA				
1 FAMILY VISITS BY DAY				
1 SINGLE INVOICES				
** ARANGO	2979575-1			
MARY		TUE	01-19-71	127658

LEVINE, MARTIN 10-086646-6

ARANGO	2979575-1			
MARY		WED	01-20-71	
MARY		WED	05-05-71	749238
MARY		MON	05-17-71	
MARY		WED	06-09-71	540329
MARY		MON	06-14-71	
MARY		TUE	08-10-71	171633
MARY		SAT	08-14-71	
MARY		WED	09-08-71	171549
MARY		THU	09-09-71	
MARY		FRI	11-05-71	171579
MARY		WED	11-10-71	
MARY		WED	12-08-71	171573
MARY		FRI	12-10-71	
MARY		FRI	12-31-71	542703
MARY		TUE	01-11-72	
MARY		WED	04-05-72	786393
MARY		FRI	06-16-72	223134
MARY		FRI	07-14-72	122774
MARY				223134
MARY		FRI	08-18-72	122774

20 FAMILY VISITS BY DAY

13 SINGLE INVOICES

** ARGO DOLORES	2496019-1			
DEBORAH		FRI	11-12-71	019512

1 FAMILY VISITS BY DAY

1 SINGLE INVOICES

** ARGO MYRTLE	1605160-1			
JEFFREY		MON	07-19-71	823238
LEONARDO				
MYRTLE				
MYRTLE				

1 FAMILY VISITS BY DAY

1 SINGLE INVOICES

** ARMSTRONG	1868953-1			
ELLEN		MON	01-04-71	732198
ELLEN				
ELLEN		THU	01-14-71	048852

DATE 04/05/72 MEDICAID PROVIDER 1971-1972 PAGE 10321

PROVIDER NAME

36-0CC838-7 INGBER, JOSEPH

VISIT DATE	PATIENT LAST NAME		FIRST NAME	PATIENT #	INVCE #	LINE #
01/11/71	HARDY	/V	VIVIAN	2549488-1	732035	3
01/11/71	HUTCHISON	/R	ROXANNE	5341347-1	020648	3
01/11/71	JUBES JOSEPHINE		CREIGHTEN	2013711-2	020644	3
01/11/71	JOHNSON SALLIE		DEBORAH	2357475-1	732032	3
01/11/71	LEFTWICH	/R	YASIN	4037706-1	020654	15
01/11/71	LEFTWICH	/R	RUTH	4037706-1	020653	17
01/11/71	LLANERAS	/R	ROSA	2566511-1	921806	15
01/11/71	NORMAN HAZEL		HAZEL	3061593-1	732036	3
01/11/71	STEVENSON MILDRED		MILDRED	2041369-1	921805	11
01/11/71	WALKER	W/R	SAMELLA	4158817-1	732054	3
* TOTAL VISITS 19						
01/12/71	HOWELL CAROLYN		RICKY	2160360-1	732030	3
01/12/71	JACKSON JANE		BETTY	2014089-1	084728	3
01/12/71	JONES	/E	MARK	1582859-1	020651	3
01/12/71	TERRY RUBY		RALPH	2542839-1	084725	3
01/12/71	TERRY RUBY		BENITO	2542839-1	084724	3
* TOTAL VISITS 5						
01/13/71	BROWELL	JC/L	JAMES	5036751-1	732086	3
01/13/71	COLON CARMEN		INZDELIA	1918795-1	824455	3
01/13/71	COPELAND	/A	ANTHONY	2144805-1	732085	3
01/13/71	GONZALEZ MARIA		MIRIAM	1482630-1	732033	3
01/13/71	GRAY	R /E	ERIC	5283066-1	020649	3
01/13/71	GREENE	/C	LYCIA	5365657-1	732034	3
01/13/71	HARDY	/V	VIVIAN	2549488-1	732035	3
01/13/71	HUTCHISON	/R	ROXANNE	5341347-1	020648	3
01/13/71	JOHNSON SALLIE		DEBORAH	2357475-1	732032	3
01/13/71	JORDAN CATHERINE		AILENE	2525797-1	020652	3
01/13/71	KAALUND MARY		AARON	1445337-1	824465	3
01/13/71	LEFTWICH	/R	RUTH	4037706-1	020653	17
01/13/71	LEFTWICH	/R	YASIN	4037706-1	020654	15
* TOTAL VISITS 13						
01/14/71	BROWN	J /E	VERA	4070090-1	020662	15
01/14/71	DIAZ ELOISA		RAYMOND	2846794-1	824457	3
01/14/71	GRAY	R /E	ERIC	5283066-1	824461	3
01/14/71	HOWELL CAROLYN		RICKY	2160360-1	732030	3
01/14/71	JACKSON JANE		BETTY	2014089-1	084728	3
01/14/71	JUBES JOSEPHINE		CREIGHTEN	2013711-2	020644	3
01/14/71	JONES	/E	MARK	1582859-1	020651	3
01/14/71	ROBINSON ARNESS		BILLY	2496007-1	824466	3
01/14/71	ROMERO	J /L	MOSES	5274846-1	824471	3
01/14/71	SCOTT DIANE		DIANE	2468764-1	732056	3
01/14/71	TAYLOR MARIE		MARIE	3045250-1	824468	3
01/14/71	TERRY RUBY		BENITO	2542839-1	084724	3
* TOTAL VISITS 12						

DATE 04/01/75

NEW MEDICAID LISTING BY RECIPIENT
1971-1972

PATIENT LAST NAME	PATIENT #	FIRST NAME	VISIT DATE	INVOICE #	PROVIDER NAME	PROVIDER #
HARRIS ALFRED	2936949-1	ALFRED	09/14/71	093761	SASSON, MELVIN	32-002696-6
HARRIS ALFRED		ALFRED	09/14/71	093761	SASSON, MELVIN	32-002696-6
HARRIS ALFRED		ALFRED	09/14/71	093761	SASSON, MELVIN	32-002696-6

DATE 04/01/75

PATIENT LAST NAME	PATIENT #	FIRST NAME	VISIT DATE	INVOICE #	PROVIDER NAME	PROVIDER #
HARRIS ALFREDA	1194714-1	MELVIN	10/21/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	10/25/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	10/26/71	057103	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	10/26/71	057103	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	10/27/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	10/29/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/02/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/04/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/05/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/09/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MEBIN	11/10/71	057899	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	11/12/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/16/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/18/71	856797	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	11/18/71	896797	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	12/04/71	002515	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	12/04/71	002515	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	02/28/72	013267	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVIN	03/04/72	013670	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVIN	03/06/72	013605	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		DUANE	04/15/72	454038	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVIN	04/15/72	454038	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVINE	05/17/72	357287	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		DUANE	05/17/72	357287	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	05/17/72	357275	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	05/18/72	357366	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	08/23/72	876887	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		DUANE	08/23/72	876887	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	08/26/72	876227	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		ALFREDA	08/26/72	876227	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		ALFREDA	08/26/72	876227	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	08/26/72	876226	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	08/26/72	876226	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	08/26/72	876226	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	10/04/72	535528	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	10/04/72	535528	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	10/04/72	535528	MARTIN, ELLIOT	31-002226-4

Senator Moss. Would it not be a great economic advantage, leaving aside all of the other abuses, to the State and to the city if they had this sort of computerized data because of the ability to detect fraud and to recover funds—you pointed out some $600,000 you have been able to recover on these that you had prosecuted?

Mr. FISKE. As I tried to make clear earlier, first it would make prosecution of those committing fraud far easier, far more efficient, and far more effective by that very process. Once the word got around that there was that kind of computer technology available which could result in instant and certain prosecution, we think that a number of others who may well be committing fraud now, where they know they can get away with it, would be deterred from committing the fraud in the first place. It would have a very definite double benefit.

Senator DOMENICI. Would the Chairman yield?

Senator Moss. I yield to the Senator from New Mexico.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. I first wanted to ask a question. I read your entire statement even though I missed being here for the first two or three pages. I didn't hear you mention in this past 45 minutes any medical society, an organization of doctors in the city or State, that may have been involved at all in any of your efforts to clean up medicaid. Is that an oversight or are they not involved?

Mr. FISKE. The medical profession itself regulating its own?

Senator DOMENICI. Yes. Is the medical society in the city or State of New York involved in trying to police or help with this kind of problem to the extent that you have been involved? Have you observed it?

Mr. FISKE. No.

Senator DOMENICI. Let me say, Mr. Chairman, for the record, that in your State, the State of Utah, and in the State of New Mexico, I think it would be fair to say the probability of finding fraud is very high. In our respective States, the medical societies are intimately involved in profile evaluation.

Provider profiles are on computers and reviewed by a professional on a regular basis. I know, as a matter of fact, because after our first hearings I was asked to come back to New Mexico and talk to them about the system, and there is just no similarity to what is occurring in New York and Illinois today. Everything that goes on with reference to treating a patient versus a doctor is computerized and examined on a regular basis by a professional board headed by a doctor who is a full-time employee of the nonprofit corporation that contracts with the State for all of these evaluations.

I just want to say for the record at this point before I ask you a couple of other questions that I agree wholeheartedly that the threat of criminal prosecution of a serious type is a deterrent and that we ought to proceed along the lines of your recommendations, but what I observed in medicaid is the creation of a whole new culture of the delivery of medical services. The people in those centers and the foreign doctors in there have no concept of the medical ethics that

the association of doctors generally propose and have posted on their office walls. They don't understand anything but trying to make a lot of money and make a little tiny clinic turn out dollars and dollars. They also get involved with factoring companies. Many of them don't understand business and they just rock along thinking, "This is the way to practice medicine." I conclude that it is serious enough that the medical professions in this country better get involved in helping with this problem because U.S. attorneys and State attorneys are not going to solve it.

Let me ask you some specific questions. Should we prohibit factoring in this whole field?

Factoring Sometimes Necessary

Mr. Fiske. I think that makes it very difficult for a legitimate operator if you have a situation like you do in New York City where the city is very far behind in making the reimbursement payments. Sometimes that can be from 3 to 6 months. I grant you that the factors have been involved very deeply in fraudulent operations that we have uncovered in these eight clinics, but on the assumption that there are some doctors who are perfectly honest in the medicaid program and who need to have a source of funds, unless there is some other way to assure them that they are going to get reimbursed properly, I think you are penalizing them.

Senator Domenici. Are not factor lenders performing the service of lending, plus collecting bills?

Mr. Fiske. Yes.

Senator Domenici. Don't we have lending institutions that are licensed and regulated that perform the service of factoring as a part of a marketplace in the United States?

Mr. Fiske. Well, I am not sure, Senator, that absolutely prohibiting a particular type of lending arrangement is, in the end, going to be a desirable thing. It may well be that the factors should be investigated very carefully and people should take a hard look at their own operations which, I might say, is part of our investigation at the present time. At least as I see it, I am not sure——

Senator Domenici. What percent is the factor making of the medicaid dollar that we are paying, based on your investigation?

Mr. Fiske. About 12 percent.

Senator Domenici. So to the extent that the Federal dollar is supposed to go to help our poor people, of that portion which is factored, 12 percent is going to the factors, is that correct?

Mr. Fiske. Well, it comes out of what the doctor himself pays.

Senator Domenici. I understand that.

Mr. Fiske. Hopefully the doctor's charge for his service is a fair charge. In other words, the one that suffers is the doctor, not the patient.

Senator Domenici. Yes; but it also moves doctors in the direction of a mill instead of a clinic, to the extent that we have the 12 and the 10 and the 5 and the other things. They have become more like mills than professional doctors and we are moving them in that direction by these impositions, it seems to me.

Mr. FISKE. Let me make this statement, Senator, which I think there would be no disagreement with. If, for example, in the city of New York the city could make the payments on these claims promptly—let's say, within 30 days—there would not be any need for a factor or any other kind of lending institution at all. That is the heart of the problem.

Senator DOMENICI. Now you have testified here of the need for assisting you as the U.S. attorney and that HEW needs more attorneys—more investigative capacity. As a matter of fact, conceptually this program is supposed to be run by the respective States of this Nation; is that not correct?

Mr. FISKE. I think that is the concept.

Senator DOMENICI. I take it that you are telling us that the State of New York does little or nothing by way of criminal investigation or has little or no capacity to move against criminal fraud in New York.

NEW YORK SUFFERS FISCAL HANDICAP

Mr. FISKE. Well, the district attorney of New York County, Mr. Morganthau, is a very effective prosecutor, but I think he suffers from the same handicaps that we do in terms of having investigative resources. Just as a practical matter, as we sit here now and try to look at medicaid fraud in New York City, if we have to wait for New York City to come up with the funds to develop the staff of investigators, there is going to be no solution.

Senator DOMENICI. I take it that along with your recommendations you would certainly like us to do what we can to coerce the States into having an adequate investigative team and fraud-type capacity also, would you not?

Mr. FISKE. Yes, sir. I would say that when you talk about requiring the States to provide services. it is there that we believe that the computer profiles are the most important.

Senator DOMENICI. Would either of you give us your idea as to what portion of medicaid fraud, in your opinion, is actually detected, investigated, and prosecuted?

Mr. FISKE. That is an extremely difficult question to answer, Senator. I have read the figures in the committee's report with respect to medicaid fraud in New York and one of the problems is the definition of fraud as I described earlier. Our criminal prosecution and civil suits have been based on what I think you could call hard-core fraud, where we can show that invoices were submitted for no service rendered at all. We have not, to date, brought criminal prosecutions for those cases where services were in fact rendered, but the argument is made that services were unnecessary. So there is a gray area in terms of what you mean by fraud. I personally find it very difficult to put a percentage on quantity. I would say, however, that we are satisfied that the system, as I said before, is so loose and slipshod in its regulatory procedures that it literally encourages fraud.

Senator DOMENICI. Thank you, Mr. Chairman.

Senator MOSS. Thank you, Senator.

I wanted to ask a question. California has a rather novel idea. The medicaid cards carry stickers—this seemingly to limit their use.

Would something like this be effective if it were nationwide? They peel one of these stickers off when a person uses his medicaid card. When he has exhausted those stickers, he has to go back and get another card. I wonder if that is a worthwhile thing.

Mr. FISKE. Under the California procedure, is the sticker attached to the invoice when it is sent in for payment?

Senator Moss. Yes, it is.

Mr. FISKE. Yes, I think that would be.

Senator Moss. That would sort of cut down on the abuse on the part of a recurring patient.

PATIENT VERIFICATION OF INVOICE

Mr. FISKE. It is a little bit like the suggestion we made before, that the patient should be required himself to certify on the invoice when it is sent in that he in fact received the treatment. None of these things are going to totally eliminate fraud; there is always going to be somebody who is really determined to do it and will design a way around these systems but, to the extent that it becomes more and more difficult to commit fraud, the marginally fraudulent operators will, I think, find it is not worth it.

Senator Moss. Do you get any special supportive service out of the Department of Justice headquarters in this field of medicaid and medicare fraud?

Mr. FISKE. Only in the sense that they just have given us permission to hire two more assistant U.S. attorneys.

Senator Moss. I think Senator Domenici covered the question I was going to ask, too, as to the extent that the State and the city were involved in prosecution of this fraud. You indicate that they, too, are limited by manpower and, therefore, have not been able to do what they could do if they had the facilities.

Mr. FISKE. That is correct.

Senator Moss. I take it also from your testimony that you are determined to seek prison sentences in cases of fraud rather than settling for just restitution and probation.

Mr. FISKE. We are doing both, Senator. We are requiring anybody that we have convicted to not only pay back the amount of the Federal money which he fraudulently obtained under medicaid, but to pay double the amount plus, in addition to that, a further amount which we look upon as sort of reimbursement between the Federal Government for the cost of conducting the investigation in the first place. In addition to those double penalties on the civil side, we are making it clear to the courts that we think prison sentences are the only effective deterrent to this kind of thing in the future.

Senator Moss. Counsel has a question.

Mr. HALAMANDARIS. I would like to direct this question to Mr. Wilson and then, Mr. Fiske, you might want to comment as well.

The question relates to the False Claims Act which permits recovery by the fact that the case may be brought by an individual. The provisions of the statute allow for a 10-percent bounty so that, if there is a conviction, the recovery of funds is paid to the individual

initiating suit. Suggestion has been made to authorize the States to act as persons under the False Claims Act for the very limited purpose of bringing medicaid fraud cases. I saw the quizzical look on your face.

Mr. FISKE. That was on my face, too.

Mr. HALAMANDARIS. The question I have is, do you think this would be helpful to allow the States, in effect, greater incentive to make fraud cases?

Mr. FISKE. Let me answer that first, if George does not mind, because it seems to me there is no reason why we should have to offer the State, which is already a victim of this fraud, some premium for doing a job that it should be doing in the first place.

Mr. HALAMANDARIS. George, do you have a comment?

BOUNTY FOR INFORMATION?

Mr. WILSON. I agree with that. The State is already getting money theoretically from HEW to pay for the cost of administering the medicaid program. I think, however, it is a good idea to publicize this type of thing and let the citizens off the street—turn them loose. I think if the citizens knew they could make a couple of bucks, we would have a lot more work.

Mr. FISKE. I think we both would endorse the concept of a 10-percent payment to a private citizen who comes forward with information that leads to a successful prosecution and the return of the money.

Mr. HALAMANDARIS. I marvel that you have been able to do so much with all the obstacles in front of you. You had to go to the city and get the computer tapes and go to Fort Monmouth and have them develop patient profiles. The question arises, why can't the city do what you did? Why can't the State of New York develop this? All that is involved is taking computer tapes over to Fort Monmouth and running profiles. Why hasn't the city or State done that?

Mr. FISKE. As to the city, I think the problem is their fiscal situation, and I fully recognize that the argument can be made that one of the reasons the city is in the fiscal straits it is is because of the situations just like this. A penny saved might well be a penny earned, in terms of resources devoted to that kind of computer technology. Up until now the problem we face with the city has always been one of insufficient funds on their part to do this kind of work. I think the State is looking to the city. It is a dead end.

Mr. HALAMANDARIS. I wanted to ask if the additions of the Ryerson Street warehouse in Brooklyn, where all these invoices are stacked up in boxes, has inhibited your prosecution in any case. In any prosecutions you have had, what kind of difficulty do you have in retrieving the original bills?

Mr. WILSON. It took us, I guess, a good part of the year just standing dead in the water getting invoices. After we went through the warehouse we still came up, in my judgment, about 20-percent short. We would pick up a good case on the computer run, our computer profile, where the treatment was given, and we would not be able to

proceed on that because we would have no invoice. It extremely frustrated some of the people getting the case ready to present to the grand jury. We ended up with many less counts than we wanted to because we didn't have the original invoice; it could not be found. That was the one thing that hampered us the most, next to, of course, the lack of some profile in the first instance.

Senator Moss. Well, thank you very much, Mr. Wilson and Mr. Fiske, for your testimony and for your great cooperation. As I indicated in the beginning, you have given us every courtesy and help as we have tried to find out what was going on and as we try to determine what, if anything, we need to do at the Federal level legislatively. We are wrestling with that problem now and you have been a great help to us. We wish you well in your prosecutions, because certain and severe prosecutions certainly should have a great deterrent effect on the abuses that we have been able to outline here.

Thank you very much.

Mr. FISKE. Thank you, sir.

Mr. WILSON. Thank you.

Senator Moss. We will now call Dr. Ingber and Dr. Styles, and they are accompanied by their attorney, Mr. Sidney Sparrow.

STATEMENT OF SIDNEY SPARROW, ATTORNEY FOR DR. JOSEPH INGBER AND DR. SHELDON STYLES, NEW YORK CITY

Mr. SPARROW. I will speak for both of the doctors in a brief preliminary statement.

Senator Moss. All right.

Mr. SPARROW. I would just like to introduce to the committee Dr. Joseph Ingber on my right and Dr. Sheldon Styles, and indicate to you that each of them has been a practicing chiropractor in the city of New York.

I should like you to know at this point that neither of these doctors has, for approximately 5 years, written, prescribed or, in any other fashion, worked under the medicaid program. They existed way back then when it was made necessary that they do so.

I should also like you all to know that after their indictment and during the course of the investigation which ultimately resulted in pleas of guilty on the part of both of them, after conference with Mr. Wilson and the staff, each of these two doctors decided that they were going to cooperate with the Government.

I am sure you are familiar with the fact that most Government criminal prosecutions depend in great measure upon the cooperation of one or another of the conspirators or other persons who might have been involved. They were asked to give 100 percent cooperation; they gave that in full, plus more.

By that I mean very simply—and I speak now particularly for Dr. Ingber whom I represented in these proceedings—in addition to giving information concerning that with which he had personally become involved and those persons with whom he had dealt, he went far afield in every way that he could to make amends. He knew of instances that might possibly lead the Government in its search.

Testimony Valuable

When I heard Mr. Fiske speaking a while ago about the need for computers and Mr. Wilson's comment about a bit of luck in finding something or getting the lead on somebody who was defrauding the Government, I think perhaps part of that luck was to have Dr. Ingber and Dr. Styles available. By their actions, not only did they save the Government enormous amounts of time and effort and money, but they also helped to unearth some of the loopholes which they became aware of and which they, in turn, conveyed to the Government.

Of course, I presume the committee must be aware at this point that, although they operated in their fraudulent manner, they make no bones about the fact that they did so. That was at a period 5 years ago when the atmosphere throughout the city of New York, insofar as it pertained to this particular type of activity, was almost so permissive it was an inducement or invitation to get involved.

Since then, of course—5 years later—there is a considerable difference, perhaps because of the fact that there have been some more affluent and perhaps more capable persons—some of whom have achieved some publicity and headlines and gotten their ultimate comeuppance—but does not compare in a measure to that which has happened to these two doctors. By reason of that we have a different atmosphere now.

I suggest to you one particular thing that each of these two doctors would like you to know, and that is that, although there are many, many facets of fraud which all of these clinics and those engaged in medicaid fraud have been resorted to, the Government in its own report to the sentencing judge indicated that neither of these defendants did at any time mistreat or ill-treat a patient. There is no question that they were involved in defrauding the Government.

Now they are down here voluntarily. They are not here to plead for themselves; they are here because they are concerned about a system which is so bad that it actually invites disaster.

The program of medicaid is obviously a very fine one; it is one which should do our citizenry a lot of good if properly administered and properly handled. I don't think Drs. Ingber or Styles are concerned right now with that which was said here a little while ago, about violators and ferreting out violators with computers to get at who was commiting crime and prosecute them.

I think it is far more important to this country that these funds be utilized for the benefit of the people they were intended, and to do what it would seem to be in order to seek to administer the program in a better fashion.

The two doctors are here intending to be as cooperative as they possibly can and to give you whatever information they can and whatever assistance they can to help locate those things which bring on this type of fraud, and to help eliminate it, if possible, so that ultimately the funds that the Government does provide will be appropriately utilized for the benefit of those who are sick and in need of care.

Senator Moss. Thank you, Mr. Sparrow. I appreciate what you have said and I confirm that the two doctors are here with our invitation and we appreciate your coming.

Maybe we could start with Dr. Ingber and ask you—how did you get into the situation that caused you to be prosecuted criminally?

STATEMENT OF DR. JOSEPH INGBER, CHIROPRACTOR, NEW YORK CITY

Dr. INGBER. Well, one step at a time, actually, Senator. The medicaid program was made known to us in late 1968 and early 1969, and I began in my own private practice to see some medicaid patients. At that time medicaid fees were $3 for a visit and it was a rationale for me, and many other people, to feel very cheated by the Government.

Here we were asked to provide a service and, at the same time, we were being paid less than 50 percent of what we were asked to receive from a private patient. This is almost a formula.

If you want to set up a system that is going to be corrupt, start out by underpaying the practitioners. At the same time make it very easy for them to cheat; don't put in any safeguards, and turn your back on the whole thing and walk away from it.

The way the system is set up, Senator—what you are trying to do is put your finger in the dike with these programs of stamps and, perhaps, stickers. The whole system is impossible. You can jury-rig it to make it a little tougher, but the way to stop it is not to make it more profitable for doctors to see patients more times. The way to stop it is to have a system much like GHI by which doctors are paid for the number of patients they treat in a year's time and doctors are paid on a salary basis.

As long as you pay people on a per-visit basis and then take away much of their income in factoring—much of their income by low fees—doctors are going to justify what they do to themselves. They are going to start out writing in an extra visit here and there and gradually, when they see nothing happens when they do it, they will do it more and more.

"SYSTEM ENCOURAGES WRONGDOING"

So the system of paying for visits is wrong, and the more you become vested in that system by which you are going to pay doctors for writing more visits, in a sense you are encouraging this kind of thing. You have to stop it from that end; it is backwards.

Senator MOSS. Did you start by simply opening your practice and having some medicaid patients, then, feeling that the payment by visit and the amount per visit was so small, you got into the problem? Is that what you are telling me?

Dr. INGBER. That is how it started, and we heard it was going on not only in our profession but in every one of the medical and paramedical professions—that doctors were writing down extra visits here and there, and there was no problem with it. The worst thing that would happen would be that the city might disallow a percentage of your visits.

In fact, the city of New York set up a system that was in a way saying "Yes; that is OK, guys," because they had a disallowance

number that was called the administrative decision which was just gobbledegook and meant "We know you are overbilling and we are going to cut you back."

Some doctors had an administrative decision cut 10 percent, 5 percent. I knew doctors that were as high as 25 to 30 percent in disallowances. If they would put in, let's say, $1,000 a week in invoices, they knew that 25 or 30 percent of that—$250 to $300 a week—would be almost automatically taken off the top by the city for administration.

It became a game between the doctor and the city:

I will overbill extra visits; you take them off, and we will play back and forth. If we put in too many, you call us down and we will pay you back $5,000 or $10,000 and we know that will be all that is done.

The city documented this in the newspapers time and time again. The doctor pays back $20,000 to the city of New York as if it were a victory when, in a sense, they were telling us this is how you play this game.

Senator Moss. Was this very widespread then in New York among all doctors and of all different specialties?

Dr. INGBER. I would say that it varied from doctor to doctor. Some doctors were maybe 99 percent honest and maybe others 1 percent honest, with all ranges in between. I don't know what every doctor did, but I know what I heard and I know what I saw.

Senator Moss. You heard us talk about ping-ponging. Is that a common practice also, to ping-pong patients around to different practitioners?

Dr. INGBER. This is one of the gray areas that is spoken about, Senator Moss. It is true that every black child should get first a blood test, and second for sickle cell. It is also true that the motivation of doctors in doing that was not always for the child's benefit, but usually for their own benefit.

"PING-PONGING" JUSTIFIED?

It may be true that some doctors were motivated by both financial gain and health. It is impossible to know why anybody does it, but a lot of the tests and a lot of the so-called ping-ponging was because these were people that had never had, in 1968 or 1969, any proper examinations before. They had never had an optometrist check their eyes; they had never had their teeth checked by a dentist or feet checked or their back checked. Therefore, it is an area that any doctor could rationalize and justify sending them to any doctor and, at the same time, his motive might be totally mercenary, and then again it might not.

Mr. HALAMANDARIS. Let me interject.

Senator Moss. Yes.

Mr. HALAMANDARIS. We talked a bit last night and we asked the question, Dr. Ingber, how many clinics are ping-ponging and conducting other abuses? What was your response?

Dr. INGBER. Every center that I knew about in the city of New York made sure that there was as much utilization as possible.

Mr. HALAMANDARIS. That is what I wanted you to say.

Senator Moss. Well, how prevalent is factoring as a means of payment for invoices?

Dr. INGBER. I would say that except for the very wealthy doctors who go into it, it is almost universal. It is done because—if a medical center, let's say, puts in an eye doctor and waits until he gets paid to get its rent, or puts in a podiatrist and chiropractor and all the medical specialists, and if the medical center owners wait to get paid until the city pays them, they would go out of business. Therefore, they insist that the doctor pay on each group of invoices as they go into the city.

Therefore, the doctor has no way of paying $3,000 or $2,000 up front waiting until the city reimburses him, because each week he would be getting deeper and deeper in debt. He must go to a factor or else he cannot work in the medical center.

Senator Moss. What is the group going rate?

Dr. INGBER. I think 10 percent up to 12 percent.

Senator Moss. That would be regardless of what length of time it took the factor to collect, whether he had 2 months, 3 months, or 6 months?

Dr. INGBER. That is a good point, Senator, because it brings out the point that that comes out if the city paid in 4 months. In a sense, the center would be making three times as much—or 36 percent.

Excuse me, Senator; may I make one other point to that?

Senator Moss. Sure, go ahead.

Dr. INGBER. The fact that 12 percent came off the top to a factor made many doctors try to recoup that 12 percent and, therefore, write extra paper and write extra visits because they knew that if they were giving an honest accounting of their billing, they were losing another 12 percent off the top. Therefore, there may be many cases they would make it 12 percent.

Senator Moss. You think that was an inducement also to cheat the system?

"AN INDUCEMENT TO CHEAT"

Dr. INGBER. Yes; I think factoring is an inducement to cheat the system.

Senator Moss. What is the cost of setting up one of these medicaid centers or clinics?

Dr. INGBER. I knew centers that went as high as $150,000 to set up and I knew centers that were set up for a matter of $5,000, depending on the amount of the equipment—the kind of facade that was built on the street and what they did and how they did it.

Senator Moss. Was this usually done by businessmen or done by doctors themselves?

Dr. INGBER. Initially I think it was done mostly by doctors, but as businessmen became aware of how profitable medicaid centers could be, real estate men and businessmen would come to doctors that they knew and say, "Let us get into this. How can we get into this? How can we get involved?"

So I think at this point there were a lot of businessmen coming in. As far as our centers were concerned, most of them were not the very expensive centers, except where we went into someone else's center.

Senator Moss. But did it turn out to be a very lucrative thing, setting up these centers?

Dr. INGBER. It did for some people. It depends on where you set up a center. For example, if you went into the heart of a ghetto neighborhood, you were pretty sure of a very busy office, but if you went into the marginal areas where there were not a large number of welfare patients, you would find that you had a marginal operation and in order to survive you would have to overbill.

This is another point that I wanted to bring up to the committee, and that is that there should be some sort of criteria or guideline set up for how many medical centers can be set up in a given population. It should not be allowed that 1,000 medical centers can be set up in a community, because most of them won't have enough actual patient load to survive; they will be encouraged to overbill just to survive.

Two or three of our centers would never have survived even for a few months without overbilling. In fact, one of our centers, even though we did overbill, was forced to close within a few months. There has got to be some proportion of centers to population, or else a group of centers will flood an area and most of them will overbill.

Senator Moss. Dr. Styles, we don't want to leave you out. If you concur generally, will you tell me, as to what Dr. Ingber has said about how you get into it—why the system was abused?

STATEMENT OF DR. SHELDON STYLES, CHIROPRACTOR, NEW YORK CITY

Dr. STYLES. Since we were together I think he has put it succinctly.

Senator Moss. Do you know of doctors who essentially sell their licenses, allowing others to bill in their name for a percentage of return?

Dr. STYLES. I have known two such doctors.

Senator Moss. You know two who do that?

Dr. STYLES. Yes.

Senator Moss. Do you know a Dr. Hugh?

Dr. STYLES. Yes, Senator.

Senator Moss. Is he one of those involved?

Dr. STYLES. Yes; but not knowingly.

Senator Moss. Do you know what percentage of his billings were false billings?

Dr. STYLES. A large majority of them, Senator. I don't know what percentage.

Senator Moss. But a majority?

Dr. STYLES. Yes.

Senator Moss. Was there a kickback arrangement in your center with a pharmacy or a clinic that you sent your work to?

Dr. STYLES. Concerning the drugs prescribed?

Senator Moss. Yes: drugs prescribed or places where procedures were done on blood—clinics of that sort.

Dr. STYLES. We received a payment from a laboratory based upon the percentage of income somewhere between 20 and 25 percent of the amount that they billed medicaid.

Senator Moss. About 20 or 25 percent?

Dr. STYLES. Approximately so; yes, sir.

Senator MOSS. Now on these problems of extra billing, how did you work them out? Were they just at random or did you have a regular system of checking off extra services?

BILLING DONE AT RANDOM

Dr. STYLES. Each doctor will have billed—many medical doctors billed on their own. Chiropractors had assistants and secretaries, and each doctor billed differently, but I imagine much of it was done at random—pulling names out.

Senator MOSS. And it would depend really on what, the financial condition, how urgent it was to get the extra billings? Has that increased the number?

Dr. STYLES. In the cases that I recall the doctor is dissatisfied with the amounts of money he was making. He knew that other doctors could go to the file, pull out the names, and write new invoices on these patients, and he might be encouraged to do the same thing.

Senator MOSS. Was it your observation that this was widespread through all of these medicaid centers? Was it being done rather universally?

Dr. STYLES. Yes, sir, it is.

Senator MOSS. Do you think it is still continuing today, or has it changed?

Dr. STYLES. From what I read in the paper, I would say that it is continuing today.

Senator MOSS. Do the doctors ever trade patients? Do you trade patients?

Dr. INGBER. In those days it was very common for one doctor to finish billing a patient, and another doctor would begin to bill that same patient.

Senator MOSS. I see. Do doctors have a practice of training new physicians that are coming into the facility—to show them the ropes and how to go?

Dr. INGBER. Senator, the atmosphere is such that they pick it up very quickly without saying anything directly. It was very seldom that anybody was told what to do. They just came into the center and looked around and began to follow, or moved on if they didn't like what was going on.

Senator MOSS. Do you think it is possible for a strictly legitimate medical center to survive, or does it have to have these extra billings to get by?

Dr. INGBER. If the fees are fair and if the number of centers are limited to those which are really needed, if those centers which are really needed are licensed and regulated, if they have, perhaps, a city employee on the premises—which might sound expensive, but it is really very cheap—and if they have one city employee at the front desk in every medical center, you would save that salary over 100 times.

Senator MOSS. What is your observation as to the quality of medical care that is given at the centers? Is it adequate, inadequate, or superior?

Dr. INGBER. It varied from superior to inadequate, depending on the individual doctors. There were residents who would come in to put in one session a week, if they could, who gave super care. There were men who wanted to earn a few extra dollars who were very conscientious and gave excellent care.

There were other marginal practitioners who could not make it in their own private practices who gave a fair level of care. Then I would say that there were a few people who didn't give a damn.

I think mostly you have to make a distinction in these medicaid centers from the nursing home industry, because in the medicaid centers patients did languish and die. In medicaid centers the Federal Government and city and State all got ripped off financially, and that is where the crime was, but the crime was not in hurting people. That may have happened to a certain extent as it may happen in any private doctor's practice—maybe even a little more—but certainly not to the extent that it happened in the nursing home industry.

Senator Moss. Well, your suggestion that a number of centers be limited and placed strategically in the population mix poses a difficult problem if we are going to have free practice of medicine.

Dr. INGBER. May I answer that one, Senator?

Senator Moss. Yes, please.

Dr. INGBER. Free practice of medicine by one professional or two or three professionals of one particular profession could be unlimited, but when you have multiprofessional centers, when you cross the line—in other words, where you have podiatry, chiropracting, dentistry, and gynecology—and you go on to more than one profession there, I think you can limit the number of those facilities.

Also, sir, you could have free and unlimited practice of profession for those people who do not do more than a certain percentage of medicaid practice, but when a center is considered a primary medicaid facility, those centers could be numbered.

Senator Moss. Now upon your conviction, did you have to give up the practice or are you—have you been able to practice?

Dr. INGBER. I am going before a board in my profession.

Senator Moss. You are going before a board?

Dr. INGBER. I have to go before a professional board, sir.

Senator Moss. Is that true of you, too?

Dr. STYLES. I gave up my practice at the time of the investigation.

Senator Moss. I see.

Mr. SPARROW. May I, for a moment, address you, Senator?

Senator Moss. Yes.

Mr. SPARROW. Appropos the taking of license and Dr. Ingber's comment that he intends to go before a board, I might just mention that the penalties and the punishment that have come to them as a result of the prosecution in this particular case have been vastly larger and greater and more harmful than anyone could ever have anticipated. In addition to civil penalties to which Mr. Wilson and Mr. Fiske alluded earlier there has been, of course, a constant exposure to the publicity involved with the fraud and their part of it. Then, of course, the indicated incarceration which has already been

imposed upon each of these two doctors and whether that would be meant as a deterrent is not before this forum at this time.

"Cooperation . . . May Be Deterrent"

However, the question of whether or not cooperation on the part of persons similarly situated to Dr. Styles and Dr. Ingber will act as a deterrent and their cooperation in an effort to unearth and ferret out any other persons may act as a deterrent, I think, is also something that merits some consideration.

So there should be some opportunity for persons who come forward at this point, those who have committed acts in the past—perhaps they may be able to help this committee eliminate some of what has been happening and get on the right track, as it were.

Senator Moss. Other than the recommendation that we limit the number of places and have an inspector there, do you have any opinion as to the bill that Senator Talmadge is proposing of having a Federal Inspector General to oversee giving medicaid? Do you think that will have any effect? Would that be a good thing or not?

Dr. Ingber. Sir, it depends on the expertise of the individuals who do the actual checking. If you have people coming around who are not knowledgeable and easily fooled, they are not going to have any real, lasting, or even a temporary effect except for sprucing up for an investigation.

You have got to have a permanent committee with permanent experts who are in the field and who you know will be around in the future to have any deterrent effect.

Senator Moss. And you don't think any deterrent effect is really being exercised yet, despite some of these prosecutions?

Dr. Ingber. Well, the enormous disparity in punishment shows that a process is at work; that is, when the spotlight comes on it is extreme punishment to show that everybody is doing their job.

When the spotlight goes off, everybody knows that it is business as usual and they can go back and do it. Before the spotlight came on Dr. Styles and myself, people were getting suspended sentences, light fines, pay back the money, or pay back half the money.

Without any rancor I have to say that I think Dr. Styles and I have taken the weight for the entire profession and we feel very much that when the spotlight goes off and you gentlemen have concluded your work, unless there are permanent committees and permanent safeguards set up now that we have taken our punishment, now that we have been the heavies, everybody else knows that it is cool again.

Senator Moss. So you think temporarily there is a repentance but that it won't last.

Dr. Ingber. Everybody will be careful for a month or two.

Senator Moss. All right. Counsel has a question.

Mr. Halamandaris. I had the benefit of talking with you gentlemen last night so if you don't mind I want to go back over things a little bit. Let's talk about how you got into this thing. I want you to tell me exactly what happened. Did you get an idea to open a mill as you were walking down the street? Give us all the specifics.

Dr. INGBER. We knew there was a doctor in a community near us who was running a very successful medicaid center and Dr. Styles went over there when we were making a patient referral. We were looking for a psychiatrist for our own private practice to see one of our patients.

FRIENDSHIP LEADS TO PARTNERSHIP

Dr. Styles went into this facility and he saw that it was a very successful operation and, over a period of time, developed a relationship with this man. When the man was going to open another clinic Dr. Styles was asked to come in as a partner.

Subsequently I came in; several other people came in. The original man did not. We had our first center and we opened it for about $8,000. We started searching around for doctors and then we found that there was a community of doctors that worked in these centers and many of them were foreign born doctors, many of them were beginning doctors, many of them were not totally successful—men who needed to make a few extra dollars.

Once we got into the first office which was in Corona, Queens, we found that initially the business was very profitable and we could make a percentage of everybody's income.

Mr. HALAMANDARIS. Tell us what you mean by "very profitable," and give us a breakdown of the first clinic you had, the number of people you had working for you and the percentages you were getting from them.

Dr. INGBER. Now you are going back about 8 years, so my memory may not be exact.

Mr. HALAMANDARIS. Take a more recent example.

Dr. INGBER. The percentages varied from 8 percent of an optometrist's income, 25 percent of a general practitioner's income, 30 percent, perhaps, of a medical specialist's income, 35 to 40 percent of a podiatrist's income, and as high as 50 percent of a chiropractor's income.

These did not come personally into my pocket but they came into the corporate covers and we used to pay bills and expenses, and then dividends were declared and income tax was paid on that.

Mr. HALAMANDARIS. Then after you had the fees that were exacted, who got the 25 and the 50 percent? Let's take the case where 25 percent to 75.

Dr. INGBER. The practitioner got 75 and 25 was written out to the medical center.

Mr. HALAMANDARIS. What happened after all the bills were paid off and you had some money left over? How was that divided?

Dr. INGBER. Among the stockholders of the operation.

Mr. HALAMANDARIS. Who were the stockholders?

Dr. INGBER. Different corporations had different stockholders. There were corporations that had three or four and some that had five or six. I may have been as low as the 10 percent stockholder in one corporation and as high as a 24 percent stockholder in another.

Mr. HALAMANDARIS. What kind of money are we talking about? An average mill ran eight at one time.

Dr. INGBER. We ran eight at different times. We never ran more than four at a time.

Mr. HALAMANDARIS. Give me the top figure.

Dr. INGBER. I have to say that I wish I could give you—you seem to be looking for big numbers.

Mr. HALAMANDARIS. I will take little ones.

"EIGHT CENTERS GROSSED $2 MILLION"

Dr. INGBER. We were not very good at what we did. There are men better than we are that are still doing it. I would say that the gross of the centers over a 3-year period—the eight centers grossed about $2 million. If you divide eight centers over 3 years, you divide $2 million by 24 and then divide that by 150 doctors, you will know what we got.

My personal billing that was judged to be false billing was $35,000 over 3 years. That is what I am paying penalties on and I have agreed to pay $100,000 back to the Government on false billings of $35,000.

Mr. HALAMANDARIS. When did you write your first phony billing and what motivated you to do it?

Dr. INGBER. I wrote my first extra billing—phony billing—in late 1968 or early 1969, and it was based on the fact that I felt that I needed to put down an extra billing because I could not make it on $3 a visit. At the same time I felt that nothing was going to happen if I did it.

Mr. HALAMANDARIS. So you were not surprised that the State and city didn't catch you at this cheating?

Dr. INGBER. No, I was not surprised because I heard of cases all the time where people were writing extra billings.

Mr. HALAMANDARIS. You said the city caught one doctor and the city gave a slight slap on the wrist.

Dr. INGBER. One doctor billed $10,000 for the members of 10 families and the city called him down and said, hey, look, you have got to keep the families down. We were called in and we were told that we are not allowed to bill more than two children in one family.

The city told us, don't you bill more than two children in one family. We were forced to pay back a few hundred dollars and we paid back a few hundred dollars.

I said, "What happens if three children in the family are sick?" In a sense they were telling us: It is all right to write false billing for two children, but don't make us look bad. Write up those eight children from four families; spread it out, guys.

Mr. HALAMANDARIS. You said entirely profitable. Give the Senator some indication of how profitable.

Dr. INGBER. As I said, I know it was most profitable for internists and pediatricians to write $100,000 a year in their own name very easily because their fees were higher.

Most of the chiropractors didn't write anything like that, maybe $20,000 or $25,000 medicaid invoices a year. The men who made the most profit out of medicaid were the very busy internists who would

very commonly see the patients on one day, write them up, and then write them up for a followup visit.

Mr. HALAMANDARIS. Where should I go to find cheating medicaid mills in New York?

Dr. INGBER. I think you should go to the centers that are in borderline areas that are not in the heart of the ghettos, because those centers are actually very busy.

The centers on the borderline—the centers in changing areas that show very large billings—are the centers where a lot of overbilling takes place. Centers run by businessmen rather than by doctors.

COALITION SUGGESTED

I also would say that if you really want to find the fraud in medicaid, you should set up a coalition with people who have been in it who know where the fraud is and who know people who know people.

There is a network. If I were to start out saying who I know and who they know and who they know, you could get through 80 percent of the people. Everybody knows everybody in the business.

So if we were to sit down and go over names and dates and places, there would be indications of who knows what.

Mr. HALAMANDARIS. Everybody knows everybody, a small group of people gets all the money. What you told us a while ago in answer to my first question is that everyone is cheating.

Dr. INGBER. Everybody is bragging about it, too.

Senator Moss. Well, we appreciate having you come and be candid with us about what has gone on and is still going on, unfortunately, and it poses a problem that is not confined to New York or any single community. It is a problem in this whole Nation, not only the cheating and the monetary scandal, but the sort of haphazard service that is given in some of these places. You have told me some was good and some was very poor. Unfortunately, the ones I had personal contact with, I would say, are very poor.

In your centers, did you give care to medicare as well as medicaid patients? Did you have patients under medicare?

Dr. INGBER. Dr. Styles can answer better than I.

Dr. STYLES. We did a minimum amount of medicare, and doctors usually charged that because that was billed through their offices.

I did want to say one thing. I always felt while this was going on, especially now that I read the figures on the list of those doctors who have collected $100,000, $200,000, et cetera, that Master Charge imposes a limit—and I could not understand why—at a level of, say, $25.000 for a busy internist. He would not have to come in to seek a higher level.

I don't know if it could be arranged, but I think it would be valuable that no one could pass $25.000, $50.000, or $75.000, without his funds being frozen at that point unless he sought the necessary permit to continue at higher levels.

Senator Moss. That is a good point to make.

Is your procedure in billing medicare different from billing medicaid? What is the difference between the two?

Dr. STYLES. Medicare was very little of it, and it required a different form submitted through, generally, Blue Cross and Blue Shield. The doctor submitted it and usually when it got paid, they paid their rent. That was a very small amount of work that we handled.

Senator MOSS. But was there any difference as to how you could proceed with a false billing as readily on medicare as you would on medicaid?

Dr. STYLES. No, sir, we did not. It was strictly held back to what the actual need of the patient was.

Senator MOSS. I see.

PATIENT RECEIVES NO COPY OF BILLING

Dr. INGBER. One more point on that, sir. I think on medicare the patient gets a copy of the doctor's billing and in medicaid they don't.

Dr. STYLES. And a percentage of the fee.

Dr. INGBER. So this is another valid point. If a patient were to get a copy of what they had been billed by a particular center and the patient saw outrageous charges for services not given by doctors never seen, these patients would run, because there is almost an adversary relationship in some of these areas with some of these centers.

The patients don't feel that they are getting a fair deal just as you didn't feel you got a fair deal when you walked in.

Senator MOSS. We have had some suggestion that there may have been arson committed in some of these less profitable centers. Are you aware of anything like that going on?

Dr. INGBER. Just what I read in the newspaper.

Mr. HALAMANDARIS. You have no direct knowledge of anyone committing arson to collect insurance?

Dr. INGBER. As I said, my first indication was reading in the newspapers. I read someone had burned down one of their medicaid centers to avoid prosecution or to destroy records or something like that. As I said, I never spoke to the person or anything like that. I just read it and I was aware of it.

Senator MOSS. Just heresay.

Mr. SPARROW. I might mention to you, Senator Moss, that Dr. Ingber today is in a somewhat different position than he was as a medicaid provider. He has in his intervening years done many other things and, as a matter of fact, until such time as he does start serving his sentence he will continue to act as a volunteer provider under a different type of situation.

He is working as a nonpaid counselor at a methadone maintenance clinic and has met many persons who have been or presently still are addicts. He has sought in every way he can to compensate society for whatever it is that he has done, and he would like this committee to know that if there is any fashion in which he and Dr. Styles as well can give assistance in the future, they would like you to know that they can be reached and called upon at any time to provide such assistance.

Senator MOSS. Thank you.

Could you tell me about this methadone use that passes through these centers? How does that work?

Dr. INGBER. Sir, methadone centers are a separate entity and they are licensed by the city in a separate manner; medicaid centers are not licensed by the city.

These centers are totally regulated and they are followed up in a much closer way. The procedures and rules that are followed in the methadone centers, many of them should be applied to the centers because the methadone centers are computer billed—printouts are run by computer. The billing is much more closely supervised than it is in medicaid centers.

METHADONE PROGRAM CLOSELY MONITORED

Medicaid centers are a very loose helter-skelter operation. Methadone centers are monitored by the city—the amount of methadone is calculated each day. It is a different procedure.

Men may have made profits on methadone centers, but at least the work and services are being given. In my opinion, anyway, they serve a valuable service. If you see some of the exaddicts in the centers now, off the street, not doing the crimes they were doing to get heroin, what they are doing in methadone centers—getting on programs, rehabilitation—it is a very good situation, in my opinion.

Mr. SPARROW. Unfortunately, I cannot agree with that. Totally different abuses do arise out of some of the methadone centers. Of course, there is the obtaining of methadone for retail. There are many other things that do transpire in connection with them, but that is not actually, I think, a subject matter of this committee's investigation.

Senator MOSS. That is true. We were not on that; we are just trying to talk about medicaid. I thought the two were intertied in some way and I wanted to find out if they were.

Mr. SPARROW. No, sir.

Dr. INGBER. No, sir, they are not.

Mr. SPARROW. Dr. Ingber, directly or indirectly in his profession or paraprofession, suggests, shows, and helps those persons who need his assistance.

Senator MOSS. The Senator from Illinois, Senator Percy, has joined us and I will ask him if he has any questions of the two witnesses, Dr. Ingber and Dr. Styles, who are before us and are represented by Mr. Sparrow.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. I had a medical problem in the family. My son had his arm set at the Orthopedic Hospital so I was not here at the beginning of your testimony.

If any of my questions are repetitious, I can just look back over the record.

I wonder if you have commented on the diligence with which HEW follows up to see whether or not there is a prudent followup in surveillance of these programs or whether we need an internal audit in the Department—in our parlance, an Inspector General. Is that a contributing factor with which you can carry on these abuses?

Is that a factor we have to take into account in reorganizing and working with the administration and reorganizing and restructuring their Department?

Mr. SPARROW. Senator Percy, before you arrived there was considerable comment about the fact that the medicaid program was a very permissive one. It actually was, as Dr. Ingber just said, a helter-skelter situation where in each instance it multiplied itself.

If you had a factor who was taking 12 percent off the top, you just write out an order and billed additionally in order to compensate for that 12 percent.

If you were followed by the city you could not bill for more than two children in one family; you then billed two children in two fictitious families to make up for the fact that you actually have to treat more than two in one family. You were invited, as it were, to play the game in that fashion.

There has been a total lack of supervision. There has been an indication where the supervision of the doctors and clinics have gotten the impression that, well, this is the way it is done. If you want to take your share of it, just jump right in and help yourself.

Senator PERCY. Those are the rules of the game. I think you made a comment this morning, something along the line that the heat is on now but when the lights go off it will just start all over again.

REPEATED INVESTIGATIONS NEEDED

Could you expand on that a little bit as to what you mean? I think we are very concerned when we have a hearing, as we had in the nursing home some years ago. We went back, audited, and we found that all of the regulations that had been implemented were not being taken seriously because they thought that it was going to be just a one-shot deal, and that was it. But we have gone back time and time again.

Every time we go back we notice the industry really knows that we are serious and we intend to do something about it. In this case what do you mean by, "when the lights are turned off," that the old practices will go back? Do you lack confidence that you are able to tighten up the system sufficiently?

Dr. INGBER. Well, Senator Percy, if the system itself is inherently encouraging overbilling by each visit the doctor gives, the doctor will look for justification and rationalization to ping-pong patients to other doctors. He will find rationalization in the gray areas.

The only way to stop the system is to not try to shore up a weak foundation—it is to start over. This system stinks. You are going to try to fix a lousy system.

I listen to these law enforcement people about how they are going to tighten it up with millions of dollars worth of computerization. That is a farce, because they will stay up night and day and they will not. They will tighten it up for a while, and spring a leak somewhere else.

I think it was Mr. Fiske who said people always look for loopholes. Design a system that does not have the same type of loopholes. Make it sophisticated. If you made a mistake, admit it, instead of saying these guys are all crooks.

Yes, we took advantage of a lousy system and one that had turned its back and said go ahead and do what you want.

The only way is not to pay for the number of visits but the number of people. No doctor will encourage extra visits because he is not getting paid by the visit, he is getting paid by the number of patients in a given community in a given period of time.

Senator PERCY. How is that different than the private practice?

Dr. INGBER. Sir, GHI——

Senator PERCY. If a doctor is willing to work 10 or 12 hours, he makes more money than a doctor who works 4 hours a day. He gets paid for the number of patients he sees. But somehow in the private sector there seems to be a different attitude. I have never seen this kind of attitude, shove them in and shove them out—put them on an assembly line. When I look back and think about the inordinant amount of time that the doctors consulted, just to decide what to do to my son's arm this morning, it's a different attitude altogether.

There was the time they took explaining to him what was wrong. When I think of the testimony we had yesterday and the way people were treated, and the only difference was that one is private pay and one is Government pay. Why this difference then? Is it a different kind of people that are on medicaid?

How many patients, for instance, were you able to see a day, or did you try to see, when you were running the mill?

"BEST CARE AVAILABLE"

Dr. INGBER. Sir, I would like to answer the first part of your question first and that is that, yes, your son got probably the best care available in the country, and maybe in the world, but when you see the size of those bills you are not going to pay them out of your pocket. They are going to be paid by medical insurance and those bills are going to be held.

Senator PERCY. But we pay the medical insurance. The insurance costs go up when the cost goes up.

Dr. INGBER. In many cases in the private sector a doctor walking through a hospital saying hello, how are you today to 25 or 30 private patients in a hospital bills every one of those patients $25 or $15 for that hello. This is in the private sector.

Maybe you will be investigating 5 years from now what is being done in the private sector with the major medical insurance companies—what kind of fraud is going on in major medical insurance.

Senator PERCY. Let me ask you about the insurance companies then, because they are the payer in this case; the Federal Government and the States are the payers in the other case.

Do the insurance companies have a system of checking up? Do they somehow have better surveillance or are doctors more careful about putting padded bills into insurance companies than they are into the Government?

Dr. INGBER. Let me give you a very straight answer, Senator. There are guidelines where you know how much you can bill an insurance company before your committee comes down on you, and within those guidelines men are ripping off the private insurance companies just as much as they can.

That is why insurance premiums are so high and the Government has its eyes closed to this. Maybe it is unsophisticated, but when you get a copy of a medical bill in many cases you are amazed at all the charges and you feel, well, it is not coming out of my pocket so it does not really matter. But it is coming out of everybody's pocket, just in a different way.

Senator PERCY. Since 1969, as the chairman indicated yesterday and this morning, this committee has been looking into medicaid fraud and abuse involving nursing home operators, pharmacies, medical laboratories, medicaid administrators, physicians, dentists, and so forth.

We had brought to the attention of this committee yesterday that we have not looked into medicaid fraud in hospitals. Do you feel that hospitals are areas across the country that we should be looking into because fraud might exist there today?

Do you think a part of our high cost of medicine is attributable to a padded system—fraud that exists in a system—payments that we are making for services that simply are not being given?

HOSPITALS MUST KEEP BUSY

Dr. INGBER. The hospitals have a vested interest in keeping Federal funds coming. They have to show that they are busy. They have to show that their beds are filled. If you see, as in New York City now, their hospitals are being underutilized, the city threatens to shut them down.

So extra visits are commonly encouraged and physicians are probably told—I don't have any right to say I know, because I don't know, I only heard, that there was a lot of encouragement to keep hospitals busy.

I am sure you saw the New York Times a couple of months ago about the amount of unnecessary operations being done in this country today because the hospitals have a vested interest in keeping themselves open.

Sir, not only overbilling in hospitals, but they are overbilling medicaid at a higher rate than individual practitioners in medical centers because they are allowed to.

Senator PERCY. Dr. Styles, could you comment on the number of patients an average doctor in a medicaid mill would be able to handle per day? What is normal practice for a physician, on a cross-section basis?

How many patients can they see normally and how many can they step it up to if they just say hello and give a cursory examination to find out what is wrong with the person?

Dr. STYLES. A session might last for 3 hours in which the specific internist would be available. In our centers he could have seen from 10 to 25 people, perhaps more, perhaps less; the optometrist would see somewhat less. He would not see people who had seen an optometrist in the past 6 months or so.

There were guidelines. They would not draw blood more than once a year. These guidelines would create different patient loads in all the different categories.

I had read about patient loads of 150 people being billed by a psychiatrist who had given an hour per patient, and this was in the period of a week—he saw them three times or so. It is not something that I saw.

I saw, as I said, 15, 20, 25 for a heavy load.

Exceptions or the Rule?

Senator Percy. I would like to ask both of you one more question. We have such a challenge to our institutions. We have a soul-search to undercut ourselves. This tendency and habit somehow erodes confidence in ourselves. The statement was made where you have the finest medical system in the world. I would like to give both of you an opportunity to comment on how frequent the kind of practices are that we have talked about here, how frequently is making money the sole objective of a person in the medical field, and whether or not you feel that we do have an absolutely outstanding medical system, that most people in it are good and went into it because of their dedication to it. We are dealing with exceptions here—a small percentage of the total volume.

I don't want to put words in your mouth. I want you to tell exactly how you feel about our medical profession in this country, because all that has come across on the tube that I have seen so far is all negative. Of course, if there is a positive side we want to provide equal time for that.

Is it a question of just tightening up the regulations, based on the system that we have, or do you think we have to think through the whole approach to the medical health care of our people?

Dr. Ingber. Sir, if the system is polluted or part of it is polluted, and we put people into that polluted system, they will get dirty.

The way the medicaid system works, it is polluting. Every doctor who steps into medicaid takes a big risk of himself generating his type of care and his type of practice to fit the system at it exists today.

Part of our system is noble and honorable and men who work there are encouraged to be noble and honorable. But when a doctor sets foot into medicaid, the atmosphere—the situation—encourages that side of human beings that exists in everyone. The temptation is there and the weakness exists to a different extent in all people, I believe. You better be very strong to run away from it or else it can engulf you, and that is what I feel happened to us.

We were weak and we took advantage of the system.

Senator Percy. Part of these weaknesses are caused by lack of supervision in the system?

Dr. Ingber. Yes, sir.

Senator Percy. Toughness of regulation, the followup—the temptations are too great.

Dr. Ingber. Enormous.

Senator Percy. Humankind is too weak in the face of those temptations, so it is a tremendous disservice to the profession to have these temptations, to have the laxity that exists, because it encourages what you are trying to prevent.

Dr. Ingber. Yes.

Senator PERCY. I would like to have Dr. Styles, if you would, comment on and add to this—your having been in the system and paid a penalty and now having been totally rehabilitated, exonerated, and leading dignified lives of contribution, in the last 5 years at least. What caused you to turn around and to see the wrongness of the course of action you were pursuing before, the weaknesses that exist in the system. There are weak people out in the system now. Maybe your testimony now would be helpful to them and cause them not to dip into the temptations.

MANY REFUSED TO BE CORRUPTED

Dr. STYLES. Before I answer that question I would like to go back to what we were discussing just prior to that. There were a lot of beautiful young doctors that came to these clinics that came there and performed superior care and could not be changed. No one ever asked them to bastardize their work, no one asked them to change their method, and we were happy they came there to take good care of the patients. I will relate one specific instance.

When medicaid introduced the fee payable for a TB tine test—that is the tine test in which a small puncture is made in the skin—down to $1.50, I recall medical doctors who were kind of angry. They had done TB tests on everybody who needed it or everyone that came to the clinic that should have had it, and they liked making money. It was a very simple procedure and they picked up some TB tests, so I guess that helped their rationale.

Then medicaid dropped the test to $1.50 and I overheard a conversation in which the doctor said, "Well, we are just going to have to make it up someplace else." That is not everybody. There are a lot of really fine residents coming through—a lot of good ethical positions.

Senator PERCY. Did the fact that you had to serve time cause you, in that period of time, to reflect on the course of your life and was that a strong influence in saying that it is just not worth it?

Sometime you are bound to get caught. A lot of people out there are engaging in these practices. Our job is to make sure that they do get caught and we are going to go about doing it and set up the procedures that are necessary—sweep the net far enough.

We caught a few of them, but I think we intend to work very closely with HEW and the Justice Department in seeing that we follow through on a program and not ruin a program that is designed for good, but has seen much fraud and waste and squandering.

Has that been a salutory effect on your life, just serving time?

Dr. STYLES. Unquestionably. I have not served time yet. I am due to begin serving time on the 16th of September. All of these things that you mentioned did come very strongly into play. One of the things that we have felt was that if we would have avoided all of the pitfalls of greed, we could have easily made a healthy amount of money very legitimately. It just required something more, somewhat less systematic.

We were angered against the reduced fees and all the rest of the things that were mentioned. There is a way to do it the right way and we have learned that.

Senator PERCY. Mr. Chairman, I would like to say to these witnesses as they conclude their testimony that I know there was a comment made by Secretary Mathews yesterday, and I can well appreciate the discomfort of a huge department and a man who has a tremendous responsibility when something like this has been exposed—they are all defensive. I am sure he is not being defensive about the abuses. I think what he is saying is that we know about them and we are trying to do something about them.

DRAMATIZATION LEAVES LASTING IMPRESSION

I well remember one time when I was sitting at a conference table with Dr. Edward Teller and talking about how much radiation we were exposed to by underground testing, and some witnesses were talking about the fact that there was quite a bit. He took off his wrist watch and he threw it down on the table—this is 20 years ago—and he said, "You have all been exposed to more radiation now than you will be with all the underground testing we intend to do in the next 2 years."

You know, he could have sat there and just said that statement and I would not have remembered it the next day, much less 20 years later, but when Edward Teller does something, he does it with dramatics.

I simply feel this subcommittee has seen fit to take this and say "Look, we have been at this for years and years and years, and we are going to do something that will somehow dramatize this to the country."

I hope Secretary Mathews—and we will be working very closely with him—will appreciate and understand that sometimes it is necessary to be dramatic about this. We are all enraged by this that has gone on and I think the subcommittee approached it in a very appropriate way to bring it to the attention of the country in such a way that it won't be forgotten.

Now I hope it will be remembered long enough for us to do something. I am sure no piece of legislation has had a better boost than this has had to correct the problems.

Senator Talmadge, who could not be here, certainly has done a magnificent job in having legislation ready now for us to act on and move on. I think we are all intending to devote hours to it without underestimating a bit what Secretary Mathews has said about the problem, the concern that the whole Department has.

We want to work with them. This is the U.S. Government. We are both separate parts of it, but we have to work together on it. I simply want to place my support to you, Mr. Chairman, in any way I can.

Now that the evidence is in, we really can do something about this problem. I thank you very much for your appearance here today.

Senator Moss. Thank you, Senator.

Thank you, Dr. Ingber and Dr. Styles and Mr. Sparrow. We appreciate your coming here at our invitation. We are glad to have your observations in our record. That will be helpful to us as we try to carry out our responsibility.

Thank you very much.

The next witness is Dr. Clyde Weissbart from New York City. Is Dr. Weissbart here?

I am told that Irving Seidman, representing Dr. Weissbart, is here.

STATEMENT OF IRVING SEIDMAN, OF RUBIN, SEIDMAN & DOCHTER LAW FIRM, NEW YORK CITY, REPRESENTING DR. CLYDE WEISSBART

Mr. SEIDMAN. Irving P. Seidman, law firm of Rubin, Seidman & Dochter in New York City.

I don't wish to take any time from this august Senate committee in its important work but, unfortunately, on the short notice given to Dr. Weissbart inviting him to appear—he cannot appear.

However, we will consider another invitation from the committee if Mr. Halamandaris communicates to our office.

Senator Moss. Well, thank you for coming to inform us.

Senator PERCY. I would like to ask a question as to when the invitation was issued and a little more detail as to what is so overwhelmingly important that the doctor could not be here today. When did he receive the invitation?

Mr. HALAMANDARIS. The invitation was issued a week ago and we had additional discussion with counsel in which the doctor was given an opportunity to appear voluntarily. A discussion of the decision that counsel made last Friday was that the physician would have to be subpenaed to appear before the committee. Evidently there has been some change of mind and in his position that he now appear voluntarily at a more convenient date.

I think that is what Mr. Seidman is saying.

Mr. SEIDMAN. Senator, I communicated with Mr. Val Halamandaris on Friday. I believe the doctor was made aware of the invitation on Wednesday, if my information is correct. I see no reason why the doctor would not consider another invitation from the committee or Mr. Halamandaris. We do not intend any disrespect for the Senate committee and its important work.

Senator PERCY. I would like to give you an opportunity, if you think it is important, to explain why Dr. Weissbart, who has been in the full time business of operating a medicaid mill in New York, could not be here today?

Mr. SEIDMAN. If Your Honor please, Senator, with all due respect I believe that the doctor did not appear in view of the fact that appropriate notice from the standpoint of preparation and scheduling did not permit.

"HE IS A DEDICATED PHYSICIAN"

Again, I reiterate that we are prepared to consider another invitation and seek to cooperate with the Senate committee. The doctor does perform important and significant work in the ghetto of New York. He has no other professional interests. He is a dedicated physician and we are prepared to cooperate with Mr. Halamandaris.

Thank you, sir.

Senator Moss. Thank you for your appearance, Mr. Seidman. We will indeed invite Dr. Weissbart to appear and, if necessary, we will provide a subpena.

Dr. Nancy Kurke, would you come forward, please?

Now, Dr. Kurke, you are presently with East Harlem Medical Center, is that right?

STATEMENT OF NANCY KURKE, M.D., EAST HARLEM MEDICAL CENTER, N.Y.

Dr. KURKE. That is right, part time only.

Senator Moss. 145 East 116th Street, New York?

Dr. KURKE. That is right; only on alternate Saturdays.

Senator Moss. I see. Is that center still open now? Is it still in operation?

Dr. KURKE. I don't know. I have not seen it since last Saturday. It was last Saturday because I was there.

Senator Moss. You were there last Saturday?

Dr. KURKE. That's right.

Senator Moss. As a predicate to your testimony I would like to read a paragraph out of the staff report [1] on our investigations done in New York. This is on page 27 and the subparagraph is No. 4.

It says:

> At the East Harlem Medical Center, Private McDew asked to see a podiatrist. He was sent, instead, to the general practitioner and owner. The doctor listened to his chest and referred him to the chiropractor. He saw the podiatrist only after he had seen all other practitioners in the facility. Despite the nature of his complaint, "The bottom of my feet hurt," blood and urine samples were taken and his chest and feet were X-rayed. The podiatrist prescribed ankle braces which Private McDew was told to obtain "down the street" from a particular supplier. He was specifically referred to the East 116th Street Pharmacy to fill three pharmaceutical prescriptions which included two antibiotics. Private Roberts entered this same clinic complaining of tiredness, and received a general physical. He was referred to the podiatrist and given a future appointment to see the psychiatrist. Blood and urine samples were taken. His feet and chest were X-rayed and he was given two prescriptions which he was told to fill at the adjoining pharmacy.

Now are you acquainted with any of those circumstances?

PING-PONGING: A ROUTINE PRACTICE

Dr. KURKE. I think that they are fairly routine for anybody who comes into the clinic and that is, according to standard practice, everyone is seen first by Dr. Weissbart or Dr. Rivera or by myself, and then, no matter what his complaint is, even if he has a specific request for the podiatrist, he has to be seen by everybody. He has to have laboratory work, he has to have a chest X-ray, and also an EKG which is worth $15 whether he needs it or not. Whether or not he needs to see the podiatrist, he should be referred to the podiatrist and also the chiropractor.

Senator Moss. I see. So what you are telling us is that what has been called the ping-ponging is routine—they are referred all around the clinic—is that right?

Dr. KURKE. That is right.

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[1] *Fraud and Abuse Among Practitioners Participating in the Medicaid Program*, staff report for the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

Senator Moss. I visited this same clinic and I experienced something of this, although I didn't get full treatment apparently. I didn't get to the podiatrist; I think it was his day off.

Dr. KURKE. Probably.

Senator Moss. Can you tell me what resulted from my visit? Was there any comment about that there? [1]

Dr. KURKE. Well, not very much because very little of it is legible.

I gather that you complained of a sore throat.

There are a few lines of history, most of which I cannot make out.

There are a few comments on physical examination, most of which I cannot understand.

Two medications were prescribed. I think one of them was bicillin.

I really don't understand why you were not scheduled for an electrocardiogram because of your age, that being one of the few common requirements of a gentleman of your age.

However, your blood pressure was not taken. Height, weight, pulse, temperature—none of those. I don't understand why.

Senator Moss. As a matter of fact, I hardly think that even my throat was examined. The doctor looked at me from a distance and shone a flashlight toward my open mouth but he didn't look in there with a depressor or even peer in closely with his eyes to see.

As you point out, I had no blood pressure or no temperature taken.

THERMOMETERS CONSIDERED "EXTRAS"

Dr. KURKE. That is because usually there is no thermometer. It is one of those extras that we can do without in this clinic that we run with an absolute minimum of supplies. One of the things you do without is a thermometer.

Senator Moss. I see. Now does that report show any results back from the blood that was drawn or the urine specimen?

Dr. KURKE. Yes, it does. Incomplete blood count because all of the blood counts are incomplete. That is to say, you had a white count and a differential, but no hemoglobin.

Your analysis was largely normal except for the fact that, quite amazingly, you had white cells in your urine.

Senator PERCY. Are you sure you want all this in the record? [Laughter.]

Senator Moss. Maybe I will have to go back for a return visit.

Dr. KURKE. I think it would be wise if you saw a urologist.

Senator Moss. I see. I should have been referred the next time to the urologist.

Dr. KURKE. You are being referred this time to the urologist.

Senator Moss. You say you worked there on alternate Saturdays?

Dr. KURKE. Yes.

Senator Moss. What is your other appointment, besides that?

Dr. KURKE. During the week I work at another center owned by Dr. Weissbart.

Senator Moss. How many centers does Dr. Weissbart have?

Dr. KURKE. To the best of my knowledge, two.

Senator Moss. Just two? You said he does not see all the patients—it might be you, or it might be a third doctor.

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[1] See examination sheet, p. 685.

FAMILY-DENTAL MEDICAL

HISTORY AND PHYSICAL EXAMINATION SHEET

M.C.D. #
S.S. #

Print Patient's Name (Last, First, Middle)	Sex	(Circle)		
Moso, J Edward	M F	S M W Div. Sep.		
Ident. Name	Occupation	Home Phone	Business Phone	
Address 144 W. 23 St.				
Age 44	Wt.	Ht.	B.P.	Temp.	Pulse	Chest X-Ray	Urine	Hgb.

HISTORY

Chief complaint Pt with C.C. of

Present illness Sore throat and stiff neck. Also with general malaise. Complaining of headache. Mod alcohol, wine, no medication. No diabetes. no hx of heart disease no asthma

Systemic review

Past history

Family history

PHYSICAL EXAMINATION

General appearance good

Skin no lesions no pallor

Eyes, ears, nose and throat

Neck and thorax no adenopathy

Breasts

Heart and lungs

Abdomen (hernia?) Soft nontender

Pelvic, genitalia and rectal

Skeletal, back and extremities

Neurological

Impression

Date 6/7/72 Signed ______ M. D.

INVOICE No.

DATE	PROGRESS
Cervical arthritis ? bursitis (X)	6/7/76 — [illegible]

Name Moss E. Edward Room ___ Hosp. No. ___

Physician ___

R.B.C. ___ W.B.C. 6900 Hb. ___ %: ___ gms. Lab. No. ___

Color Index ___ Reticulocytes ___ Platelets ___

Coagulation Time ___ Bleeding Time ___ Prothrombin Time ___

Schilling Differential	Count	Basos.	Eosins.	Myelos.	Juveniles	Stabs.	Segs.	Lymphs.	Monos.
							68	28	4

Neutrophils, immature ___ mature ___

Hematocrit 42% ESR 14 mm/hr

Technologist ___ Date 6.7.76

FORM MCD-212 1 BLOOD (Morphology)

PHYSICIANS' RECORD CO., BERWYN, ILL. PRINTED IN U.S.A.

Name [illegible]

Physician ___

Color yellow Character clear Lab. No. ___

Specific Gravity 1020 Reaction acid

Albumin ___ W.B.C. 10-15

Sugar ___ R.B.C. ___

Acetone ___ Ep. Cells few

Diacetic Acid ___ Casts ___

Bile ___ Bacteria ___

Occult Blood ___ Crystals ___

Urobilinogen ___

(Albumin through Occult Blood: neg)

Technologist ___ Date 6-7-76

FORM MCD-211 1 URINALYSIS

PHYSICIANS' RECORD CO., BERWYN, ILL. PRINTED IN U.S.A.

Dr. KURKE. Dr. Rivera who works evenings and alternate Saturdays.

Senator Moss. When Dr. Weissbart is there, does he see everyone that comes during his time on?

Dr. KURKE. Yes, indeed, he certainly does.

Senator Moss. That is what I observed from sitting there waiting. I thought he saw everybody.

Dr. KURKE. I have even had patients tell me that they saw him professionally when they stopped in to say hello.

Senator Moss. I see. Now we have had some information that perhaps the clinic there had been closed down just yesterday or the day before. You have not had any information of that sort?

Dr. KURKE. No.

Senator Moss. You are an M.D.?

Dr. KURKE. Right.

Senator Moss. What kind of fee arrangement do you have with the clinic?

Dr. KURKE. I get 50 percent of my billing.

Senator Moss. And 50 percent goes to the clinic, supposedly for overhead?

Dr. KURKE. Whatever it goes for, I don't get it.

Senator Moss. I see. As part of this visitation, how many patients a day are you able to see?

Dr. KURKE. Well, I am very seriously handicapped by the fact that I feel obliged to talk to patients and examine them, so I usually never see more than 20. I am not a very profitable doctor.

Senator Moss. I see. How many did Dr. Weissbart see in a day?

SEES 40 OR 50 PATIENTS A DAY

Dr. KURKE. Oh, according to what his receptionist says, about 40 or 50.

Senator Moss. Are you an internist?

Dr. KURKE. I am an internist.

Senator Moss. You are an internist. The other practitioners around there—would they see that many if they get ping-ponged around?

Dr. KURKE. Certainly.

Senator Moss. Do you have any comment on the kind of extended care that people were getting there—the quality of medical care?

Dr. KURKE. Many, many comments. I think the quality of care is appalling. It is the worst medical care that I have ever seen in all of my experience working anywhere, and only with poor patients. I have worked in a city hospital. I have worked in the emergency room at St. Luke's Hospital in Newburgh, N.Y. I have never seen anything to equal the absolute poverty of medicine that is practiced in this clinic.

Senator Moss. Why don't you withdraw from the clinic?

Dr. KURKE. I have.

Senator Moss. You have now?

Dr. KURKE. Yes.

Senator Moss. I see. How long a time did you serve with Dr. Weissbart?

Dr. KURKE. I started in March.

Senator MOSS. Since March of this year?

Dr. KURKE. Right.

Senator MOSS. Well, this paragraph that I read about what happened to Privates McDew and Roberts, is that a rather typical situation?

Dr. KURKE. Absolutely. Absolutely typical. Most patients will put up with it. I had a woman come in one day when I was covering who wanted to see the podiatrist. She went along for a while with the physical, but refused to have blood drawn and walked out because she said she was not going to go through all that to see a podiatrist.

Most people will, because they simply do as they are told. They have blood drawn, they have X-rays, electrocardiograms—whatever anybody can do to them is done to them.

Senator MOSS. Is it customary, when a medicaid patient comes in with a green card, to xerox several copies of it?

Dr. KURKE. Yes, it is.

Senator MOSS. Why do they do so many copies?

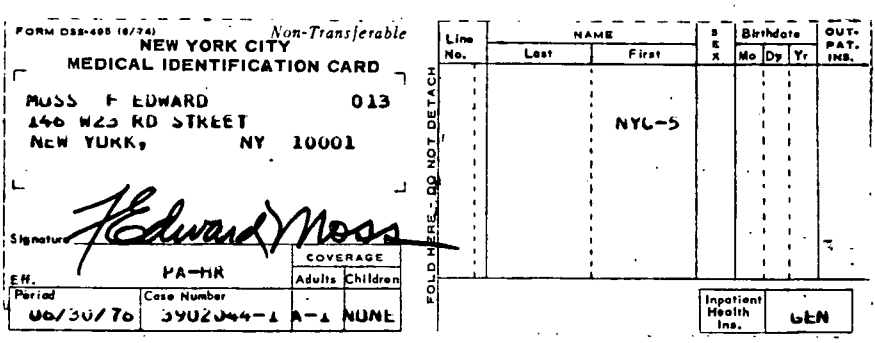
Dr. KURKE. I have no idea. I never saw anybody do anything with any of them. I don't know why. I think perhaps it might have something to do with verification of old invoices that are returned when there is something wrong with the billing, but since our Xerox machine has been broken for 4 months, we didn't do it. I think it is much more of a problem that no one ever checks to find out whether the medicaid cards are valid; many patients use invalid medicaid cards.

MEDICAID CARDS PURCHASED ON STREET

Many patients are issued multiple medicaid cards and for that reason they go out on the street and sell them. Anyone can go out on Fulton Street and buy a medicaid card for $3. When he presents it in the clinic he will not be asked to prove that he is the person whose name is on that card. Or if he really wants to play it safe, he will spend another $5 and get a phony photo ID to go with his card.

Senator MOSS. My medicaid card had my name on it all right although the middle name was spelled out which is unusual, that is the only difference, and it had the address of the hotel where I stayed when I was in New York. That was never questioned at all, although I think it was a well-known address and should have been recognized by any New Yorker, I believe.

[The card referred to follows:]



Dr. KURKE. Well, not necessarily. However, I would think it varies. It is very surprising for someone coming to 116th Street when near 23rd Street there are many fine hospitals and clinics. That would certainly be bizarre behavior.

Senator Moss. Well, you verified what happened. Do you have any other examples that approximate what happened with Privates McDew and Roberts?

Dr. KURKE. I think there are things that happened that are much more important than that, because there are people who are not treated at all for what is really wrong with them.

There are people who are treated very badly or inadequately even when their primary condition is recognized. One of the great lacks we have is of adequate equipment. We have one size of blood pressure cuff and, unfortunately, that is good for taking blood pressure only on a normal sized arm. Any other size arm needs a special size cuff.

Many, many of our patients are obese and if you use a normal size cuff on an obese arm you get what is called factitious hypertension. I have seen many, many patients, seen regularly by Dr. Weissbart, who came in and saw me when he was on vacation and 90 percent of them were not hypertensive. They were taking very potent antihypertensive medications and some of them were symptomatic to the point of loss of balance, dizziness, and weakness. They were being treated for a condition they didn't have simply because we didn't have a proper blood pressure cuff.

So far as I could make out they were never fully examined, which is quite routine in patients who are supposed to be hypertensive: one checks the state of the blood vessels and what they look like in the retina.

There was no record made of the electrocardiograms, which is just as well because they were useless. They were not good tracings, and they were not tracings that had ever been interpreted by anyone. They had not been standardized so they were really not meaningful. Largely they were not even labeled so that there was no way of knowing that the electrocardiogram actually belonged to that patient.

INSUFFICIENT INFORMATION ON CHARTS

There was never any statement in the chart about chest X-rays although the chest X-rays of patients with hypertension are very important to describe the size of the heart, the shape of the heart, the size of the aorta, and whether it is dilated. None of that information was available on the patients who were receiving fairly large doses of medication for a condition that they did not have.

Senator Moss. There are quite a number who present themselves, who are really ill and in need of care, and you are saying that their chances of getting effective care are very slight?

Dr. KURKE. Precisely. Many of the patients I saw complained that when they came to see Dr. Weissbart they came in the door of the office and he said, "Stand there, don't move," wrote something down on the chart, wrote a prescription, and took them out—particularly patients who spoke foreign languages. They never had a chance to say what was wrong.

If I said, "Oh, I see here at the last visit that you complained of having a headache," he said, "Oh, no, I never complained of headache, I complained of burning on urination"—which is an entirely different complaint.

They were very peeved about that but they kept coming back anyway which is something that I never understood. The chances were very poor that their real complaint would get on the chart before they made several visits, if ever.

Senator Moss. Now, I just complained of a sore throat when I went in there and yet I wound up getting at least two, I think, two or three prescriptions out of that. Is that quite customary?

Dr. KURKE. Quite customary. There is really very little point in having the patient stop by without getting medication. So far as I know, Dr. Weissbart owns the pharmacy. He runs a pharmacy that is attached to each clinic.

Senator PERCY. Have you actually seen drugs prescribed which, if taken, could have an adverse effect?

Dr. KURKE. Very definitely.

Senator PERCY. So, while the patient is paying for the prescription, the doctor will give him medicine that will do harm, rather than good?

Dr. KURKE. Absolutely. Unfortunately, yes.

Senator PERCY. I wonder if you could tell me—if Senator Moss would allow an interjection—how you happened to get into the medicaid mill business. How and why did you get into this particular one?

"MUCH TRAVEL AND LONG HOURS"

Dr. KURKE. Well, I worked at Francis Delafield Hospital in New York City which was the first hospital that was closed by New York City. I thought I would work in Westchester County. I worked part time as an emergency room physician which, unfortunately, was very demanding because of the traveling and the fact that the hours were long.

When I saw an ad in the paper, which Dr. Weissbart placed in the New York Times, I answered the call. Initially, what he was looking for was somebody to work alternate Saturdays. After I talked with him he said:

"I have a wonderful idea. Wait, wait, I have a wonderful idea. We have this clinic in Brooklyn and we are in trouble. What we need is someone like you. We need a doctor."

He sent me over to look and wanted to know if I would work there, and since I needed a job I said yes. It was a very amazing experience.

Senator PERCY. How long did it take you to size up the situation and know what you were involved in?

Dr. KURKE. About 10 minutes.

Senator PERCY. What caused you to stay 20 minutes then?

Dr. KURKE. Well——

Senator PERCY. Was this in line with your motivation in going into the practice of medicine or did you feel you could reform it, or at least offer some good service to the people that came?

Dr. KURKE. After I had a few weeks of experience and I got over being shocked and reached the point of being enraged, I contacted a friend of mine, a lawyer, Mr. Robert Silk. I asked if he could find out who it was in the New York area investigating medicaid mills. He gave me the name of George Wilson, whom I contacted and who in turn put me in touch with Bill Halamandaris.

Essentially, what I have been working for thus far is to accumulate evidence about how medicaid mills work, what the patients are like, why they go to medicaid mills, how they get treated, and hopefully, what will be done about it. I think that it is impossible to have any contact with these patients without realizing that we have a double standard of medical practice.

What you were talking about this morning was what you know about the practice of medicine, what you recognize as a member of the middle or upper class. You have health insurance, you have a regular income, you have a family physician.

There is a very large segment of our population which is in no such position. They have no concept of medicine as you see it. They go from doctor to doctor, from clinic to clinic. They have very little faith in the care they are getting and as a result almost all of them go to many doctors in the same week with the same complaint and usually they will go from one to another until someone listens to them.

It is very uncommon for them to find someone, certainly in the first week or two. Eventually perhaps they do.

NO CROSS-CHECK FOR MULTIPLE VISITS

Senator PERCY. What if the same person who was on medicaid went to three different clinics with the same problem? What cross-check is there to see that someone catches up with that?

Dr. KURKE. There is absolutely none.

Senator PERCY. So, today there is nothing to prevent anyone going to four, five, or six clinics?

Dr. KURKE. And many patients do.

Senator PERCY. Just to get someone to talk to—to tell their problems.

Dr. KURKE. Or to get medication to go out on the street and sell, which is also very common.

Senator PERCY. So there is a trade on the street?

Dr. KURKE. Absolutely.

Senator PERCY. Medicine which they have obtained from a clinic?

Dr. KURKE. Many patients who are on methadone go to the centers to get treatment so they can sell their methadone. There is a very brisk trade in methadone as a result.

Senator PERCY. Do you have any idea what Dr. Weissbart's income is? Have you ever wondered about this in your idle moments?

Dr. KURKE. No, I am afraid I don't. I was really astonished.

Senator PERCY. Have you made any kind of estimate?

Dr. KURKE. No, I really have not.

Senator PERCY. Do you know anything about his lifestyle?

Dr. KURKE. Not a thing, except that he likes to play golf.

Senator PERCY. That he lives comfortably and well?

Dr. KURKE. I have no idea.

Senator PERCY. But you do have some idea that there has to be some money coming in if he is seeing 40 or 50 patients a day.

Dr. KURKE. Definitely, and because of what I read in the New York Times most specifically, which gave the total of Dr. Weissbart's billing for last year and also discussed the billing for 1974.

Senator PERCY. That figure in 1974 was $100,000, and in 1975 $136,000.

Dr. KURKE. That was really very upsetting to me because in the Brooklyn clinic I had to provide my own otoscope, ophthalmoscope, and sphygmomanometer. I had to provide my own liquid soap with which to wash my hands, and a soap dispenser. So it was very upsetting to discover that Dr. Weissbart's income was $136,000 last year.

Senator Moss. And he got 50 percent of all of your billings while you worked there?

Dr. KURKE. Yes. He was not really satisfied with my billings because he didn't feel I was doing a large enough volume of business. We had a meeting several weeks ago with Dr. Weissbart's brother-in-law, Dr. Sampson. They wanted me to take over the Brooklyn clinic as a tenant, take all of the money and pay all of the bills, because they felt that I would have greater incentive and, therefore, I would see patients once a week whether they needed to be seen or not, and I would write more prescriptions because that way more money would be coming into the clinic.

PRIMARY AIM: TO MAKE MONEY

There just was not any way that these patients could be seen legitimately every week. I don't mean there was no way to write more prescriptions, but the point was made that the aim of prescribing medications was to make money.

Senator Moss. What about the laboratory work? What did Dr. Weissbart use for a lab?

Dr. KURKE. Well, there are regulations concerning what any doctor may do in his own office. There is a list of some simple tests, such as complete blood counts, red cell count, things like that. This is in the handbook that is sent out through the medical assistance program.

One of the first things I discovered about the clinic at 116th Street was that they didn't have a hemoglobinometer. When I asked Dr. Weissbart about it every week he said very vaguely, "Oh, yes, we will have to do something about that."

I said, "Yes; we are going to have to do something about that because these blood counts don't mean anything."

When I got this little booklet that detailed what was supposed to be done, which is available to all physicians, although I didn't get it for a while, it states unequivocally that a complete blood count includes the hemoglobin.

Now, I know that Dr. Weissbart's charts are surveyed repeatedly and audited. It seems to me that it would be very difficult to miss the fact that not a single one of these blood counts has a hemoglobin value and yet these were billed as complete blood counts and paid for as such, which I regard as fraud.

Senator Moss. I understand that Dr. Weissbart does not have anybody working in his laboratory on Saturday.

Dr. KURKE. That is right.

Senator Moss. What does he do with specimens that are taken on Saturday?

Dr. KURKE. They are held until Monday.

Senator Moss. Just hold them over?

Dr. KURKE. That is right.

Senator Moss. What is the likely result?

Dr. KURKE. They are examined as though they were fresh specimens although they are useless.

Senator Moss. Would they deteriorate considerably over 2 or 3 days?

Dr. KURKE. Yes. There is no point in taking a urine specimen unless it is done within 2 hours and a good blood count might be obtained if you kept it for 24 hours, but ideally that also should be done fresh.

EMERGENCY CASES REFERRED TO HOSPITAL

Senator PERCY. What would happen to a patient who came in seriously ill and obviously needed urgent medical attention? Would they just refer him to a hospital?

Dr. KURKE. Yes.

Senator PERCY. They will get rid of them as quickly as they can. Of course, that would be customary in a clinic.

Dr. KURKE. Yes; because there are not any emergency facilities. It depends upon what hospital you sent him to and what length of care they get. Some patients are referred to hospitals who don't need hospitalization or who need hospitalization in a better hospital.

Senator PERCY. Dr. Ingber mentioned this morning that in medicaid mills the only crime is, as he put it, ripping off the Government. He said that he gave adequate care in the medicaid mill. In your experience, have you seen the provision of adequate or good care in a medicaid mill at all?

Dr. KURKE. No.

Senator PERCY. Have you worked in any other than just these two?

Dr. KURKE. No, but I have talked to all the patients I have seen at great length, with great curiosity, which is something that is also part of the regulation. You are supposed to ask patients if they have seen, or are seeing, another doctor and refer the patient back to that physician.

This is something that is never done as a matter of practice. Patients have told me about their experiences in the Harlem clinic and in many, many other clinics that they went to. I could not make out that they were treated any differently anywhere.

Senator Moss. Dr. Kurke, have you had a chance to see this report that has been drafted?

Dr. KURKE. I looked through it briefly.

Senator Moss. It quotes you in a number of places and I just wondered if that represented accurately what you reported to our investigators? Are there any errors in there?

Dr. KURKE. I have not seen it exactly but I think the ones having to do with patients, yes, certainly are accurate—quality of laboratory work, yes—general quality of care, definitely.

Senator Moss. The reason I asked; there are some very shocking things about patients and failure to care for them, even to observe a growth in the throat, things of that sort. Those actually happened?

Dr. KURKE. Yes. Some of the most amazing things that I have ever seen in all of my experience in medicine. One was a patient of 50 who came in, who had been seen by 6 other physicians in the Brooklyn clinic, among them Dr. Weissbart. He asked for medication for pain in his face. I asked him why he had a pain in his face and he was very surprised.

"You know, none of the other doctors asked me that."

I said, "Well, why do you have a pain?"

He said, "Well, I have this thing in my mouth."

"What thing?"

"Well, sort of a growth."

What he had was the largest growth that I have ever seen—about the size of an egg—that was literally choking him. I looked through the chart and I said, "You know, I really don't understand this. Is it really true that no one has looked in your mouth?"

"THEY NEVER LOOKED IN MY MOUTH"

He said, "Yes, that's right, they never looked in my mouth." He said, "I had a pain in my face and they gave me medication but they never looked in my mouth." He said, "It really does not matter because I know that this is killing me anyway."

But I think it does matter because I think it is concrete evidence of a double standard in medical care. When you go to see a doctor, someone should look in your mouth if you can't swallow, if you can't lie down and breathe at night.

He knew that this tumor, which was removed originally 15 years ago, had recurred 5 years before he saw me. In the 2 years since he started coming to the Brooklyn clinic it had achieved large enough size that he could not eat, which was why one of the physicians noticed he was losing weight.

By the time I saw him it was literally embarrassing his respiration but no one had looked in his mouth. No one cared to know. It was not worth the trouble to take the time to look in his mouth because you don't get paid for that, it is a waste of time. Anything you do that you can't put down on an invoice is a waste of time.

Senator Moss. He didn't even get the flashlight treatment that I got?

Dr. KURKE. No; he was not asked to open his mouth, just simply given a prescription.

Senator Moss. Dr. Kurke, I do appreciate your coming and giving us your personal experience and your viewpoint. I am sure that Senator Percy and I both would like to continue the colloquy, however, that single button up there says a vote has started and we must go to the floor.

This does complete the number of witnesses we had called for today and I want to thank all of them for appearing, and you especially. You give us great pause about this system that we have underway in medicaid and obviously it is being abused terribly.

We simply must find the answer out of this so it will not continue. Thank you.

At this point I would like to insert in the record the New York Times editorial entitled "Medicaid Scandals."

[The article referred to follows:]

[From the New York Times, Aug. 31, 1976]

MEDICAID SCANDALS . . .

Rumors and suspicions about abuses of medicaid funds have been rampant for so long that the public, expecting the worst, may not react with adequate anger and disgust to disclosures by the Senate Subcommittee on Long-Term Care. Without the outrage these findings so clearly call for, there is small hope that the revelations will be quickly followed, not only by essential reforms but by criminal prosecution of those who have enriched themselves at the expense of the taxpayers and of the poor for whom the funds are intended.

High on the agenda of any prosecution of medicaid profiteers ought to be the recovery of the stolen money and its return to the local, State and Federal treasuries. At the same time, every effort must be made to prevent medicaid abuses from generating popular and political opposition to the sound and necessary concept of medicaid—the vital Federal-State program that provides medical aid payments to the aged, blind, and disabled.

Senator Frank E. Moss, Democrat of Utah, as the subcommittee's chairman, and other members of his staff performed an extraordinary public service by personally posing as indigent patients as they sought to uncover widespread medicaid irregularities. What they found is a catalog of flagrant breaches of the law and medical ethics. The compendium of thievery, which resembles more nearly the kind of revelations ordinarily associated with the Mafia than with members of a respected profession, includes the following carefully documented charges:

(1) Individual physicians collected huge Medicaid payments, as illustrated by a list in New York State that cites more than 100 physicians whose Medicaid payments last year ranged from $100,000 to nearly $800,000.

(2) Medicaid "mills" are flourishing in poverty areas, designed to defraud rather than serve the poor, while fly-by-night operators share the profits with greedy doctors.

(3) Unnecessary diagnostic tests and X-rays are being routinely administered for only one discernible purpose—to enrich the laboratories, cooperating physicians and pharmacists, the latter in payment for unnecessary and therefore possibly harmful prescriptions.

(4) A high incidence of false diagnoses arising from these practices poses a ready threat of physical damage to unsuspecting patients. Senator Moss himself displayed evidence in the form of bruises he suffered in the course of batteries of blood tests.

Senator Moss. The hearing is adjourned.

[Whereupon, at 12:30 p.m. the hearing adjourned.]

APPENDIXES

Appendix 1

REPORT TO THE SENATE SUBCOMMITTEE ON LONG-TERM CARE SPECIAL COMMITTEE ON AGING BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Improvements Needed In Managing And Monitoring Patients' Funds Maintained By Skilled Nursing Facilities And Intermediate Care Facilities

Social and Rehabilitation Service
Department of Health, Education, and Welfare

Mismanagement of patients' personal funds in Medicaid facilities in five States and proposals for dealing with the problem are the subjects of this report.

It deals with

--the adequacy of Federal and State regulations and guidelines for the handling of Medicaid patients' personal funds in the custody of facilities,

--how selected facilities have handled patient funds, and

--the adequacy of the States' monitoring activities regarding facility compliance with regulations and guidelines.

MWD-76-102

MARCH 18, 1976

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Frank E. Moss
Chairman, Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report discusses improvements needed in managing patients' funds maintained by skilled nursing facilities and intermediate care facilities participating in the federally assisted Medicaid program. The report points out inadequacies in the Department of Health, Education, and Welfare's regulations and the States' monitoring of nursing facilities, as well as deficiencies in handling patients' funds at selected facilities.

Our review was made pursuant to your request of December 19, 1974. As your staff requested, we have not given the Department of Health, Education, and Welfare; the States; or the selected nursing homes an opportunity to review and formally comment on our report. However, we have discussed our findings with departmental representatives and communicated our findings to the States and facilities involved.

This report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on the actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HUD	Department of Housing and Urban Development
ICF	intermediate care facility
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service
SSI	Supplemental Security Income

COMPTROLLER GENERAL'S
REPORT TO THE SUBCOMMITTEE
ON LONG-TERM CARE
SENATE SPECIAL COMMITTEE
ON AGING

IMPROVEMENTS NEEDED IN MANAGING AND MONITORING PATIENTS' FUNDS MAINTAINED BY SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

Social and Rehabilitation Service
Department of Health, Education, and Welfare

D I G E S T

Each aged, blind, or disabled Medicaid patient in a skilled nursing home or intermediate care facility is entitled to an allowance of at least $25 a month for his personal needs. (See p. 2.) The Department of Health, Education, and Welfare (HEW) has issued limited regulations or instructions on managing these patients' funds. (See p. 4.) The States have issued regulations and/or instructions which vary widely. (See p. 5.)

HEW regulations and some States' instructions do not deal with such important areas as

--how patients' funds should be safeguarded and accounted for,

--the services or items that properly could be considered as personal needs, or

--how personal funds should be disposed of upon the death or discharge of the patient. (See pp. 4 to 7.)

GAO identified deficiencies in managing patients' funds in each of the 30 facilities it reviewed. (See p. 8.) Problems identified included:

--Shortages in patients' funds.

--Medical supplies and services being charged to patients' funds.

--Funds of deceased and transferred patients being kept by the facilities.

--Interest earned on patients' funds being kept by the facilities. (See p. 8.)

All facilities participating in the Medicaid program are required to be inspected annually by the State in which they are located. (See p. 15.) These inspections should include reviews of their patients' funds procedures.

Of the five States GAO reviewed, Michigan did not include this as part of its inspection process until August 1975. At 21 of the 24 facilities GAO reviewed in the other 4 States, the inspection reports showed that they were in compliance with patients' funds requirements.

Fifteen of the 24 facilities did not comply with one or more existing HEW or State requirements.

Moreover, there is some question as to the inspectors' ability to determine whether a facility has properly implemented the policies and procedures for handling patients' funds.

In at least one region, HEW has not provided training to State inspectors on the proper handling of patients' funds. (See p. 16.)

State audits disclosed deficiencies similar to the ones GAO identified. However, there were few audits in the five States GAO reviewed. (See pp. 17 to 18.) As of June 30, 1975, 33 States had agreements with Medicare fiscal intermediaries for common audits of hospitals. The intermediaries are also responsible for Medicare audits of 4,000 skilled nursing facilities that also participate in Medicaid.

Therefore, it may be possible that the States could modify common audit agreements with fiscal intermediaries to include making reviews of patients' funds at skilled nursing facilities where they are making reviews. (See p. 18.) GAO recommends that the Secretary of HEW direct the Administrator of the Social and Rehabilitation Service to:

--Issue additional regulations designed to safeguard patients' funds. (See p. 7.)

--Require Missouri to amend its Medicaid Instruction Manual so that it complies with Federal regulations. (See p. 7.)

--Train State inspectors to identify problems that exist in a facility's management of patients' funds. (See p. 20.)

--Encourage the States to modify their common audit agreements with Medicare fiscal intermediaries to include a review of patients' funds at skilled nursing facilities. (See p. 20.)

CHAPTER 1

INTRODUCTION

In a December 19, 1974, letter, the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, asked us to review certain areas of nursing home costs under Medicaid. In a later discussion, the Subcommittee asked us to make a separate review of the controls over Medicaid patients' personal funds maintained by skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program in which the Federal Government pays part of the costs (50 to 78 percent) incurred by States in providing medical services to persons who are unable to pay. The Social Security Act requires that State Medicaid programs provide skilled nursing home services. Services in intermediate care facilities, which provide care to patients that do not require skilled nursing services, are an optional Medicaid service. About 7,100 SNFs and 8,400 ICFs are participating in the Medicaid program. About 4,000 SNFs also participate in Medicare.[1]

At the Federal level the Medicaid program is administered by the Social and Rehabilitation Service (SRS), within the Department of Health, Education, and Welfare (HEW). States have the primary responsibility for initiating and administering their Medicaid programs under the Social Security Act.

SOURCES OF PATIENTS' FUNDS

For Medicaid patients residing in Medicaid facilities, one source of personal funds is the Federal Supplemental Security Income (SSI) program which was established by title XVI of the Social Security Act. The program became effective in January 1974 and replaced and broadened the previous

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[1]Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also covers certain posthospital care in SNFs or in a patient's home.

federally assisted, State-administered cash assistance programs for the aged, blind, and disabled.

Section 1611(e) of the act provides that an SSI recipient residing in a Medicaid facility will receive a reduced SSI payment of up to $25 a month (provided the recipient's other retainable income is less than $25) to provide for the patient's personal needs. In conformance with the SSI payment level, Medicaid regulations require that the personal needs maintenance level for any institutionalized aged, blind, or disabled Medicaid recipient be a minimum of $25 a month. However, a State may set a higher personal needs allowance level. Any income above the personal needs level must be applied to the cost of facility care. This application of excess income reduces the amount paid by Medicaid.

In addition to SSI benefits, patients' funds may come from a variety of sources, including social security benefits, veterans' benefits, disability compensation, and contributions from relatives.

SCOPE OF REVIEW

The objectives of our review were to determine

--the adequacy of Federal and State regulations and guidelines for handling Medicaid patients' personal funds in the custody of facilities,

--how selected facilities have handled patients' funds, and

--the adequacy of the States' monitoring activities regarding facility compliance with regulations and guidelines.

Our review included work at HEW headquarters in Washington, D.C.; HEW regional offices in Atlanta, Chicago, Kansas City, New York, and San Francisco; and State agency offices in California, Florida, Michigan, Missouri, and New York. These States were selected to give wide geographical distribution and to insure that only one State was located in each of the HEW regional offices reviewed. We also visited 30 SNFs or ICFs in the 5 States. These institutions were selected on the basis of size; location within the State; and type of facility such as proprietary, private nonprofit, and public. We reviewed the procedures and practices used to manage and account for patients' funds at

each facility. We interviewed appropriate facility officials, reviewed available accounting records, tested transactions in individual accounts, and interviewed patients.

CHAPTER 2

HEW's AND SOME STATES' REGULATIONS AND GUIDELINES FOR HANDLING PATIENTS' FUNDS ARE INADEQUATE

HEW and the five States in our review have issued regulations and/or instructions for SNFs and ICFs on the handling of patients' funds. However, HEW regulations and guidelines have been limited and the scope and substance of State regulations and guidelines varied considerably.

FEDERAL REGULATIONS AND GUIDELINES

For SNFs, Federal regulations (20 CFR 405.1121(k)(6)) require that patients be allowed to manage their personal financial affairs or be given at least a quarterly accounting of financial transactions made on their behalf if the facility accepts written delegations of the responsibility in conformance with State law.

For ICFs, Federal regulations (45 CFR 249.12(a)(1)(iii)) require that a written account be maintained and available to the residents and their families.

We could locate little of HEW interpretive instructions pertaining to such matters as (1) how patients' funds should be safeguarded and accounted for, (2) the services or items provided by the institution that could be properly considered as personal needs and charged to the patients' personal funds and what services or items were to be considered as part of the Medicaid reimbursement to the facility, or (3) how personal funds were to be disposed of upon the death or discharge of patients.

The HEW interpretive instructions included an SRS headquarters memorandum dated July 31, 1974, to the SRS Kansas City regional office which stated that items such as wheelchairs, walkers, and crutches should be considered part of normal SNF services and thus should not be charged to the patients and that a State should stipulate in its agreements with facilities the items and services expected as part of routine care.

Another SRS headquarters memorandum dated August 18, 1975, to the SRS New York regional office stated that a nursing home was not allowed to charge a fee for managing patients' funds and that interest earned on patients' funds should accrue to the individual patients.

STATE REGULATIONS AND GUIDELINES

Each of the five States we visited had issued some instructions to nursing homes with regard to the handling of patients' personal funds. However, these instructions varied from the rather comprehensive regulations issued by California to a booklet which Missouri provided to nursing homes that included a section listing items for which Medicaid patients' personal funds could or could not be charged. A summary of the regulations in the five States follows.

California

Facilities participating in Medicaid must be licensed by the State, and in California the licensing regulations included detailed requirements concerning the use, custody, and disposition of patients' personal funds. These requirements included the following:

1. No licensee shall use patients' moneys or valuables as its own or mingle them with its own.

2. Each licensee shall maintain adequate safeguards and accurate records of patients' moneys and valuables entrusted to its care.

3. Patients' moneys not kept in the facility shall be deposited in a checking account in a local bank.

4. A person, firm, partnership, etc., which is licensed to operate more than one facility shall maintain a separate checking account for each facility and shall not mingle patients' funds in different facilities.

5. When the total amount of a patient's moneys entrusted to a licensee exceeds $500, all moneys and valuables in excess of $500 shall be deposited in a demand trust account.

6. Upon patient discharge, all moneys and valuables of that patient which have been entrusted to the licensee shall be surrendered to the patient in exchange for a signed receipt. Those moneys kept in a demand trust account shall be made available within 3 normal banking days.

7. Within 30 days following the death of a patient, all moneys and valuables of that patient shall be surrendered to the person responsible for the patient.

8. Upon change of ownership of a facility, a written verification by a public accountant of all patients' moneys which are being transferred to the custody of the new owner shall be obtained by the new owner in exchange for a signed receipt.

Florida

Like California, Florida required that facilities (1) not use patients' moneys nor mingle them with the facilities' own, (2) keep complete and accurate records of all funds and other effects and property of their patients, and (3) provide for safekeeping of personal funds.

Michigan

Michigan had regulations that (1) did not permit the mingling of patients' funds with the facilities' funds and (2) required the facilities to report the amounts of a deceased patient's funds to the person responsible for the patient or to the county. Michigan also required its facilities to secure bonds covering trust funds and to give a quarterly accounting of all patients' funds to the patient.

Missouri

Missouri published a Medicaid Instruction Manual in May 1974 which was distributed to nursing facilities in the State and which specified those services not covered by the State's reimbursement rate. These noncovered services were categorized as either personal items which could be charged to the patient or specified medical items which could be charged to third parties such as relatives. An SRS Kansas City regional office official said, however, that this section of the manual was not in compliance with Federal regulations because some of the items or services listed as noncovered Medicaid items should have been covered by Medicaid.

New York

New York had regulations which specified the items and services that must be included in the basic rate of the facility. These included board, including special diets;

lodging; laundry service for personal clothing items; and the use of walkers, wheelchairs, and other supportive equipment.

Although New York had not issued any regulations directly related to the use, custody, and disposition of patients' funds at the time of our fieldwork, the State issued an administrative letter on December 10, 1975, which detailed how patients' funds were to be administered.

CONCLUSIONS

HEW has issued limited regulations and guidelines to the States on managing patients' funds. HEW has relied on the States to specify and control the methods to be used by SNFs and ICFs to manage patients' funds. Certain States have detailed regulations on managing patients' funds while others have limited regulations or guidelines. Accordingly, there is a need for HEW to establish minimum standards for the management of patients' funds maintained by SNFs and ICFs participating in Medicaid.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator of SRS to issue regulations setting forth the minimum standards that the States are required to follow in establishing requirements for patients' funds maintained by SNFs and ICFs participating in Medicaid. These standards should cover such matters as

- --how patients' funds should be safeguarded and accounted for,
- --the services or items that could be properly considered as a personal need and charged to the patients' funds and the services or items that should be considered as part of the Medicaid reimbursement to the facility, and
- --how personal funds should be disposed of upon death or discharge of patients.

The Secretary should also direct the Administrator of SRS to require Missouri to modify its Medicaid manual to comply with Federal regulations.

CHAPTER 3

DEFICIENCIES IN MANAGING PATIENTS' FUNDS AT SELECTED FACILITIES

The 30 facilities in the 5 States we visited included 18 proprietary, 5 private nonprofit, and 7 public facilities. At each of the 30 facilities we identified either major and/or procedural deficiencies in managing patients' funds. A major deficiency is one which, unless corrected, results in measurable losses to patients or their estates; whereas a procedural deficiency involves noncompliance with requirements or poor accounting practices. In some instances a procedural deficiency may have resulted in losses to patients, but we were unable to establish that such a loss actually occurred. In summary, we found that:

--The 18 proprietary nursing facilities reviewed had 11 major deficiencies and 72 procedural deficiencies.

--The 7 public facilities reviewed had 6 major deficiencies and 19 procedural deficiencies.

--The 5 nonprofit facilities had 5 major deficiencies and 15 procedural deficiencies.

A summary of the deficiencies identified in each of the facilities, including those deficiencies which represented violations of HEW or State requirements, is shown in appendix I.

MAJOR DEFICIENCIES

Following are the major deficiencies identified.

1. Shortages between patients' ledger balances and the bank accounts.

The most common method used by the facilities to account for patients' funds consisted of maintaining individual ledger accounts and a bank account in which patients' funds were deposited. The bank account amount should equal or be reconciled to the ledger balances, but at three facilities in three States, the bank accounts had fewer funds than the individual ledger balances showed there should have been. These shortages amounted to $445, $9,044, and $23,275. The $445 shortage was replaced by the facility's administrator soon

after we brought it to his attention. The other two shortages go back several years and were further complicated by changes in ownership. We reported these two shortages to State or Federal officials.

An example of a shortage involved a proprietary nursing facility in North Miami, Florida, where the available records indicated a shortage of $9,044 at July 28, 1975. At that time, the patients' ledger cards showed a balance of $10,447 applicable to Medicaid and non-Medicaid patients. Of this amount, $4,286 consisted of inactive accounts of discharged or deceased patients with the dates of last-recorded transactions in the individual accounts ranging from April 1971 to November 1974 and $6,161 consisted of the active accounts of patients in the home.

The bank statement balance for inactive and active accounts was $1,403, or $9,044 less than the patients' ledger accounts. We noted that the home had changed ownership in April 1971, at which time about $5,000 had been withdrawn from the patients' fund bank accounts. According to the home's accountant, the seller had withdrawn the funds and given the buyer credit on the purchase price. The buyer was supposed to replace the funds, but we were unable to confirm that this was done. This facility regularly commingled patients' funds with its operating funds.

2. Charging patients for medical supplies and services.

Federal regulations (45 CFR 250.30 (a)(7) (1975)) require that Medicaid facilities accept the rate established by the State as payment in full for services provided.

The regulations and related instructions were not specific in this area, and at six facilities in three States, patients' funds were being charged for items or services which we believe should have been provided as part of routine care. These included wheelchair rentals, restorative services, and routine medical supplies.

One facility in Missouri charged patients $60 a month for medical supplies and services whether or not they used this amount. All funds received by the patient up to $60 were used to pay this arbitrary charge. These charges included moneys over the patient's personal allowance that should have been applied to reduce the Medicaid payment to the facility but were not.

Another facility in Missouri charged one patient $262 for the period January to July 1975 for medical supplies and services.

3. Retaining funds of deceased and transferred patients.

Federal regulations are silent as to the disposition of the personal funds of transferred or deceased patients. Two of the five States we visited had regulations concerning the disposition of deceased patients' personal funds. They provided that funds of deceased patients are to go to their estates, families, or the State. In California, one of the States with such regulations, one facility was retaining funds of deceased or transferred patients. Also, eight facilities in three other States without such regulations were also retaining funds of deceased or transferred patients. At one facility, as of April 1975, the balance of deceased patients' funds totaled $17,762, of which $11,013 had belonged to patients who had died before April 1, 1974. An official at this facility said these funds would eventually be transferred to the facility's operating account.

4. Keeping interest earned on patients' funds.

As previously discussed, an SRS memorandum dated August 18, 1975, stated that interest earned on a patient's funds belongs to the patient.

At four facilities in three States we noted that interest earned on patients' funds was being kept by the facilities. At one facility the interest earned amounted to $13,200 since 1969 and at another facility the interest earned from October 1968 through December 1974 amounted to $1,639.

PROCEDURAL DEFICIENCIES

In addition to the major deficiencies discussed above, we also identified the following procedural deficiencies:

--11 facilities in 5 States mingled patients' funds with their own and used such funds to pay operating expenses. One facility in California had used patients' funds as collateral for a loan for operating purposes.

--20 facilities in 5 States had poor procedures for documenting transactions in patients' fund accounts. A common weakness was not properly documenting with receipts how funds were spent by third parties, such as relatives, on a patient's behalf.

--5 facilities in 2 States allowed patients to accumulate personal funds above the State resources limit instead of applying the excess funds toward the patients' cost of care.

--16 skilled nursing facilities in 4 States did not provide patients with at least a quarterly accounting of their accounts as required by Federal regulations.

ILLUSTRATIONS OF DEFICIENCIES AT TWO SELECTED FACILITIES

Following are two extreme examples of how specific proprietary facilities in California and Missouri improperly handled patients' funds.

California facility

As of July 1, 1975, there were 91 patients in this facility, 77 of whom were covered by Medicaid. The State inspected this facility for participation in the Medicaid program in March 1975 and the inspection report did not identify any deficiencies involving patients' funds. The inspectors indicated that the facility was in compliance with patients' funds requirements.

HEW regulations (45 CFR 250.30(a)(7)(1975)) require that Medicaid facilities accept the rate established by the State as payment in full for services provided. We believe that medical supplies should be provided as part of routine care. This facility charged Medicaid patients for such medical supplies as gauze dressing, catheters, and tubing.

This facility had a central supply unit to provide medical supplies for patients. An individual schedule of use was prepared for each patient, except for Medicaid patients, showing the supplies used by each. A single list was prepared for Medicaid patients showing the total supplies used. There was no listing of individual Medicaid patient usage.

The facility's bookkeeper stated that Medicaid patients were charged on the basis of their ability to pay and not their actual usage. She said this was done to reduce the facility's medical supply expenses because not all Medicaid patients had enough funds to pay for the medical supplies that they used.

This facility charged some patients $3 per month for maintaining their funds. The bookkeeper stated that the $3 service charge was assessed when (1) a patient receives a

check which has to be split between the cost of care and the personal allowance and (2) when a patient has "many" withdrawals from the trust account during the month. The bookkeeper further stated that there were no criteria for how many transactions constituted many withdrawals.

We discussed this service charge with the administrator. He stated that all patients should have been assessed this service to compensate for the amount of time the facility's accounting staff spent on patients' funds. As previously discussed, an SRS memorandum dated August 18, 1975, stated that a facility may not charge a Medicaid patient for managing his personal funds.

The California regulations provide that money of deceased patients entrusted to a licensed facility be turned over to the patient's estate or that the county public administrator be notified within 30 days of death. Seven deceased patient accounts we examined had balances that were not surrendered to the patients' estates. Balances in these accounts ranged from $12 to $1,041, with dates of death as early as January 1974. The facility used the funds in several of these accounts to offset bad debts losses. We found no evidence that these patients' next of kin or the public administrator were advised of the existence of the balances of the patients' funds in these accounts.

This facility also (1) had incomplete documentation for patients' funds spent by facility employees on behalf of the patients, (2) commingled patients' funds with the facility's operating funds in violation of the California regulations, and (3) failed to provide patients with a quarterly accounting of transactions in violation of Federal regulations.

Missouri facility

As of June 25, 1975, there were 162 Medicaid patients in this facility. The State last inspected this facility for participation in the Medicaid program in January 1975. At that time, the inspection report did not identify any problems involving patients' funds.

The Department of Housing and Urban Development (HUD) had foreclosed a mortage on this facility on April 4, 1974, after the facility had been in receivership from February to April 1974. At the time of our fieldwork, the facility was being managed by a private management corporation on behalf of HUD. A HUD official said that, during the period this facility was in receivership, the agency became aware

of a shortage in the patients' funds but did not know the amount of the shortage.

In March 1975 the comptroller for the management firm reconciled the patients' accounts as of April 8, 1974, and found the shortage in patients' funds was $23,275, which represented the difference of the balance in the patients' ledger accounts of $59,562 and an adjusted bank balance of $36,287. A HUD official said that he had requested that the HUD Office of Inspector General in the Kansas City, Missouri, regional office make an audit of the patients' trust fund accounts. We informed the HEW Kansas City regional office and Missouri officials about this shortage because the interests of Medicaid patients were involved.

As stated previously, Federal regulations require that the facility accept the rate established by the State as payment in full for medical supplies and services provided as routine care. Further, the Missouri Medicaid manual specifies those services that cannot be charged to patients. Nevertheless, this facility charged patients for services and supplies which the State said could not be billed to patients. For example, four patients at this facility were charged $125, $206, $262, and $88 for such services and items as wheelchair and equipment rentals, medical and surgical supplies, and restorative services for the period January to June 1975. The comptroller of the home said that the home operated on the theory that charges not covered in the State's Medicaid per diem rate were to be billed to whomever could pay.

In addition to the patients' fund shortage and the charging of patients for routine medical supplies and services, this home

--did not set aside $25 each month for the personal needs of the patients,

--did not provide a quarterly accounting of transactions to the patients,

--had no written procedures for the handling of patients' funds, and

--commingled patients' trust funds with its own operating funds.

CONCLUSIONS

For the 30 institutions we visited in 5 States, we identified an average of 4 major and/or procedural deficiencies in the facilities' management of patients' funds. Because our selection of institutions for review was not based on any prior knowledge of facilities with deficiencies, we believe it is logical to conclude that the mismanagement of patients' funds in the custody of SNFs and ICFs participating in Medicaid is likely to be widespread. Further, because we found major deficiencies at all types of facilities (e.g., proprietary, private nonprofit, or public) we believe that none of the types could be considered any better or worse than any other type of facility.

CHAPTER 4

STATE MONITORING OF FACILITIES' MANAGEMENT OF PATIENTS' FUNDS HAS BEEN INEFFECTIVE

The States' monitoring activities pertaining to patients' funds involve the annual inspections required for certification for participation in Medicaid, usually by the State Department of Health and periodic audits of such facilities by various State auditing organizations.

CERTIFICATION INSPECTIONS COULD BE IMPROVED WITH TRAINING

Regarding inspections, HEW regulations require that each SNF and ICF certified for Medicaid be inspected at least annually by State inspectors to determine whether the facility is in compliance with Federal regulations.

State inspectors, as part of the certification process for SNFs, are required to determine whether (1) the facility has written policies with regard to patients' rights (including management of patients' funds) and (2) the staff of the facility is trained and involved in implementing these policies. For ICFs, State inspectors must assure themselves that the facility maintains on a current basis, and makes available to residents and their families, an accounting for each resident's fund balance with written receipts for all disbursements made to, or on behalf of, the resident.

Michigan did not include patients' funds in its certification inspection process until August 1975. We identified items of noncompliance with Federal and State requirements in the six facilities visited in Michigan. In 21 of the 24 nursing homes and intermediate care facilities in the other 4 States visited, State inspection reports showed that the facilities were in compliance with the standards for handling patients' funds. For 15 of these 24 facilities, the deficiencies we identified included items which represented noncompliance with one or more specific HEW or State requirements. Although we identified various deficiencies in managing patients' funds in each of the 30 facilities visited, for about half the facilities which had been previously inspected by the States and where the inspections covered patients' funds, we found items of noncompliance with specific HEW or State requirements which had not been identified by the State inspectors.

Moreover, there is some question as to the inspectors' ability to determine whether a facility has properly implemented the policies and procedures for handling patients' funds. For example, in Missouri the facility survey is performed by a two-person team consisting of a sanitary engineer and an institutional advisory nurse.

During the survey, the sanitary engineer is concerned with such areas as the physical condition of the facility, fire safety, and sanitation. The nurse is responsible for completing the parts of the survey form that involve patients' funds and/or patients' rights.

The supervisor of the State's Bureau of Institutional Advisory Nurses said that during a facility survey a nurse visually checks to see if ledger cards or something similar has been prepared for the patients. The nurse also checks whether the facility has written procedures for managing patients' funds. The supervisor further informed us she doubted any of her nurses performed any verification of the transactions shown on patients' ledger cards because her nurses did not know how to verify that written procedures for patients' funds were being followed. The supervisor said that she had asked the HEW regional office to conduct training seminars on how to review patients' funds, but that none had been provided in that region.

The Social Security Amendments of 1972 authorized 100-percent Federal funding of expenditures under approved State Medicaid plans for the compensation and training of inspectors of long-term care institutions through June 30, 1974. There are currently about 2,000 State inspectors, many of whom have been trained under this program.

According to HEW officials, the period authorized for 100-percent Federal financial support for developing and operating State programs for inspecting long-term care institutions was not long enough to permit all the States to develop the capability to properly inspect long-term care institutions. Therefore, the authorization for 100-percent Federal reimbursement of State expenditures for inspectors of long-term care facilities was extended for 3 years through June 1977 by Public Law 93-368, approved August 7, 1974.

Because a review of patients' funds involves simple cash transactions and related fundamental questions of adequate documentation and internal controls, we believe that with the establishment of clearcut requirements, State

inspectors could be trained to identify deficiencies in a facility's management of patients' funds. The more complicated or serious problems could be referred to appropriate State or Federal auditing or investigating agencies for further development.

Thus, it seems to us that while the authority for 100-percent Federal funding of inspections and related training exists, HEW or the States have an opportunity to emphasize the review of patients' funds in their training program.

STATE AUDITS COULD BE AUGMENTED BY MEDICARE AUDITS

Although State Medicaid plans are required to assure appropriate audits of nursing home records by the State, HEW does not require that the plans specify the frequency of such audits or that patients' funds be included in the audits.

In three of the five States we visited, State audit agencies made, or were making, a number of audits of patients' funds. In New York, which has approximately 540 facilities, the State audit agency had completed 25 audits and another 36 were in progress as of April 1975. These were comprehensive audits of the facilities which included (1) the determination of eligibility for Medicaid, (2) the propriety of billings submitted by the facility, and (3) the propriety of procedures used in the receipt, maintenance, and use of personal funds paid to Medicaid recipients. The final reports or report drafts included the following deficiencies:

--Proper records of receipts and disbursements of patients' personal funds were not maintained.

--One nursing home had used about $7,000 of a total of $16,000 in patients' funds to meet operating expenses.

--One facility kept patients' funds in separate envelopes bearing the patients' names. This facility made bulk purchases of clothing for patients. Then an employee collected the funds for payment for such purchases from all the envelopes without regard to who benefited from the purchases.

We visited two of the facilities in New York approximately 7 months after the reports were issued to the facility to determine whether corrective actions had taken place. In each of these facilities we found that corrective actions had not been taken.

In Florida, which has 251 SNFs and 8 ICFs participating in the Medicaid program, the Florida audit agency had issued one report on patients' funds as of May 30, 1975. This January 31, 1974, report cited activities of three Dade County nursing homes and questioned the handling of about $75,588 in patients' funds. Activities questioned by the Florida audit agency included charging for wheelchairs and bedspreads, clothing which patients testified they did not receive, physical therapy, and recreational programs. However, in January 1975, when an additional 23 nursing home audits were in progress, all nursing home audits were suspended and the audit effort was directed to other areas. These audits were resumed in October 1975.

Michigan made periodic audits of nursing homes. Audits of nursing homes in 1973 and 1974 disclosed 18 instances where nursing homes were commingling patients' funds with operating funds.

California and Missouri have not made audits of patients' funds maintained by SNFs and ICFs.

In summary, New York and Florida had audit coverage pertaining to patients' funds for about 10 percent of their facilities. The extent of Michigan's audit coverage was not determinable and we could identify no specific coverage of patients' funds by State audit groups in California and Missouri.

Common audit agreements between Medicare and Medicaid

Historically, the Medicare and Medicaid programs have both required that inpatient hospital services be reimbursed on the basis of reasonable costs. To assure that this was being achieved, a provider audit function has been needed under both programs. Therefore, in order to eliminate duplication of auditing effort, the Social Security Administration and SRS, among others, developed a common audit agreement. The purpose of the agreement was to have one audit of a participating hospital which would serve the needs of all programs reimbursing the hospital, with such programs sharing the audit's cost. As of June 30, 1975, 33 States had agreements with Medicare fiscal intermediaries for common audits of hospitals.

Usually the Medicare intermediaries also make cost reimbursement audits of SNFs participating in Medicare.[1] Of the 7,100 SNFs participating in the Medicaid program, about 4,000 also participate in Medicare, whereas only 337 of the SNFs participating in the Medicare program did not participate in Medicaid. Of the 30 Medicaid facilities in our review, 27 were SNFs, of which 6 also participated in Medicare. As of September 30, 1975, the Medicare intermediaries had started 1,981 field audits of the 4,419 SNFs (45 percent) that had filed cost reports for reporting periods ending during fiscal year 1974.[2] Therefore, it may be possible that the States could modify their common audit agreements with fiscal intermediaries to include making reviews of Medicaid patients' funds at SNFs where the Medicare intermediaries were already making field audits.

CONCLUSIONS

Monitoring efforts by the States have not been effective in assuring compliance by SNFs and ICFs with requirements for managing patients' funds. A basic problem appeared to be that State inspectors may not have been qualified to make inspections of matters involving accounting or auditing skills. There has been a lack of formal training by HEW and the States in this area. Both the inspections and related training are currently financed entirely by the Federal Government.

State audits in three of the five States disclosed deficiencies similar to the ones we identified; however, such audits of patients' funds involved relatively few of the facilities participating in Medicaid in these States.

In our view, the management of patients' personal funds by SNFs and ICFs is an area that has been neglected and/or overlooked by the States. Our review indicates that there is a need to obtain more extensive coverage in this particular problem area.

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[1] Medicare posthospital institutional inpatient coverage is limited to SNFs.

[2] Under SSA policy, the frequency and scope of provider audits for any particular reporting period is a matter of an intermediary's judgment. However, audits must be initiated within 3 years.

Under the existing monitoring systems the broadest onsite coverage of long-term care facilities participating in Medicaid is provided under the annual State certification inspections which are required for all facilities.

We believe that, with increased training of inspectors in reviewing patients' funds, these certification inspections could be an important vehicle for providing the necessary monitoring.

In view of the limited coverage of patients' funds provided by the State auditing agencies in the States reviewed, another potential method for providing additional monitoring of the management of patients' funds maintained by SNFs is by using the fiscal intermediaries' audit capability under the Medicare program. As previously discussed, about 45 percent of the 4,000 SNFs participating in Medicare were being audited onsite by Medicare intermediaries for fiscal year 1974. For those States having common audit agreements with Medicare intermediaries, such agreements could be modified to provide for audit coverage of the management of patients' funds at SNFs, provided the States were willing to pay for such coverage.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary should direct the Administrator of SRS to:

--Train State inspectors so that they can identify problems that exist in a facility's management of patients' funds.

--Encourage States to modify their common audit agreements with the Medicare fiscal intermediaries to include a review of patients' funds at SNFs.

APPENDIXES

APPENDIX I

APPENDIX I

SUMMARY OF DEFICIENCIES IN

NURSING FACILITIES'

MANAGEMENT OF PATIENTS' FUNDS

Facilities	Major deficiencies: Shortages	Charging for medical supplies	Maintaining funds of deceased or transferred patients	Keeping interest earned on patients' funds	Subtotal of major deficiencies
Proprietary:					
1. Florida	X		X		2
2. Florida					0
3. Florida		a/X			1
4. Florida					0
5. Michigan					0
6. Michigan					0
7. Michigan				X	1
8. Michigan					0
9. Michigan					0
10. Missouri	X	a/X			2
11. Missouri		a/X			1
12. Missouri		a/X			1
13. California					0
14. California					0
15. California		a/X	a/X		2
16. New York					0
17. New York					0
18. New York	X	-	-	-	1
Subtotal	3	5	2	1	11
Public:					
19. Florida			X		1
20. Michigan				X	1
21. Missouri					0
22. Missouri		a/X	X		2
23. California					0
24. New York			X		1
25. New York	-	-	X	-	-
Subtotal	0	1	4	1	6
Private non-profit:					
26. Florida			X	X	2
27. California				X	1
28. New York			X		1
29. New York					0
30. New York	-	-	X	-	-
Subtotal	0	0	3	2	5
Total	3	6	9	4	22

a/Facility did not comply with HEW or State requirements.

APPENDIX I

APPENDIX I

Procedural deficiencies						
Using patients' funds for operating expenses (commingling)	No quarterly accounting at skilled homes	No written procedures for handling of patients' funds	Poor receipt procedures	Other procedural deficiencies	Subtotal of procedural deficiencies	Total number of deficiencies
a/X	a/X	a/X	X	1	5	7
a/X	a/X	a/X	X	1	5	5
	a/X	a/X	X	0	3	4
a/X	a/X		X	2	5	5
			X	2	3	3
a/X	a/X	a/X	X	1	5	5
	a/X	a/X		0	2	3
	a/X	a/X		1	3	3
	a/X	a/X	X	2	5	5
X	a/X	a/X		2	5	7
	a/X	a/X	X	3	6	7
X			X	2	4	5
	a/X		X	1	3	3
	a/X		X	0	2	2
a/X	a/X		X	3	6	8
X			X	2	4	4
				2	2	2
--	--	--	X	3	4	5
8	13	9	14	28	72	83
	a/X	a/X	X	0	3	4
		a/X		1	2	3
		a/X	X	4	6	6
				0	0	2
	a/X			0	1	1
X			X	2	4	5
--	--	--	--	3	3	4
1	2	3	3	10	19	25
	a/X	a/X	X	2	5	7
a/X	a/X			0	2	3
				1	1	2
			X	1	2	2
X	--	--	X	3	5	6
2	2	1	3	7	15	20
11	17	13	20	45	106	123

APPENDIX II

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR THE ADMINISTRATION OF

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
F. David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1976	Present
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969

Appendix 2

MATERIAL RECEIVED FROM DR. NANCY C. BOOTH KURKE [1]

PELHAM MANOR, N.Y., *September 22, 1976.*

Senator FRANK E. MOSS,
Subcommittee on Long-Term Care,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MOSS: I thought you might be interested in the results of the audit of the East Harlem Medical Group on August 16–17, 1976. I am therefore enclosing a Xerox copy of the report (which I belatedly received yesterday), as well as my direct response to medicaid. I assume the delay was intended to discourage my response, which it didn't.

Since you are rather familiar with the clinic in question and the general level of medical practice there, I'm sure you will be amused by the superficiality of the survey. The penalties for failure to correct deficiencies are really awe-inspiring, namely delay in payments or a provider discussion at medicaid headquarters! I don't consider this appropriate punishment nor an effective way to improve regulation of such clinics.

In case you haven't heard, it's business as usual at the East Harlem Medical Group.

Sincerely,

NANCY C. BOOTH KURKE, M.D.

[Enclosures.]

Memorandum

BROOKLYN, N.Y., *September 10, 1976.*

Received: September 21, 1976.
To: N. Kurke, M.D.
Subject: Medicaid audit of facility No. 038 of August 16–17, 1976.

Enclosed herewith is a copy of an audit evaluation recently received from medicaid. Steps are presently being taken to comply with medicaid's standards and requirements.

If you have any questions concerning this matter, kindly advise this office.

TAD H. GWIRTZMAN.

[Enclosure.]

THE CITY OF NEW YORK,
DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES,
New York, N.Y., August 26, 1976.

Facility No. 038
Date of Audit: August 16, 17, 1976.
Dr. CLYDE WEISSBART,
Medical Director,
East Harlem Medical Group,
New York, N.Y.

DEAR DR. WEISSBART: The New York City Department of Health is charged with the responsibility of monitoring the quality of health services provided Medicaid patients. In assessing quality the Department examines how well individual practitioners perform those activities for which they are responsible.

In addition, the quality of care is also dependent upon the adequacy of necessary support services and follow-up activities. Therefore, the practitioners

[1] See statement, p. 683.

are personally responsible for providing total care within a practice setting conducive to accepted standards of medical care. Future payments to all practitioners in the center are contingent upon compliance with such standards.

At the time of the above visit, various problem areas were identified. These findings are recorded on the accompanying report form. Please note that these deficiencies include both failure to comply with existing regulations and failure by the center to provide individual practitioners and their patients with support services and follow-up activities considered necessary to render quality care.

Please be advised that it is necessary for the problem areas cited to be rapidly addressed and remedied in such a manner as to assure that the overall care that patients receive in your center meets all minimum standards.

Each practitioner is required to advise this office in writing of the steps that will be taken to correct the cited deficiencies. A joint response by the administrator/medical director will be accepted in lieu of the individual responses, with the stipulation that each practitioner also individually sign the joint response. In either case, the response must be received in this office within 15 days of the date on which you receive this communication. Failure to do so may result in either a delay in payments to all practitioners or a provider discussion to be held in this office with all practitioners, or both.

We will be happy to respond to any questions you may have.

Very truly yours,

AL SCHWARZ, CSW, ACSW,
Assistant Commissioner,
Deputy Executive Director of the
Medical Assistance Program.

New York City Department of Health, Bureau of Health Care Services (medicaid)—report of facility compliance with health regulations and quality of care standards, East Harlem Medical Group No. 038, 145 East 116th St., New York, N.Y.

(Date of audit: Aug. 16–17, 1976)

	Compliance
I. General:	
*A. Physician on premise at all times when facility is open	Yes.
*B. Arrangements for assisting patients requiring care during off hours	Yes.
C. Designation of an individual responsible for coordinating and managing facility activities	Yes.
II. Pharmacy:	
*A. Maintenance of patient drug use profiles for pharmacies in or adjacent to the facility (formulary P. M2)	No.
*B. A sign indicating free choice of purveyors conspicuously posted, facility or pharmacy	Yes.
III. Patient flow in shared health facility:	
*A. Operational appointment system for revisit patients	Yes.
*B. Patients assigned primary physician on initial visit	Yes.
*C. Patients scheduled to see same primary physician on follow-up visits	Yes.
IV. Record system:	
A. Maintenance of all patients' medical records in a centralized recordkeeping system	Yes.
*B. Patient's records or a complete abstract available at all times to all practitioners (excluding dental)	Yes.
*C. Maintenance of a central day book for the facility which includes: patient's name, medicaid number, doctors seen, referrals	No.
D. Recall and management of patients with positive diagnostic findings	Yes.
E. Positive diagnostic findings recorded in records	No.

	Compliance
V. Radiology:	
*A. Facilities for x-ray on premises	Yes.
*B. Use of Radiology equipment inspected and registered (by the N.Y.C. Health Code 175.52a)	Yes.
a. Central	Yes.
b. Podiatry	Not applicable.
c. Dental	Yes.
d. Fluoroscopy	Not applicable.
*C. Identification of all x-ray films to include:	
1. Patients name or identifying code	Yes.
2. Date	Yes.
3. L/R indication (view of sides of area x-rayed)	Yes.
VI. E.K.G.'s:	
A. The availability of an E.K.G. machine on the premises at all times	Yes.
B. E.K.G. machine equipped with 12 leads	No.
VII. Laboratory:	
A. Laboratory on premises	Yes.
B. Current license from N.Y.C. Department of Health	Yes.
C. Lab procedures performed limited to those approved by Bureau of Labs	Yes.
D. Labeling of lab specimens to include: patient's name and Medicaid number	Yes.
E. Use of commercial laboratory that holds permit issued by the N.Y.C. Health Department	Yes.
F. Routine laboratory specimens picked up daily	Yes.
G. Stat lab capability	Yes.
*H. Refrigerator with temperature between 40°–50° for lab specimen only (N.Y.C. Health Code 13.236)	Yes.
VIII. Emergency equipment and supplies:	
*A. Availability of the following emergency equipment:	
1. Ambulance bags (or portable oxygen)	Yes.
2. Airway	No.
3. Ephinephrine (aqueous 1:1000)	Yes.
4. Aromatic spirits of ammonia	Yes.
5. Corticosteroids	Yes.
6. Benadryl	Yes.
7. 50 pct Glucose and H_2O	Yes.
*B. Refrigerator for biologicals maintained at temperature between 36°–40°	Yes.
*C. Thermometer in refrigerator to monitor temperature	No.
*D. Biologicals currently dated	Yes.
*E. Adequate supply of clinical thermometers	Yes.
*F. Provisions for destruction of syringes/needles	Yes.
*G. 1. Infant weight scale	No.
2. Adult height and weight scale	Yes.
*H. Provisions for hot sterilization	No.
*I. Snellen eye chart with mark to identify 20 or 10 ft distances	No.
IX. Physical facilities:	
A. 1. Current certificate of occupancy	No.
*2. Lighting sufficient to meet minimum public facility lumination requirements	Yes.
*3. Ventilation-Heating and cooling capacities sufficient to meet minimum public facility ventilation standards	Yes.

IX. Physical facilities—Continued	Compliance
*4. Seating sufficient to meet needs of patients	Yes.
*5. Clean patient toilet facilities with soap, towels and a functioning sink with hot and cold running water	No.
*6. No evidence of rodents or vermin infestation	Yes.
*7. Wall surfaces clean and in good repair	Yes.
*8. Ceiling in good repair	No.
*9. Floor surfaces clean and in good repair	No.
*10. Storage space area for necessary supplies and equipment	Yes.
*11. Locked space for syringes and needles	Yes.
*12. Alternate means of egress	Yes.
*13. Exits identified	Yes.
*14. Fire extinguishers available	Yes.
B. Examining room:	
*1. Complete audio and visual privacy	Yes.
*2. A functioning sink with running water, soap and towels	No.
*3. A sufficient quantity of all required supplies and equipment	Yes.

COMMENTS

(1) Poor housekeeping standard as reflected by
(a) Floors dusty and dirty (3d & 4th Floors).
(b) Stairwells dustladen.
(c) Waste baskets uncovered and overflowing.
(2) Sink in toilet rooms dirty. Floor tiles broken in laboratory room, toilet room and corridor area.
(3) Protective covering not provided for radiators.
(4) Evidence of leak in ceiling of X-ray room.

SUMMARY OF RECORD AUDIT—FACILITY NUMBER 038

	Number of applicable records	Number deficient records	Percent deficient records
Documentation on chart not complete:			
1. Charts were illegible	50	39	78
2. Name, address, medicaid number not on patient's record	50	0	0
3. Visits are not dated chronologically	50	5	10
4. There is no practitioner's signature for each visit	50	25	50
5. Chief complaint not listed for each new illness	50	7	14
6. There is no documentation of a history or interim information for each visit	50	11	22
7. There is no documentation of a physical exam for each visit	50	17	34
8. There is no diagnostic impression for each visit	50	14	28
9. Medications ordered did not include precise dosage and prescription regimen	50	50	100
10. Records do not indicate date and reason for referral	43	37	86
11. Reports of referrals not in chart	43	1	2.3
12. Chart does not state whether patient is to return or not and if yes, there is no return appointment	50	50	100
All exams and screenings were not requested by M.D.:			
13. Laboratory tests	50	0	0
14. X-rays	44	0	0
15. E.K.G.'s	19	0	0
Results of exams or screenings were not recorded (more than 2 weeks):			
16. Laboratory tests	50	2	25
17. X-rays	44	30	68
18. E.K.G.'s	19	11	57
19. Results of tests and screenings not affixed to record in chronological order	35	9	25
Initial routine exams were not performed:			
20. E.K.G. (males over 40)	3	2	66
21. Rectal (males over 40)	3	1	33
22. Blood pressure (any adult)	40	25	62
23. Pap smear (females over 20)	35	33	94
24. Hematocrit (females 20–40)	35	1	2

SUMMARY OF RECORD AUDIT—FACILITY NUMBER 038—Continued

	Number of applicable records	Number deficient records	Percent deficient records
PEDIATRIC			
Recording on chart was not complete:			
25. Past medical history	10	3	30
26. Child's previous health care	10	9	90
27. Family history	10	4	40
Immunizations were not complete:			
28. DPT	10	8	80
29. Polio	10	9	90
30. Measles	10	10	100
31. Rubella	10	10	100
32. Mumps	10	10	100
Lab work, tests or screenings were not complete:			
33. Tine test	10	10	100
34. Hematocrit	10	0	
35. Urine	10	4	4
36. Lead	10	10	10
37. Vision	9	9	9
38. Audio	9	9	9
39. Height and weight	10	10	10
40. Developmental assessment	10	7	7

PELHAM MANOR, N.Y., *September 21, 1976.*

MR. AL SCHWARZ,
Assistant Commissioner,
Deputy Executive Director of the Medical Assistance Program,
Bureau of Health Care Services,
New York, N.Y.

DEAR MR. SCHWARZ: I received from Mr. Tad Gwirtzman today a copy of an audit done on August 16 and 17, 1976 of the facilities and patient records of The East Harlem Medical Group (facility #038), and read it with great interest. I would have responded within the required time period if I had had the opportunity to do so. It would appear that Dr. Weissbart and Mr. Gwirtzman wanted to save me the trouble involved in replying even to the point of not having me sign the joint response. I should like to comment on the deficiencies described in this report, and enumerate a few you seem to have overlooked or underestimated.

Of primary importance are the poor housekeeping standards observed, since they reflect a marked improvement over normal conditions and resulted from a considerable housecleaning effort on 8/14/76 which took place while I was working. I was told, in fact, that it was very important to "get the place clean" because of the scheduled audit. In short, the facility displayed an unusual degree of cleanliness which was achieved specifically for the inspection, but which by no means reflected its normal state.

I was disappointed that there was no mention of the fact that the paper rolls used to cover the examining tables rest on the floor, which is in open violation of D.H. regulations. There was a reference to dirty sinks in the bathrooms, but unfortunately no description of the atrocious state of the "staff" bathroom. The latter is remarkable in that neither soap nor towels are provided; that it is used for the disposal of laboratory specimens and that contaminated containers are then discarded in its trash receptacle; that there are large holes in its walls and that the spaces behind the walls are full of trash; that the sink is usually full of dirty standing water because its drain is usually clogged. Despite the sign on the door, this bathroom is often used by patients.

Supposedly there was no evidence of rodent or vermin infestation, but I saw roaches in the third floor bathroom every time I used it, and even killed some in the examining room. I reported this to Dr. Weissbart repeatedly, but saw no evidence of extermination measures.

I was also surprised that your investigators failed to notice a large hole in the sink in the file room, in which area bloods are drawn. This means that contaminated water is continually dripping from the sink, which is surely an unsanitary situation.

One of the faults found with the physical plant was lack of a current certificate of occupancy, although the fact that current registration certificates of physicians, chiropractors, and podiatrists are not displayed was apparently of no significance. According to state law, office display of these documents is required, and should be enforced by the city agencies involved in regulation of medicaid clinics.

I must take issue with many items in the audit report, which I will designate with the classification used in the report itself, as follows:

I.B. Contrary to your report there were no provisions of any kind made for assisting patients requiring care during off hours, nor was there any great concern about such deficiencies.

VII.C. Lab procedures performed are limited to those approved by the Bureau of Laboratories, but do NOT include a hemoglobin because there is no hemoglobinometer. According to the Medicaid Provider Handbook, page 11, a complete blood count ALWAYS includes a hemoglobin determination. I assume that your office is familiar with these regulations: it seems strange therefore that this deficiency is not included either in the limitations of the laboratory or in the reports produced by it.

VII.F. Routine laboratory specimens are picked up daily, except on Saturday. Specimens of blood and urine obtained on Saturday are therefore held until the following Monday, or even until Tuesday if Monday is a holiday. Even if refrigerated these specimens are essentially useless for examination: despite this fact the tests are performed anyway.

VII.H. The refrigerator which is technically supposed to be used only for laboratory specimens is also the repository for frequently used biologicals and medications (i.e. Tine tests, tetanus toxoid, penicillin for injection, etc.).

VIII.A.7. Even though 50% glucose is available, there are no sterile 50 cc. syringes suitable for its administration.

VIII.E. The clinical thermometers were obviously provided for the inspection, but were almost never available routinely when needed for patients.

VIII.H. Since no provisions for hot sterilization are available I feel obliged to suggest that routine use of glass clinical thermometers is inadvisable. Alcohol cleaning is not usually adequate to sterilize, and in any event neither alcohol nor heat have any effect on the virus of homologous serum jaundice. For this reason electronic thermometers with disposable plastic shields are in common use in city hospitals and clinics, and are now even available in department stores. I think the DH should make the use of such a device mandatory in clinics to improve public health practices.

IX.B.3. A sufficient quantity of all required supplies and equipment was supposedly found, but there is only one size blood pressure cuff available, one that is adequate only for the average adult. There is neither a pediatric cuff nor an oversize cuff: the latter is mandatory for measuring the blood pressure accurately in the oversize arm. I think both Dr. Gentry and Dr. Paris will confirm the necessity of such equipment. Even casual inspection of the patient population in any clinic will reveal a significant number of patients who require either a very small or a very large cuff for blood pressure measurement. Since such equipment is regarded as standard by even minimally knowledgeable physicians I cannot believe that any clinic with one blood pressure cuff can be considered adequately equipped to evaluate one of the single most important measurements in the entire physical examination.

The portion of the audit related to review of the patients' records was equally interesting but also open to discussion, if only for its lack of concern for quality. I cannot recall seeing X-ray results in the charts more than twice, but surely the quality of the X-rays reported has to be considered. All of the films I saw were of very poor quality: the majority would have been considered inadequate for diagnostic purposes at any hospital in which I have ever worked. The majority of EKG's were inadequate because they were unlabeled; unstandardized and without lead identification markings; not run long enough to show a stable baseline; incomplete; and most importantly, were never suitably mounted nor interpreted, nor was any interpretation ever identifiable in the progress notes. Qualitatively and medically there is a huge difference between a strip of paper and real EKG, although I was informed that such a strip of paper itself was regarded as "documentation" for purposes of payment. In essence, then, Medicaid is paying for pieces of paper, and NOT for medical evaluation or treatment.

As far as the Tine test goes, it was often performed but the results almost never got into the chart because no provisions were ever made to have patients return in 48 hours for reading, nor were patients ever given induration evaluation cards to record the results themselves, although the latter are available in unlimited quantities, in Spanish and English, at no cost from Lederle.

Despite the tardiness of this reply I think it reveals more than a casual interest in the clinic which was audited. Since I am no longer employed there I am unable to take any steps towards correcting the deficiencies you noted. I can say unequivocally that Dr. Weissbart was never particularly enthusiastic about facilitating any of the numerous suggestions and recommendations I made to this end. I certainly hope that someone in the city administration has enough interest and authority to achieve compliance with what seems to me to be the most inadequately enforced code of regulations I have ever read.

I trust that you will not be upset by the knowledge that I am forwarding a copy of the audit report and this letter to Senator Frank E. Moss of the Subcommittee on Long-Term Care. He has a rather personal interest in this particular clinic and in the improvement in regulation of such clinics in general.

If there is any further way in which I can be of help to you, please feel free to contact me directly.

Sincerely,

NANCY C. BOOTH KURKE, M.D.

Appendix 3

APPLICATION TO REVIEW GRAND JURY MINUTES

APRIL 11, 1976.

HON. ROBERT M. MORGENTHAU,
District Attorney,
County of New York,
New York, N.Y.

DEAR MR. MORGENTHAU: On behalf of the members of the United States Senate Special Committee on Aging, I am requesting a copy of the minutes of the Fourth November 1969 Grand Jury on the Administration of Medicaid in the City of New York (People of the State of New York v. John Doe, et al convened November 24, 1969 and concluding April 15, 1971).

The minutes of these proceedings will aid the Committee in the exercise of its oversight function with respect to Medicaid. The Committee is in the process of evaluating the administration of the public assistance programs in several states with an eye toward the enactment of legislation to correct what are apparently widespread abuses in the program.

Needless to say, names or other pertinent data from the Grand Jury minutes will not be disclosed to the general public.

Your cooperation in this matter will be greatly appreciated.

With best wishes,

Sincerely,

VAL J. HALAMANDARIS,
Associate Counsel, U.S. Senate,
Special Committee on Aging.

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK
v
JOHN DOE, ET AL, DEFENDANTS

APPLICATION TO REVIEW GRAND JURY MINUTES FOR FOURTH NOVEMBER 1969 GRAND JURY MEDICAID INVESTIGATION

STATE OF NEW YORK,
COUNTY OF NEW YORK, *ss.*:

Val J. Halamandaris, being duly sworn, deposes and says:

1. I am an Associate Counsel to the United States Senate Special Committee on Aging.

2. That Senate Committee is currently investigating abuses in the administration of medical assistance programs in several states, including New York, toward the enactment of legislation which will correct apparent widespread abuses.

3. From on or about November 24, 1969 through on or about April 15, 1971, the Fourth Grand Jury for the County of New York investigated various abuses in the administration of the Medical Assistance Program and returned an indictment against Dr. Frederick Fisher and others for the crime of Filing a False Instrument, Forgery and Grand Larceny.

4. I have informed Peter D. Andreoli, Assistant District Attorney in charge of the Frauds Bureau that a review of these Grand Jury minutes would serve to give the Committee an overview of the administration of the New York State Medicaid Program and facilitate the committee's efforts to draft and enact legislation and obtain investigative leads. The said Grand Jury minutes will not be used for general publication.

Wherefore, it is hereby requested that the District Attorney of New York County be authorized to release a copy of the above-cited Grand Jury minutes to the United States Senate Special Committee on Aging, their Counsel and representatives.

VAL J. HALAMANDARIS,
Associate Counsel, U.S. Senate,
Special Committee on Aging.

Sworn to before me this 14 day of April 1976.
EMILE L. BERNIER,
Notary Public, State of New York.

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK
v
JOHN DOE, ET AL, DEFENDANTS

AFFIRMATION IN SUPPORT OF APPLICATION TO REVIEW GRAND JURY MINUTES FOR FOURTH NOVEMBER 1969 GRAND JURY, MEDICAID INVESTIGATION

Peter D. Andreoli, an attorney admitted to practice in the courts of this state, hereby affirms under the penalties of perjury that the following statements are true:

1. I am an Assistant District Attorney, of counsel to Robert M. Morgenthau, District Attorney of New York County, and am in charge of the Frauds Bureau.

2. On April 13, 1976, Val J. Halamandaris, Associate Counsel, United States Senate Special Committee on Aging, informed me that the United States Senate Special Committee on Aging is currently investigating abuses in the administration of medical assistance programs in several states, including New York, toward the enactment of legislation which will correct apparent widespread abuses in these programs.

3. From on or about November 24, 1969 through on or about April 15, 1971 the Fourth Grand Jury for the County of New York, investigated various abuses in the administration of the Medical Assistance Program and returned an indictment against Dr. Frederick Fisher and others for the crimes of Filing of False Instruments, Forgery and Grand Larceny.

4. Mr. Halamandaris informs me that these Grand Jury minutes would serve to give the committee an overview of the administration of the New York State Medical Assistance Program and aid in its evaluation of said program (see Exhibit A). He further informs me that the said minutes will not be used for general publication.

5. Accordingly Val J. Halamandaris, Associate Counsel to the U.S. Senate Committee on Aging requests a copy of the entire minutes of the testimony before the Fourth November 1969 Grand Jury for the County of New York concerning the Medicaid Investigation.

6. The review of these minutes by the United States Senate Special Committee on Aging is for the purpose of preparing legislation and not for the purpose of general release to the public and will not interfere with any ongoing investigation.

Wherefore, the District Attorney joins in the request for an order by this court releasing the said Grand Jury minutes to the United States Senate Special Committee on Aging, their counsel and representatives.

PETER D. ANDREOLI.

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK
v
JOHN DOE, ET AL, DEFENDANTS

ORDER

At a Term, Part 30 of the Supreme Court of the State of New York, New York County, held at the Courthouse thereof, 100 Centre Street, City and County of New York, on the 14th day of April, 1976.

Present: GERALD P. CULKIN, JUSTICE OF THE SUPREME COURT.

An application having been made on this 14th day of April, 1976, by Val J. Halamandaris, Associate Counsel, United States Senate Special Committee on Aging and the District Attorney being represented by Peter D. Andreoli, Assistant District Attorney of New York County, consenting thereto, and after considering the argument and merits of the said notice,

Now, upon reading the affidavits of Val J. Halamandaris, Associate Counsel, United States Senate Special Committee on Aging, and Peter D. Andreoli, Assistant District Attorney for New York County.

It is hereby ordered, that the U.S. Senate Special Committee on Aging by their official representatives be entitled to obtain a copy of the Grand Jury minutes in the above entitled action, and it is further

Ordered, that upon filing this order with the Clerk of the Court and service being made upon Robert M. Morgenthau, District Attorney of New York County, that the said District Attorney is authorized to release a copy of the said minutes of the Grand Jury to the said United States Senate Special Committee on Aging, their counsel and representatives.

Enter,

GERALD P. CULKIN,
Justice of the Supreme Court.

Appendix 4

SENTENCING MEMORANDUMS OF THE U.S. DISTRICT COURT OF THE SOUTHERN DISTRICT OF NEW YORK

ITEM 1. UNITED STATES OF AMERICA *v.* SHEILA TOBY STILES, DEFENDANT

[75 Cr. 1201 (HFW)]

SENTENCING MEMORANDUM

This sentencing memorandum is respectfully submitted to apprise the court of the circumstances of the medicaid fraud of which the defendant was a part. The information to which the defendant pleaded and the allocution at the time of the plea contain a partial statement of the facts pertaining to her offense. This memorandum will elaborate upon these facts, illuminate defendant's role in the overall scheme, and focus upon certain factors which the Government deems relevant to the sentence in this case. It is divided as follows:

Part I—The Overall Scheme
Part II—Defendant's Role
Part III—The Government's View of the Crime
Part IV—Matters in Mitigation

Sheila Toby Styles, the defendant, presently a children's clothes designer, pleaded guilty on November 10, 1975 to a three-count criminal Information charging her with having conspired to defraud the United States and to violate Title 18, United States Code, §§ 287, 1001, and 1341, in violation of Title 18, United States Code, § 371, with having filed false claims against the United States in violation of Title 18 U.S.C. §§ 287 and 2, in connection with the submission of fraudulent Medicaid invoices, and with having failed to file a personal income tax return for the year 1971, in violation of Title 26, United States Code, § 7203.

I. THE OVERALL SCHEME

During the period 1969–1972 Joseph Howard Ingber, Sheldon Max Styles,[1] and others owned and operated eight medical clinics in low income areas of New York City. These clinics or "Medicaid Mills" which catered almost exclusively to Medicaid recipients are as follows:

1. Galler Medical Building, 858 Flushing Avenue, Brooklyn, N.Y.
2. Claremont Medical Building, 3589 3rd Avenue, Bronx, N.Y.
3. Queensbridge Medical Building, 38–81 13th Street, Queens, N.Y.
4. Laconia Medical Building, 4025 Laconia Avenue, Bronx, N.Y.
5. 8th Street Medical Building, 8–01 Astoria Blvd., Queens, N.Y.
6. Kent Street Medical Building, 156 Kent Street, Brooklyn, N.Y.
7. RIN Realty Corp. (also known as Centro Medico, also known as St. Mary's; also known as St. Ann's), 567 E. 149th Street, Bronx, N.Y.
8. Corona Medical Building, 105–05 Northern Blvd., Queens, N.Y.

In the early nineteen-sixties, Ingber and Styles were classmates at the Chiropractic Institute of New York. After graduating in 1963, Ingber began a private practice in a Manhattan office. Styles associated himself with Ingber's private practice, working alternate days.

In 1968 Styles also began working in a Jamaica, Queens Medicaid clinic run by an optometrist. Allegedly false Medicaid billings were submitted from this

[1] All persons mentioned by name have either been convicted of Medicaid Fraud charges, or have waived indictment and pleaded guilty to criminal informations ranging from one to seven felony counts.

clinic. Shortly thereafter, when Ingber and Styles opened their own office at 168th Street in Jamaica the lessons learned at the optometrist's clinic were applied.

Business was brisk at the Jamaica office and by 1969 false Medicaid billings were regularly being written. With a growing patient load Ingber and Styles sought to add another chiropractor to their staff. Ingber contacted his former teacher, Dr. Max Kavaler, who had been unemployed since the failure of the Chiropractic Institute in 1968, and offered him a job. Kavaler accepted and Ingber and Styles explained that the financial arrangement would consist of him paying them 25% of his Medicaid income (after factoring) for rent, after which Kavaler, Styles, and Ingber would share the remainder equally: 1/3 to each, (an overall net for Kavaler of approximately 25% of the face value of his invoices.) This was to become the typical financial arrangement for all chiropractors who were to work for Ingber and Styles in the years ahead.

From March to September 1969 Kavaler worked under this arrangement when he entered into a partnership with Ingber, Styles, an attorney, and another chiropractor, to form the 105–05 Northern Blvd. Corporation and operate a clinic at that Corona, Queens address.[2]

Fraudulent Medicaid billings were submitted early in the Corona clinic's operation. Patients were "ping-ponged" throughout the clinic (i.e., examined by every medical specialty on the premises despite the patients' wishes or medical needs), and invoices were submitted for patients never actually treated. Routinely, when a patient visited the clinic the receptionist took a complete family history, i.e., first name, sex, and birthdate of all Medicaid-eligible family members. Since all members of a family are covered by a single Medicaid number, the family history provided those providers, who were so inclined, with all information required to prepare fraudulent invoices for submission to the City of New York which administered the Medicaid program. The practice of billing various members of a Medicaid eligible family when no such visits or treatments ever took place became commonplace at Corona and other clinics operated by Ingber and Styles.

Patients at most of these clinics routinely had blood taken on each visit regardless of the ailment. Blood tests, ekg's and x-rays (at those clinics which actually had ekg or x-ray machines) were taken or administered by "nurses," clinic employees generally not licensed to perform these procedures, who were trained by other employees and acting under various degrees of doctors' supervision ranging from none to some. One effect of the ping-ponging, and the attendant waiting to see the doctor who could treat the actual complaint, was to cause many patients to cease taking their children back to the clinics or to cease going themselves, for that matter, for illnesses or complaints that were anything short of urgent. Whether the indirect effect of the ping-ponging and other abuses patients were subjected to was to cause persons to not seek treatment, and thereby worsen their health or become more ill, can only be speculated; however, it seems probable that such occurances did happen.

In 1969, while the Corona clinic was in operation, Ingber, Styles and Kavaler took over the practice of Dr. Herman Galler, who had just died and left a thriving practice at a "good" Brooklyn location. A center was organized which was financed by Rose Galler (Dr. Galler's widow), two attorneys[3] and Stanley Reichler. In exchange for his investment in the Galler clinic, Reichler was to become manager of the Corona clinic at a salary.

The Galler clinic opened with Sheldon Styles as its manager. A few months later, Styles left Galler to manage his and Ingber's latest acquisition, (the Queensbridge clinic on 13th Street, Queens) and Kavaler replaced him as Galler's manager.

The Queensbridge clinic was originally owned by two doctors, (one of whom was Ralph Bell, a defendant). In 1969 Ingber and Styles entered into an arrangement with them, forming the 38–18 13th Street Corporation. Ingber and Styles purchased 70% of the Corporation's stock, with the original owners each retaining 15%. In return, Ingber and Styles paid one doctor $7,000 and gave the other, Bell, a 10% interest in the Corona clinic and a 5% interest in Galler.

In the summer of 1970 Ingber and Styles were approached by Donald Trager, another chiropractor. Trager, a friend of Ingber, wanted to open a clinic in the

[2] The attorney and chiropractor have not been charged.
[3] Neither the attorneys nor Mrs. Galler have been charged.

Bronx. He had been offered the lease to the existing Claremont clinic, at 3589 3rd Ave., by two dentists who wanted to divest themselves of an unprofitable location. Ingber and Styles liked the idea and in October, 1970 they and Trager became equal partners in the 3589 3rd Ave. Corporation.

The Claremont clinic, managed on a part-time basis by Trager, was not a success. The patient load was small and unable to support the clinic. Later investigation would reveal that without large scale falsifying of Medicaid invoices by the medical and chiropractic staff, the Claremont clinic would not have stayed in operation as long as it did.

Claremont finally shut its doors in June, 1971 because of its inability to attract patients. Before its closing, however, Ingber, Styles, and Trager opened a new clinic nearby on Laconia Avenue. Trager, believing that he could make a success out of this new location, bought out Ingber's and Styles' interest in the 3589 3rd Ave. Corporation for $500 each. Despite Trager's optimism, the Laconia clinic suffered the same fate as its predecessor. Consequently, as with the Claremont clinic, fraudulent Medicaid invoices were all that kept the clinic financially afloat. Laconia closed in November of 1971.

In the Spring of 1971 Kavaler wanted to disassociate himself with Ingber and Styles. His cousin, an official in the City Medicaid Program, allegedly had warned him to make such a break because of a pending investigation of Ingber and Styles by the New York City Department of Investigation. Kavaler offered to trade his shares in the Queensbridge and Corona clinics in exchange for Ingber's and Styles' shares in the Galler clinic. Ingber and Styles agreed and Kavaler received their Galler stock. He and Rose Galler (who had since bought out Stanley Reichler's and one attorney's interests) remained as the sole owners of Galler.

When rumors of the pending City investigation surfaced in April, 1971, Ingber and Styles decided to dissolve their partnership and go their separate ways.

Shortly thereafter, Ingber opened a new clinic in Queens on 8th Street, with two medical doctors (one of whom was Bell), as partners. Styles joined in a partnership with Reichler, the manager of Corona, Rene Nolan, (a former receptionist at Queensbridge), and a coin dealer. Their efforts were directed at a new clinic on Kent Street in Brooklyn.

Despite prospects of a city investigation, fraudulent Medicaid practices continued at these two locations, although to a lesser extent than had occurred previously at the other clinics. The Kent Street clinic closed in June of 1972 for lack of business, and the 8th Street clinic was sold late in 1972.

During the period 1970–1973 doctors working at the eight Ingber and Styles-operated clinics billed the New York City Medicaid program at least $2,222,699 as follows:

Year:	*Amount*
1970	$510, 655
1971	1, 014, 060
1972	640, 998
1973	56, 986
Total	2, 222, 699

An analysis of available records revealed that the eight Medicaid clinics operated by Ingber, Styles, and others received a total income of $469,195.42. The sources of this income were as follows:

Source:	*Amount*
Doctors (rent, fees)	$325, 658. 14
Alpone Laboratory (kickbacks for lab work)	34, 471. 54
Principals (investments)	5, 644. 45
Deposits from unknown sources	103, 421. 29
Total	469, 195. 42

Doctors doing business at the various clinics factored their Medicaid invoices for an average fee of 12 percent. 25 to 30 percent of their net billings after factoring was paid to the clinic owners. In addition, chiropractors paid the clinic owners (Ingber, Styles, Reichler, and Kavaler) 40 to 50 percent of the balance remaining after the clinic rent was paid. This money (not recorded on the clinic books of accounts), was paid primarily to Ingber and Styles, but the

other principals were also recipients. The total value of such "off the book" payments was approximately $105,000.

The fraudulent practices varied in manner and degree. Certain doctors engaged in the activity known as "padding" invoices, the device of billing for more services than actually rendered to a patient who was actually seen. Another practice was the submission of completely false invoices for patients never treated or seen by the doctor. This would occur by submitting invoices for subsequent visits for patients only seen once or for members of a patient's family who were never seen in the clinic. In many cases a mother would bring her well children with her if she could not find a baby sitter. Invoices would be submitted for all of the children, although none of them may have been seen. In one instance four doctors billed Medicaid for services rendered to a child who had been dead for nine months. In another, three doctors submitted invoices for an individual who, at the time of his alleged treatment was an inmate at Elmira prison. In addition to false invoices for treatments, bills were submitted for ancillary services such as X-ray and EKG from clinics that had no such equipment.

Another lucrative activity engaged in by the owners involved the use of X,[4] an elderly senile medical doctor. Early in 1970 an agreement was entered into between Dr. X, Ingber and Styles wherein, for a weekly salary of $120 all Medicaid income earned by Dr. X reverted to his employers. Dr. X was assigned to write fraudulent invoices. Sheila Styles drove Dr. X from clinic to clinic, where he would be seated at a desk with a pile of patient records and blank invoices to be filled out. He rarely saw any patients, spending all of his time writing. His total billing of $88,370, is estimated at being 98 percent fraudulent. In April, 1970 a joint savings account was opened at the Whitestone Savings and Loan Association in the names of Bell and Dr. X. The purpose of this account, as well as a subsequent joint account in the names of Sheldon Styles and Dr. X, was to launder Dr. X's Medicaid receipts. Checks made out to Dr. X were deposited in these accounts and then disbursed among the owners.

The Bell-X account was used to disburse funds generated at the Queensbridge and Corona clinics. The beneficiaries of this conspiracy were Bell, Ingber, and Sheldon Styles. In 1971 a second joint account in the name of Sheldon Styles and X was opened. The account disbursed Medicaid funds generated at the Kent Street clinic. Beneficiaries were the partners in that clinic, Sheldon Styles, Stanley Reichler, and Rene Nolan Clark.

Although the doctors themselves wrote many of their own false invoices, many of them were prepared by receptionists at the clinics, in particular Rene Nolan Clark and Sheila Stypes (Sheldon Styles' ex-wife). When they falsified invoices, Rene Nolan Clark and Sheila Styles referred to old invoices, old medical records, and family histories of former and current clinic patients for information from which to fabricate visits and treatments that never took place. They prepared enormous amounts of completely false Medicaid invoices for doctors and chiropractors.

II. DEFENDANT'S ROLE

In 1970, five years after her divorce from Sheldon Styles, Sheila Styles was out of a job and looking for work. At the time Sheldon Styles was operating the Queensbridge Medical Center, a Medicaid mill, in partnership with two other chiropractors, Joseph Ingber and Max Kavaler. Sheldon Styles offered his ex-wife a job at Queensbridge, where her duties consisted of cleaning and sweeping up the clinic as well as chauffeuring Dr. X to and from his home.

Shortly after beginning work at Queensbridge, Sheila Styles was informed that a decline in business at the center meant that she would have to take a salary cut. However, she was presented with the opportunity to earn even more money, off the books, by writing Medicaid invoices for Ingber and Styles. She accepted. Ingber and Styles then instructed Mrs. Styles in the ways of preparing fraudulent invoices, first for themselves and eventually for other chiropractors who entered into various agreements with Ingber and Styles intending to defraud the Medicaid programs.

Initially Sheila Styles wrote only three-visit invoices because, according to Medicaid regulations, invoices with three or fewer visits did not require prior

[4] This doctor, who is quite old and senile has not been charged.

approval. In order to generate significant profits, large amounts of these relatively small individual claims had to be written. The solution was to bill Medicaid for the family members of patients on file with the Ingber and Styles clinics. This provided Sheila Styles with large quantities of names with which to bill three-visit invoices. However, the City's Medicaid office discovered this pattern of family "gang" billing and put a stop to it.

With this avenue shut off, Sheldon Styles proceeded to teach Sheila Styles how to write up false chiropractic treatment plans. These plans were the means of getting approval for more than three visits, and usually authorized them to bill Medicaid for twelve to fifteen visits on individual patients. Mrs. Styles has admitted getting the information for these plans from copies of other treatment plans which had already been submitted to the City. She simply changed the patient's name, Medicaid number, and other identifying information and copied the diagnosis and prognosis.

Towards the end of 1970 Sheila Styles began working for chiropractors other than Ingber and Sheldon Styles. For weekly fees ranging from $25–35 per chiropractor, Sheila Styles wrote false Medicaid invoices and treatment plans for a dozen chiropractors during the period 1970–71. By her own admission, virtually all the Medicaid paperwork she performed for these chiropractors was fraudulent.

Among the chiropractors Mrs. Styles wrote false invoices for were two providers who never treated a single patient at an Ingber and Styles clinic, but who, for a share of the proceeds, allowed their names and Medicaid provider numbers to be affixed to fraudulent invoices. The other chiropractors who hired Sheila Styles used her services to supplement the income they were already receiving from the clinics.

Sheila Styles continued writing fraudulent invoices through 1971. In the Fall of that year the New York City Department of Investigations began an active inquiry into the activities of Ingber and Styles. Sheila Styles was called to testify before the Department of Investigations on two occasions. On her first appearance on November 16, 1971 she perjured herself.

On her second appearance before the Department of Investigations, on March 16, 1972, Mrs. Styles invoked her Fifth Amendment privileges to all questions relating to her involvement with Ingber and Styles.

Mrs. Styles has contended that in the course of the City's investigation she was offered a grant of immunity in return for her testimony against the chiropractors she worked for. She did not avail herself of this offer, she claims, in an attempt to protect those individuals. Although the Government is not in possession of any evidence of a formal offer of immunity by the Department of Investigations to Mrs. Styles, it has no basis to suspect that an offer of that sort was not made.

In the course of the investigation into Ingber and Styles conducted by the Federal Government, Sheila Styles was called to testify before a Grand Jury. She appeared on July 22, 1975 and invoked the Fifth Amendment to all questions asked relating to Medicaid fraud.

In November 1975 Mrs. Styles was confronted by the U.S. Attorney's Office with the weight of the evidence against her, including an allegation of having failed to file an income tax return for 1971, and she reached an agreement to waive indictment and plead to the Information before the court.

Only two individuals were prosecuted in this case who were not themselves clinic owners, administrators or Medicaid providers. One was Rene Nolan Clark who has previously been sentenced by Judge Frankel, the other Sheila Styles. Other secretaries and receptionists who wrote false invoices but were not paid specifically for such invoice writing were given informal immunity in return for their truthful testimony before the grand jury. In the Government's judgment, although their roles differed slightly, Sheila Styles' and Rene Nolan (Clark's) culpability were equal. Ms. Styles, however agreed to cooperate at the time of the government's first serious overture for such cooperation; at a time when the information and documents she was able to supply were of vital assistance in the successful prosecution of the chiropractors who paid her to write their false invoices.

III. THE GOVERNMENT'S VIEW OF THE CRIME

Although these crimes may be described merely as "crimes committed with a pen," or "white collar crimes" they are nevertheless substantial and serious

offenses. The crimes, moreover, were not ones of impulse or of short duration, but were committed repeatedly on a daily basis over many months.

The Medicaid program is substantially subverted by these acts. Money allocated by Federal, State and City Governments is squandered without any benefit whatever inuring to the intended beneficiaries of the program. The widespread fraud and abuse only serves to jeopardize the continued existence of health assistance programs like Medicaid, as the public and the congress perceive that the taxpayer's dollars are being funnelled into the pockets of venal professionals. The ultimate victim is the American public at large, but the immediate victims of these crimes are the Medicaid recipients, the poor and elderly who are unable to pay for adequate medical care, and who are usually poorly served by, at best, generally indifferent treatment at medicaid mills.

The deterrent value of the sentences meted out in these cases cannot be underestimated. At present there are literally thousands of eligible medicaid providers (doctors, podiatrists, chiropractors, etc.) and hundreds of "medicaid mills" operating in New York City alone. The frauds perpetrated here are widespread and often difficult to discover and prove.

IV. MATTERS IN MITIGATION

Immediately upon agreeing to enter her plea, Mrs. Styles cooperated with Government investigators by turning over vital records and information concerning her Medicaid activities. As a precaution against double billing patients for different chiropractors on the same day, Sheila Styles had kept a record of every false invoice and treatment plan by date. These 1970 and 1971 records had been retained by her, and were turned over to the government. The existence of these records, combined with Mrs. Styles' potential testimony against the chiropractors she worked for, were factors in the Government's success at securing guilty pleas from all but one of the dozen chiropractors she worked for. In the opinion of the two Assistant United States Attorneys who prosecuted this case Mrs. Styles' agreement to cooperate and turning over of her records was the single biggest "break" in this investigation.

The one chiropractor who did not waive indictment, Dr. Robert March, was tried in District Court before Judge Milton Pollack (76 Cr. 114) in May of this year. Sheila Styles appeared at trial as a witness for the Government and her testimony was material towards the conviction of Dr. March on thirteen counts of submitting false Medicaid claims to the Government.

In connection with her plea Mrs. Styles has appeared whenever requested to supply information and prepare for her testimony. In the opinion of the Assistant United States Attorneys in charge of this case, she has been fully cooperative and completely candid concerning her role in the clinics and the activities of others.

Finally, by her plea, Mrs. Styles has saved the government the time and expense of preparing and trying a case, of about a week's length, against her.

Respectfully submitted,

ROBERT B. FISKE, Jr.,
U.S. Attorney for the
Southern District of New York,
Attorney for the United States of America.

GEORGE E. WILSON
JOEL N. ROSENTHAL
Assistant United States Attorneys of Counsel.

ITEM 2. UNITED STATES OF AMERICA *v.* JOSEPH HOWARD INGBER, DEFENDANT

[75 Cr. 1221 (HFW)]

SENTENCING MEMORANDUM

This sentencing memorandum is respectfully submitted to apprise the court of the circumstances of the medicaid fraud of which this defendant was a part. The information to which the defendant pleaded and the allocution at the time of the plea contain a partial statement of the facts pertaining to his offense.

This memorandum will elaborate upon these facts, illuminate defendant's role in the overall scheme, and focus upon certain factors which the Government deems relevant to the sentence in this case. It is divided as follows:

Part I—The Overall Scheme and the Defendant's Role
Part II—The Government's View of the Crime
Part III—Matters in Mitigation

Joseph Howard Ingber, the defendant, a chiropractor licensed in the State of New York, pleaded guilty on December 19, 1975 to a six-count criminal Information consisting of one count charging him with having conspired to defraud the United States to violate Title 18, United States Code, § 287, 1001 and 1341, in violation of Title 18, United States Code, § 371; two counts of having filed false claims against the United States in violation of Title U.S.C. §§ 287 and 2; one count of having submitted false statements to the United States in violation of Title 18, U.S.C. § 1001 and 2; two counts of mail fraud in violation of Title 18 U.S.C. § 1341 and 2, and in connection with the submission of fraudulent Medicaid invoices during the years 1969–72.

I. THE OVERALL SCHEME AND DEFENDANT'S ROLE

During the period 1969–1972 Joseph Howard Ingber, Sheldon Max Styles,[1] and others owned, operated, or held financial interests in eight medical clinics in low income areas of New York City. These clinics, or "Medicaid Mills" which catered almost exclusively to Medicaid recipients, were as follows:

1. Galler Medical Building, 858 Flushing Avenue, Brooklyn, N.Y.
2. Claremont Medical Building, 3589 3rd Avenue, Bronx, N.Y.
3. Queensbridge Medical Building, 38–81 13th Street, Queens, N.Y.
4. Laconia Medical Building, 4025 Laconia Avenue, Bronx, N.Y.
5. 8th Street Medical Building, 8–01 Astoria Blvd., Queens, N.Y.
6. Kent Street Medical Building, 156 Kent Street, Brooklyn, N.Y.
7. HIN Realty Corp. (also known as Centro Medico, also known as St. Mary's; also known as St. Ann's), 567 E. 149th Street, Bronx, N.Y.
8. Corona Medical Building, 105–05 Northern Blvd., Queens, N.Y.

Between 1959–1963 Joseph Ingber and Sheldon Styles were classmates at the Chiropractic Institute of New York. After graduating in 1963, Ingber began a private chiropractic practice in a Manhattan office. He subsequently opened another office in Jamaica, Queens, where, in 1968, he began accepting and treating Medicaid patients.

Ingber and Styles had maintained a close friendship since their school days. In early 1969, with the advent of Medicaid, Ingber's business began to grow. Styles joined him at the Jamaica office, providing assistance to Ingber's practice. Styles brought with him a means by which to increase even further the patient load at Ingber's office. Styles at that time was associated with a Medicaid clinic run by a Dr. Andrew Portoguese, an optometrist, in the general vicinity of Ingber's office. A deal was reached with Dr. Portoguese wherein Styles was allowed to refer patients from Dr. Portoguese's clinic to Ingber and Styles' office for x-rays and chiropractic treatments. For this Ingber and Styles were able to bill Medicaid for substantial numbers of patients to which they would not otherwise have had access.

At that time the Medicaid reimbursement rate per chiropractic patient visit was $3. This compared with the $7–$10 Ingber charged his private patients. Ingber, like other chiropractors, felt that he should be receiving more from Medicaid and thus began falsifying his invoices to reflect visits and treatments that never occurred in order to compensate himself for the rate differential. This practice began after Ingber realized that many of his patients did not return for all of the treatments authorized. When Styles joined the practice he, too, engaged in the falsifying, or "padding," of invoices for services never rendered. It became common practice for invoices to be submitted by Ingber and Styles billing for thirteen to fifteen visits when only one or two actually took place.

Shortly after Styles joined Ingber a third chiropractor, Max Kavaler, joined Ingber and Styles at Jamaica. Kavaler, the former dean of the Chiropractic Institute of New York, was brought in because he was out of a job and the workload was heavy. His expertise was seen as a valuable asset to the budding enterprises of Ingber and Styles.

[1] All persons mentioned by name have either been convicted or have waived indictment and pleaded guilty to criminal information ranging from one to seven felony counts.

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From March to September 1969 Kavaler worked at Jamaica under this arrangement. In May, 1969 he entered into a partnership with Ingber, Styles, an attorney and another chiropractor, to form the 105–05 Northern Blvd. Corporation and operate a clinic at that Corona, Queens address.[2]

Fraudulent Medicaid billings were submitted from the Corona clinic's inception. Patients were "ping-ponged" throughout the clinic (i.e., examined by every medical specialty on the premises despite the patients' wishes or medical needs), and invoices were submitted by medical doctors, podiatrists, and chiropractors for patients never actually treated. Routinely, when a patient visited the clinic the receptionist, in accordance with her training, took a complete family history, i.e., first name, sex, and birthdate of all Medicaid-eligible family members. Since all members of a family were covered by a single Medicaid number, the family history provided those doctors, who were so inclined, with all information required to prepare fraudulent invoices. Fraudulent patient records were often prepared to agree with the invoices making detection by the authorities extremely difficult. The practice of billing various members of a Medicaid eligible family when no such visits or treatments took place became commonplace at Corona and other clinics operated by Ingber and Styles.

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Ingber and Styles paid one doctor $7,000 and gave the other, Dr. Bell, a 10% interest in the Corona Clinic and a 5% interest in the Galler Clinic.

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Sheila's duties changed within a short time, and she became an author on a wholesale basis of fraudulent-Medicaid invoices for Ingber and Styles. Sheldon Styles trained Sheila to enter false treatments and visits on invoices, as well as to falsify chiropractic treatment plans by copying diagnoses, prognoses, and courses of treatment from old Treatment Plans by merely inserting the names and Medicaid numbers of currently eligible Medicaid recipients.

Sheila Styles became very facile in her endeavors, and her talents were soon utilized by other chiropractors working in various clinics for Ingber and Styles. In all she wrote entirely fraudulent Medicaid invoices and Treatment Plans for a dozen chiropractors in the years 1970–71, for weekly salaries ranging from $25–35 per chiropractor. Among the dozen chiropractors were two who never showed up to work at all, and who merely "sold" Ingber and Styles the use of their names and Medicaid Provider numbers for a small percentage of the receipts.

In the summer of 1970 Ingber and Styles were approached by Donald Trager, another chiropractor. Trager, a friend of Ingber, wanted to open a clinic in the Bronx. He had been offered the lease to the existing Claremont clinic, at 3589 3rd Ave., by two dentists who wanted to divest themselves of the unprofitable location. Ingber and Styles liked the idea and in October, 1970 they and Trager became equal partners in the 3589 3rd Ave. Corporation.

The Claremont clinic, managed on a part-time basis by Trager, was not a success. The patient load was small and unable to support the clinic. Later investigation would reveal that without large scale falsifying of Medicaid invoices by the medical and chiropractic staff, (four of whom are co-defendants), the Claremont clinic would not have stayed in operation as long as it did.

Claremont finally shut its doors in June, 1971 because of its inability to attract patients. Before its closing, however, Ingber, Styles, and Trager opened a new clinic nearby on Laconia Avenue. Trager, believing that he could make a success out of this new location, bought out Ingber's and Styles' interest in the 3589 3rd Ave. Corporation for $500 each. Despite Trager's optimism, the Laconia clinic suffered the same fate as its predecessor. Consequently, as with the Claremont clinic, fraudulent Medicaid invoices were all that kept the clinic financially afloat. Laconia closed in November of 1971. Six of its former staff have been convicted of medicaid frauds.

In the spring of 1971 Kavaler wanted to disassociate himself with Ingber and Styles. His cousin, Florence Kavaler, a Deputy Commissioner of the New York City Department of Health and in charge of the New York City Medicaid program, allegedly had warned him to make such a break because of a pending investigation of Ingber and Styles by the New York City Department of Investigation. Kavaler offered to trade his shares in the Queensbridge and Corona clinics in exchange for Ingber's and Styles' shares in the Galler clinic. Ingber and Styles agreed and Kavaler received their Galler stock. He and Rose Galler (who had since bought out Stanley Reichler's and one attorney's interests) remained as the sole owners of Galler.

When rumors of the pending City investigation surfaced in June 1971, Ingber and Styles decided to dissolve their partnership and go their separate ways.

Shortly thereafter, Ingber opened a new clinic in Queens on 8th Street, with two medical doctors (one of whom was Ralph Bell), as partners. Styles joined in a partnership with Reichler, the manager of Corona, Rene Nolan, (a former receptionist at Queensbridge), and a coin dealer to open a new clinic on Kent Street in Brooklyn.

Despite prospects of a city investigation, fraudulent Medicaid practices continued at these two locations, although to a lesser extent than had occurred previously at the other clinics. The Kent Street clinic closed in June of 1972 for lack of business, and the 8th Street clinic was sold in late 1972.

The New York City Department of Investigation's inquiry into Ingber and Styles led Ingber to attempt a cover-up of his activities. In an attempt to get everyone to "stick together" and present a plausible defense, a private investigator was hired to take written and tape recorded statements from over a dozen of his co-conspirators, all of whom falsely stated (without much prompting) that they never did anything wrong, knew of no one who did, and blamed any Medicaid discrepancies on clerical errors.

When Ingber himself was called down to testify before the Department of Investigation on December 6, 1971, he perjured himself by denying any wrong doing in response to questions asked about fraudulent Medicaid invoices. In addition, when the United States Attorney for the Southern District of New York entered the case and subpoenaed Ingber's former secretary, Jeanine Vetrano, to testify before a Federal Grand Jury in May 1975, she persisted in the old story given to the investigator and perjured herself. (Subsequently, as part of his arraignment to plead to an Information, Ingber secured for Jeanine Vetrano the opportunity to recant her perjured testimony and avoid prosecution. She did this, and subsequently testified as a government witness in the trial of Max Kavaler.)

During the period 1970–1973 doctors working at the eight Ingber and Styles-operated clinics billed the New York City Medicaid program at least $2,222,699 as follows:

Year:	*Amount*
1970	$510, 655
1971	1, 014, 060
1972	640, 998
1973	56, 986
Total	2, 222, 699

An analysis of available records revealed that the eight Medicaid clinics operated by Ingber, Styles, and others received a total income of $469,195.42. The sources of this income were as follows:

Source:	*Amount*
Doctors (rent, fees)	$325, 658. 14
Alpone Laboratory (kickbacks for lab work)	34, 471. 54
Principals (investments)	5, 644. 45
Deposits from unknown sources	103, 421. 29
Total	469, 195. 42

Doctors doing business at the various clinics factored their Medicaid invoices for an average fee of 12 percent. 25 to 30 percent of their net billings after factoring was paid to the clinic owners. In addition, chiropractors paid the clinic owners (Ingber, Styles, Reichler, and Kavaler) 40 to 50 percent of the balance remaining after the clinic rent was paid. This money (not recorded on the clinic books of accounts), was paid primarily to Ingber and Styles, but the other principals were also recipients. The total value of such "off the book" payments was approximately $105,000.

The fraudulent practices at the clinics varied in manner and degree. Certain doctors engaged in the activity known as "padding" invoices, the device of billing for more services than actually rendered to a patient who was actually seen. Another practice was the submission of completely false invoices for patients never treated or seen by the doctor. This would occur by submitting invoices for subsequent visits for patients only seen once or for members of a patient's family who were never seen in the clinic. In many cases a mother would bring her well children with her if she could not find a baby sitter. Invoices would be submitted for all of the children, although none of them may have been seen. In one instance four doctors billed Medicaid for services rendered to a child who had been dead for nine months. In another, three doctors submitted invoices for an individual who, at the time of his alleged treatment in a New York City clinic, was an inmate at Elmira prison. In addition to false invoices for treatments, bills were submitted for ancillary services such as x-ray and EKGs from clinics that had no such equipment.

Another lucrative activity engaged in by the owners involved the use of Dr. X,[3] an elderly senile medical doctor. Early in 1970 an agreement was entered into between Dr. X, Ingber and Styles wherein, for a weekly salary of $120, all Medicaid income earned by Dr. X reverted to his employers. Dr. X was assigned to write fraudulent invoices. Sheila Styles drove Dr. X from clinic to clinic, where he would be seated at a desk with a pile of patient records and blank invoices to be filled out. He rarely saw any patients, spending all of his time writing invoices. His total billing of $88,370 is estimated at being 98 percent fraudulent. In April, 1970 a joint savings account was opened at the Whitestone Savings and Loan Association in the names of Bell and Dr. X. The purpose of this account, as well as a subsequent joint account in the names of Sheldon Styles and Dr. X, was to launder Dr. X's Medicaid receipts. Checks made out to Dr. X were deposited in these accounts and then disbursed among the owners.

The Bell-X account was used to disburse funds generated at the Queensbridge and Corona clinics. The beneficiaries of this conspiracy were Bell, Ingber, and Sheldon Styles. In 1971 a second joint account in the name of Sheldon Styles and Dr. X was opened. The account disbursed Medicaid funds generated at the Kent Street clinic. Beneficiaries were the partners in that clinic, Sheldon Styles, Stanley Reichler, and Rene Nolan Clark.

Although the doctors themselves wrote many of their own false invoices, many of them were prepared by receptionists at the clinics, in particular Rene Nolan Clark and Sheila Styles. When they falsified invoices, Rene Nolan Clark and Sheila Styles referred to old invoices, old medical records, and family histories of former and current clinic patients for information from which to fabricate visits and treatments that never took place. They prepared enormous amounts of completely false Medicaid invoices for doctors and chiropractors, charging them weekly fees of $25–35.

An analysis by the Government of Dr. Ingber's personal Medicaid invoices during the period of 1969–71 indicates that he submitted $35,116 worth of false invoices. In addition, his use of Dr. X, the elderly senile physician, to generate false invoices whose proceeds Ingber, Styles and others shared, made him liable, in the Government's view, for a portion of Dr. X's fraudulent earnings. The following table represents Dr. Ingber's fraudulent Medicaid earnings and his share of the fraudulent income derived via Dr. X:

	1969	1970	1971	Total
Ingber's Fraudulent medicaid income	$18,930	$5,604	$10,582	$35,116
Dr. X fraudulent medicaid income	5,296	17,006	12,465	34,777
Total				69,893

Dr. Ingber has settled a civil suit brought by the Government in the amount of $109,807, and has agreed to pay the Government that sum over a period of years. This amount reflects his reimbursement for fraudulent claims plus penalties, and his proportionate share of the cost of the Government's investigation.

II. THE GOVERNMENT'S VIEW OF THE CRIME

Although these crimes may be described merely as "crimes committed with a pen", or "white collar crimes" they are nevertheless substantial and serious offenses. The very nature of the rental arrangements encouraged inflated and false claims in order to increase one's own "take-home" pay. The crimes, moreover, were not ones of impulse or of short duration, but were committed repeatedly on a daily basis over many years by educated and intelligent men fully capable of supporting themselves without resort to illicit means. The very nature of Ingber and Styles' rental arrangements with doctors and the kickback arrangement with Alpone Labs encouraged false claims in order to increase a Medicaid provider's take-home pay.

The Medicaid program is substantially subverted by these acts. Money allocated by Federal, State and City Governments is squandered without any benefit whatever inuring to the intended beneficiaries of the program. The widespread fraud and abuse only serves to jeopardize the continued existence of

[3] This doctor, who is quite elderly and senile, has not been charged.

health assistance programs like Medicaid, as the public and the congress perceive that the taxpayer's dollars are being funnelled into the pockets of venal professionals. The ultimate victim is the American public at large, but the immediate victims of these crimes are the Medicaid recipients, the poor and elderly who are unable to pay for adequate medical care, and who are usually poorly served by, at best, generally indifferent treatment at medicaid mills.

The deterrent value of the sentence meted out in the cases of medicaid providers who abuse their trust cannot be underestimated. At present there are literally thousands of eligible medicaid providers (doctors, podiatrists, chiropractors, etc.) and hundreds of "medicaid mills" operating in New York City alone. The frauds perpetrated here are widespread and often difficult to discover and prove.

Commission of these crimes involves calculated, deliberate acts of intelligent, educated individuals in positions to realize the consequences of their behavior, who are capable of weighing the risk of punishment against the benefits to be gained from the crime. The Government believes that the frequency of this crime can be reduced most effectively if potential perpetrators are placed on notice that those who commit this crime risk greater penalties than merely having to disgorge their ill-gotten gains.

III. MATTERS IN MITIGATION

Dr. Ingber has cooperated since his plea of guilty by appearing for interviews and supplying documents whenever requested. In the opinion of the Assistant United States Attorneys in charge of this investigation, Dr. Ingber has been fully cooperative and candid with the Government since his decision to plead guilty. Dr. Ingber has appeared as a material witness for the Government at two criminal trials, *United States* v. *Robert March*, (76 Cr. 114) and *United States* v. *Max Kavaler*, (76 Cr. 241), and his testimony at both trials contributed substantially towards the convictions of both defendants of multiple counts of defrauding the Medicaid Program. Moreover, at the time of his decision to plead guilty and thereafter, Dr. Ingber spoke with other targets or was interviewed by their attorneys. Many of these targets ultimately decided to plead guilty, motivated in part, without question, by Dr. Ingber's anticipated testimony against them. Additionally, during his debriefings, Ingber gave additional investigative leads against potential targets. In addition, Dr. Ingber's plea and full disclosure have enabled the Government to cease its efforts in preparing a case against him, and to use his information and the fact of his guilty plea in its efforts to persuade several other defendants to plead guilty and similarly cooperate. Additionally, time and expense have been saved by eliminating the necessity of a trial of Ingber of about two weeks' duration. Finally, Dr. Ingber has agreed to a settlement of his civil action with the Government in the sum of $109,807. Moreover, although medical practices at many of the clinics may have been incompetent or directly detrimental to patients' health, the Government has no evidence of any actual chiropractic malpractice or mistreatment by Dr. Ingber of any patients actually treated by him or under his direct care.

Respectfully submitted,

ROBERT B. FISKE, Jr.,
U.S. Attorney for the
Southern District of New York,
Attorney for the United States of America.

GEORGE E. WILSON,
JOSEL N. ROSENTHAL,
Assistant U.S. Attorneys of Counsel.

ITEM 3. UNITED STATES OF AMERICA *v.* SHELDON MAX STYLES, DEFENDANT

[75 Cr. 1222 (HFW)]

SENTENCING MEMORANDUM

This sentencing memorandum is respectfully submitted to apprise the court of the circumstances of the medicaid fraud of which this defendant was a part. The information to which the defendant pleaded and the allocution at the time

of the plea contain a partial statement of the facts pertaining to his offense. This memorandum will elaborate upon these facts, illuminate defendant's role in the overall scheme, and focus upon certain factors which the Government deems relevant to the sentence in this case. It is divided as follows:

Part I—The Overall Scheme and the Defendant's Role
Part II—The Government's View of the Crime
Part III—Matters in Mitigation

Sheldon Max Styles, the defendant, a chiropractor currently working as a salesman, pleaded guilty on December 19, 1975 to a seven-count criminal Information consisting of one count charging him with having conspired to defraud the United States to violate Title 18, United States Code, § 287, 1001 and 1341, in violation of Title 18, United States Code, § 371; two counts of having filed false claims against the United States in violation of Title 18 U.S.C. §§ 287 and 2; one count of having submitted false statements to the United States in violation of Title 18, U.S.C. § 1001 and 2; two counts of mail fraud in violation of Title 18, U.S.C. § 1341 and 2, all in connection with the submission of fraudulent Medicaid invoices during the years 1969–72; and one count of Income Tax evasion for the year 1971, in violation of Title 26, U.S.C., § 7201.

I. THE OVERALL SCHEME

During the period 1969–1972 Joseph Howard Ingber, Sheldon Max Styles,[1] and others owned, operated, or held financial interests in eight medical clinics in low income areas of New York City. These clinics, or "Medicaid Mills" which catered almost exclusively to Medicaid recipients, were as follows:

1. Galler Medical Building, 858 Flushing Avenue, Brooklyn, N.Y.
2. Claremont Medical Building, 3589 3rd Avenue, Bronx, N.Y.
3. Queensbridge Medical Building, 38–81 13th Street, Queens, N.Y.
4. Laconia Medical Building, 4025 Laconia Avenue, Bronx, N.Y.
5. 8th Street Medical Building, 8–01 Astoria Blvd., Queens, N.Y.
6. Kent Street Medical Building, 156 Kent Street, Brooklyn, N.Y.
7. HIN Realty Corp. (also known as Centro Medico, also known as St. Mary's; also known as St. Ann's), 567 E. 149th Street, Bronx, N.Y.
8. Corona Medical Building, 105–05 Northern Blvd., Queens, N.Y.

Between 1959–1963 Joseph Ingber and Sheldon Styles were classmates at the Chiropractic Institute of New York. After graduating in 1963, Ingber received his license and began a private chiropractic practice in a Manhattan office. He subsequently opened another office in Jamaica, Queens, where, in 1968, he began accepting and treating Medicaid patients.

Styles, on the other hand, was unlicensed. However, he practiced chiropractic legally under a provision in the State's licensing code known as the "present practitioner" clause. Styles was allowed to render chiropractic service as long as he made periodic attempts to pass his licensing examinations. Although he made five attempts, Styles was unable to pass his tests. Yet he was able to legally practice and participate in the Medicaid program. It is the Government's understanding that upon his fifth failure, Styles became ineligible to retake the exam and to be licensed. Accordingly he no longer can practice chiropractic.

Ingber and Styles had maintained a close friendship since their school days. In early 1969, with the advent of Medicaid, Ingber's business began to grow. Styles joined him at the Jamaica office, providing assistance to Ingber's practice. Styles brought with him a means by which to increase even further the patient load at Ingber's office. At the time Styles was also associated with a Medicaid clinic run by a Dr. Andrew Portoguese, an optometrist, in the general vicinity of Ingber's office.

The association between Sheldon Styles and Dr. Andrew Portoguese began when Portoguese asked Styles to come to work for him at his Flushing, Queens private office. Portoguese wanted Styles to perform physical examinations on his patients and Styles, with his paramedical background, agreed. Assisting Styles was Dr. Portoguese's mother, Alice, who, when the first patient was brought to the examining room, introduced a surprised Sheldon Styles not as himself but as "Dr. Schweikert."

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Dr. Schweikert, now deceased, was at that time a senile practitioner working at Portoguese's Medicaid clinic in Jamaica. Besides using Schweikert's name to defraud Medicaid by false billings, Portoguese, an optometrist, also posed as Dr. Schweikert at the clinic.

Thrust into the role of Dr. Schweikert, as Styles has himself characterized the charade, Styles returned to see patients at Portoguese's office on seven or eight occasions. Although Styles was not a physician, nor Alice Portoguese a nurse, Mrs. Portoguese routinely prescribed medication for the patients and Styles signed prescriptions using Dr. Schweikert's name. According to Styles, the patients he tended to at Portoguese's office were not seriously ill, and any who were seriously ill were referred to a local hospital.

Ingber and Styles reached a deal with Dr. Portoguese wherein Styles was allowed to refer patients from Dr. Portoguese's clinic to Ingber and Styles' office for x-rays and chiropractic treatments. For this Ingber and Styles were able to bill Medicaid for substantial numbers of patients to which they would not otherwise have had access.

At that time the Medicaid reimbursement rate per chiropractic patient visit was $3. This compared with the $7–$10 Ingber charged his private patients. Ingber, like other chiropractors, felt that he should be receiving more from Medicaid and thus began falsifying his invoices to reflect visits and treatments that never occurred in order to compensate himself for the rate differential. This practice began after Ingber realized that many of his patients did not return for all of the treatments authorized. When Styles joined the practice he, too, engaged in the falsifying, or "padding," of invoices for services never rendered. It became common practice for invoices to be submitted by Ingber and Styles billing for thirteen to fifteen visits when only one or two actually took place.

Shortly after Styles joined Ingber a third chiropractor, Max Kavaler, joined Ingber and Styles at Jamaica. Kavaler, the former dean of the Chiropractic Institute of New York, was brought in because he was out of a job and the workload was heavy. His expertise was seen as a valuable asset to the budding enterprises of Ingber and Styles.

Kavaler's experience was quickly put to use as the amount of fraudulent Medicaid billings grew. An integral part of Medicaid chiropractic billing was the submission of Treatment Plans, which were justifications required by the Medicaid Division of the City Department of Health before approval was given to a chiropractor to bill Medicaid for treating a patient more than three times. Kavaler's expertise as a diagnostician, superior to that of Ingber and Styles, provided them with highly polished, though fictitious, chiropractic diagnoses and prognoses to include in their Treatment Plans. The more impressive the Treatment Plan the less suspicious and more generous Medicaid was in approving multiple visits.

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From March to September 1969 Kavaler worked at Jamaica under this arrangement. In May, 1969 he entered into a partnership with Ingber, Styles, an attorney and another chiropractor, to form the 105–05 Northern Blvd. Corporation and operate a clinic at that Corona, Queens address.[2]

Styles renovated this center from an old bakery to an eleven room medical building and outfitted these rooms with appropriate medical equipment. He secured the providers (doctors, dentists, optometrists, etc.) and trained their secretaries and administrative personnel. He also trained the secretaries to give electrocardiograms, draw blood, do bookkeeping, and assist the doctors.

Fraudulent Medicaid billings were submitted from the Corona clinic's inception. Patients were "ping-ponged" throughout the clinic (i.e., examined by every medical speciality on the premises despite the patients' wishes or medical needs), and invoices were submitted by medical doctors, podiatrists, and

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Aside from income derived by directly billing Medicaid, Ingber and Styles had an arrangement with Alpone Laboratories of Manhattan wherein, in return for referring blood tests to Alpone Labs, Ingber and Styles received a percentage commission, or kickback, in the form of "rent" from Alpone. Sheldon Styles has admitted to this arrangement in which Alpone assured him that blood tests would yield his clinics from $10 to $15 for each sample referred to the laboratory. Thus, as the volume of laboratory tests from the clinics increased Ingber and Styles' commissions from Alpone enjoyed a corresponding rise.

In mid-1969, shortly after the Corona clinic was opened, Ingber, Styles and Kavaler took over the practice of Dr. Herman Galler, who at his death left a thriving practice at a Brooklyn location. A medical center named the Galler Medical Building was organized with the financial backing of Dr. Galler's widow, two attorneys, and Stanley Reichler, a friend of Sheldon Styles who would later become manager of the Corona clinic. In addition to these shareholders, Ingber, Styles and Kavaler also held stock in the corporation, known as the 858 Flushing Avenue Corporation.

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In the summer of 1970 Ingber and Styles were approached by Donald Trager, another chiropractor. Trager, a friend of Ingber, wanted to open a clinic in the Bronx. He had been offered the lease to the existing Claremont clinic, at 3589 3rd Ave., by two dentists who wanted to divest themselves of the unprofitable location. Ingber and Styles liked the idea and in October, 1970 they and Trager became equal partners in the 3589 3rd Ave. Corporation.

The Claremont clinic, managed on a part-time basis by Trager, was not a success. The patient load was small and unable to support the clinic. Later investigation would reveal that without large scale falsifying of Medicaid invoices by the medical and chiropractic staff, (four of whom are co-defendants), the Claremont clinic would not have stayed in operation as long as it did.

Claremont finally shut its doors in June, 1971 because of its inability to attract patients. Before its closing, however, Ingber, Styles, and Trager opened a new clinic nearby on Laconia Avenue. Trager, believing that he could make a success out of this new location, bought out Ingber's and Styles' interest in the 3589 3rd Ave. Corporation for $500 each. Despite Trager's optimism, the Laconia clinic suffered the same fate as its predecessor. Consequently, as with the Claremont clinic, fraudulent Medicaid invoices were all that kept the clinic financially afloat. Laconia closed in November of 1971. Six of its former staff have been convicted of medicaid fraud.

In the spring of 1971 Kavaler wanted to disassociate himself with Ingber and Styles. His cousin, Florence Kavaler, a Deputy Commissioner of the New York City Department of Health and in charge of the New York City Medicaid program, allegedly had warned him to make such a break because of a pending investigation of Ingber and Styles by the New York City Department of Investigation. Kavaler offered to trade his shares in the Queensbridge and Corona clinics in exchange for Ingber's and Styles' shares in the Galler clinic. Ingber and Styles agreed and Kavaler received their Galler stock. He and Rose Galler (who had since bought out Stanley Reichler's and one attorney's interests) remained as the sole owners of Galler.

When rumors of the pending City investigation surfaced in June 1971, Ingber and Styles decided to dissolve their partnership and go their separate ways.

Shortly thereafter, Ingber opened a new clinic in Queens on 8th Street, with two medical doctors (one of whom was Ralph Bell), as partners. Styles joined in a partnership with Reichler, the manager of Corona, Rene Nolan, (a former receptionist at Queensbridge), and a coin dealer to open a new clinic on Kent Street in Brooklyn.

Despite prospects of a city investigation, fraudulent Medicaid practices continued at these two locations, although to a lesser extent than had occurred previously at the other clinics. The Kent Street clinic closed in June of 1972 for lack of business, and the 8th Street clinic was sold in late 1972.

The New York City Department of Investigation's inquiry into Ingber and Styles led Ingber to attempt a cover-up of his activities. In an attempt to get everyone to "stick together" and present a plausible defense, a private investigator was hired to take written and tape recorded statements from over a dozen of his co-conspirators, all of whom falsely stated (without much prompting) that they never did anything wrong, knew of no one who did, and blamed any Medicaid discrepancies on clerical errors. When Ingber himself was called down to testify before the Department of Investigation on December 6, 1971, he perjured himself by denying any wrongdoing in response to questions asked about fraudulent Medicaid invoices. In addition, when the United States Attorney for the Southern District of New York entered the case and subpoenaed Ingber's former secretary, Jeanine Vetrano, to testify before a Federal Grand Jury in May 1975, Ingber, in an attempt to conceal the fraudulent activities at his Jamaica office, convinced her to perjure herself. (Subsequently, as part of his arrangement to plead to an Information, Ingber secured for Jeanine Vetrano the opportunity to recant her perjured testimony and avoid prosecution. She did this, and subsequently testified as a government witness in the trial of Max Kavaler.)

During the period 1970–1973 doctors working at the eight Ingber and Styles-operated clinics billed the New York City Medicaid program at least $2,222,699 as follows:

Year:	*Amount*
1970	$510, 655
1971	1, 014, 060
1972	640, 998
1973	56, 986
Total	2, 222, 699

An analysis of available records revealed that the eight Medicaid clinics operated by Ingber, Styles, and others received a total income of $469,195.42. The sources of this income were as follows:

Source:	*Amount*
Doctors (rent, fees)	$325, 658. 14
Alpone Laboratory (kickbacks for lab work)	34, 471. 54
Principals (investments)	5, 644. 45
Deposits from unknown sources	103, 421. 29
Total	469, 195. 42

Doctors doing business at the various clinics factored their Medicaid invoices for an average fee of 12 percent. 25 to 30 percent of their net billings after factoring was paid to the clinic owners. In addition, chiropractors paid the clinic owners (Ingber, Styles, Reichler, and Kavaler) 40 to 50 percent of the balance remaining after the clinic rent was paid. This money (not recorded on the clinic books of accounts), was paid primarily to Ingber and Styles, but the other principals were also recipients. The total value of such "off the book" payments was approximately $105,000.

The fraudulent practices varied in manner and degree. Certain doctors engaged in the activity known as "padding" invoices, the device of billing for more services than actually rendered to a patient who was actually seen. Another practice was the submission of completely false invoices for patients never treated or seen by the doctor. This would occur by submitting invoices for subsequent visits for patients only seen once or for members of a patient's family who were never seen in the clinic. In many cases a mother would bring her well children with her if she could not find a baby sitter. Invoices would be submitted for all of the children, although none of them may have been seen. In one instance four doctors billed Medicaid for services rendered to a child who had been dead for nine months. In another, three doctors submitted invoices for an individual who, at the time of his alleged treatment in a New York City clinic, was an inmate at Elmira prison. In addition to false invoices for treatments, bills were submitted for ancillary services such as x-ray and EKGs from clinics that had no such equipment.

Another lucrative activity engaged in by the owners involved the use of Dr. X,[3] an elderly senile medical doctor. Early in 1970 an agreement was entered into between Dr. X, Ingber and Styles wherein, for a weekly salary of $120, all Medicaid income earned by Dr. X reverted to his employers. Dr. X was assigned to write fraudulent invoices. Sheila Styles drove Dr. X from clinic to clinic, where he would be seated at a desk with a pile of patient records and blank invoices to be filled out. He rarely saw any patients, spending all of his time writing. His total billing of $88,370, is estimated at being 98 percent fraudulent. In April, 1970 a joint savings account was opened at the Whitestone Savings and Loan Association in the names of Bell and Dr. X. The purpose of this account, as well as a subsequent joint account in the names of Sheldon Styles and Dr. X, was to launder Dr. X's Medicaid receipts. Checks made out to Dr. X were deposited in these accounts and then disbursed among the owners.

The Bell-X account was used to disburse funds generated at the Queensbridge and Corona clinics. The beneficiaries of this conspiracy were Bell, Ingber, and Sheldon Styles. In 1971 a second joint account in the name of Sheldon Styles and Dr. X was opened. The account disbursed Medicaid funds generated at the

[3] This doctor, who is quite elderly and senile has not been charged.

Kent Street clinic. Beneficiaries were the partners in that clinic, Sheldon Styles, Stanley Reichler, and Rene Nolan Clark.

Although the doctors themselves wrote many of their own false invoices, many of them were prepared by receptionists at the clinics, in particular Rene Nolan (Clark) and Shelia Styles. When they falsified invoices, Rene Nolan Clark and Shelia Styles referred to old invoices, old medical records, and family histories of former and current clinic patients for information from which to fabricate visits and treatments that never took place. They prepared enormous amounts of completely false Medicaid invoices for doctors and chiropractors, charging them weekly fees of $25–35.

An analysis by the Government of Dr. Styles' personal Medicaid invoices during the period 1969–71 indicates that he submitted $28,232 worth of false invoices. In addition, his use of Dr. X, the elderly senile physician, to generate false invoices whose proceeds Ingber, Styles and others shared, made him liable, in the Government's view, for a portion of Dr. X's fraudulent earnings. The following table represents Dr. Styles' fraudulent Medicaid earnings and his share of the fraudulent income derived via Dr. X.:

	1969	1970	1971	1972	Total
Styles' fraudulent medicaid income	$3,105	$15,192	$9,935	0	$28,232
Dr. X fraudulent	5,296	17,006	20,702	$10,498	53,592
Total					81,824

Dr. Styles has settled a civil suit brought by the Government in the amount of $128,498. This amount reflects his reimbursement for fraudulent claims plus penalties, and his proportionate share of the cost of the Government's investigation. He has agreed to pay that sum to the government over a period of years.

II. THE GOVERNMENT'S VIEW OF THE CRIME

Although these crimes may be described merely as "crimes committed with a pen", or "white collar crimes" they are nevertheless substantial and serious offenses. The crimes, moreover, were not ones of impulse or of short duration, but were committed repeatedly on a daily basis over many years by educated and intelligent men fully capable of supporting themselves without resort to illicit means. The very nature of Ingber and Styles' rental arrangements with doctors and the kickback arrangement with Alpone Laboratory encouraged inflated and false claims in order to increase a Medicaid provider's "take-home" pay.

The Medicaid program was substantially subverted by these acts. Money allocated by Federal, State and City Governments was squandered without any benefit whatever inuring to the intended beneficiaries of the program. The widespread fraud and abuse only served to jeopardize the continued existence of health assistance programs like Medicaid, as the public and the Congress perceive that the taxpayer's dollars are being funnelled into the pockets of venal professionals. The ultimate victim is the American public at large, but the immediate victims of these crimes are the Medicaid recipients, the poor and elderly who are unable to pay for adequate medical care, and who are usually poorly served by, at best, generally indifferent treatment at medicaid mills.

The deterrent value of the sentences meted out in the cases of medicaid providers who abuse their trust cannot be underestimated. At present there are literally thousands of eligible medicaid providers (doctors, podiatrists, chiropractors, etc.) and hundreds of "medicaid mills" operating in New York City alone. The frauds perpetrated here are widespread and often difficult to discover and prove.

Commission of these crimes involves calculated, deliberate acts of intelligent, educated individuals in positions to realize the consequences of their behavior, who are capable of weighing the risk of punishment against the benefits to be gained from the crime. The Government believes that the frequency of this crime can be reduced most effectively if potential perpetrators are placed on notice that those who commit this crime risk greater penalties than merely having to disgorge their ill-gotten gains.

III. MATTERS IN MITIGATION

Dr. Styles has cooperated since his plea of guilty by appearing for interviews and supplying documents whenever requested. In the opinion of the Assistant United States Attorneys in charge of this investigation, Dr. Styles has been generally cooperative and candid with the Government since his decision to plead guilty. Dr. Styles has appeared as a material witness for the Government at one criminal trial, *United States* v. *Max Kavaler*, (76 Cr. 241), and his testimony contributed substantially towards the conviction of the defendant of multiple counts of defrauding the Medicaid Program. In addition, Dr. Styles' plea and full disclosure have enabled the Government to cease its efforts in preparing a case against him, and to use his information and the fact of his guilty plea in its efforts to persuade several other defendants to plead guilty and similarly cooperate. Of equal importance is the fact that time and expense have been saved by eliminating the necessity of a trial of Styles of about two weeks' duration.

Respectfully submitted,

ROBERT B. FISKE, Jr.,
U.S. Attorney for the
Southern District of New York,
Attorney for the United States of America.

GEORGE E. WILSON
JOEL N. ROSENTHAL
Assistant United States Attorneys of Counsel.

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MEDICARE AND MEDICAID FRAUDS

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 5—WASHINGTON, D.C.

AUGUST 30, 1976

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Medicare and Medicaid Frauds:
Part 1. Washington, D.C., September 26, 1975.
Part 2. Washington, D.C., November 13, 1975.
Part 3. Washington, D.C., December 5, 1975.
Part 4. Washington, D.C., February 16, 1976.
Part 5. Washington, D.C., August 30, 1976.
Part 6. Washington, D.C., August 31, 1976.
Part 7. Washington, D.C., November 17, 1976.
Part 8. Washington, D.C., March 8, 1977.
Part 9. Washington, D.C., March 9, 1977.

(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

MEDICARE AND MEDICAID FRAUDS

MONDAY, AUGUST 30, 1976

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

The subcommittee met, pursuant to notice, at 9:40 a.m., in room 318, Russell Senate Office Building, Hon. Frank E. Moss (chairman) presiding.

Present: Senators Moss, Clark, Nunn, Percy, Beall, and Domenici.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Patricia G. Oriol, chief clerk; Alison Case, assistant chief clerk; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

This of course is a very busy time in the Senate and we want to get started promptly because we have much ground to cover.

Senator Percy, Senator Domenici, Senator Beall, and I are happy to welcome you here this morning to this hearing which is conducted by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

We are expecting to be joined by other Senators. Particularly, Senator Talmadge had planned to be with us this morning; however, he is on the conference committee on the tax bill that went into session at 9:30 and obviously had to be there because of the nature of that conference.

Senator Nunn, chairman of the Oversight Subcommittee of the Senate Government Operations Committee, is expected to join us and we hope that he will be able to come in shortly.

Senator Church and Senator Williams, both members of the Special Committee on Aging, have submitted statements.[1] They will not be able to be with us this morning. Senator Church is the chairman of the full committee. We have their statements which will be placed in the record.

Also, Senator Muskie is chairman of the Budget Committee with whom we have cooperated in some of these hearings.

I mention all of this because they all have a great interest in the matter that is before us. But because of the multiple duties that Sen-

[1] See pp. 523 and 524.

ators have, it was not possible for them to be here at the opening this morning. We do value the cooperation of these Senators and of the committee staffs that serve Senator Talmadge's Subcommittee on Health of the Commitee on Finance and Senator Nunn's Committee on Government Operations.

Senator Talmadge has been kind enough to incorporate several of our recommendations into his bill—S. 3205—the Medicare and Medicaid Reform Act of 1976.

27 Hearings on Fraud and Abuse Since 1969

The subject of today's hearing is fraud and abuse among practitioners in the medicaid program. Before discussing this topic a few words of background are in order.

From July 1969 until the present we have conducted some 27 hearings dealing with fraud and abuse in the nursing home field. We have drafted the bulk of a 12-volume report with our recommendations which we have presented to the Congress.

Last September joint hearings were held by this subcommittee and the Subcommittee on Health of the Elderly, chaired by Senator Edmund S. Muskie. In this exploratory hearing we took a quick look at fraud and abuse by other medicare or medicaid practitioners associated in one way or another with long-term care. In these hearings we learned about the excesses of factoring companies, the problems associated with some hospitals that cater to welfare patients and possible kickbacks among clinical laboratories.

In October, hearings were held dealing with possible abuse of the medicaid program by for-profit home health agencies.

In December, hearings were held on conditions in Kane Hospital, a 2,200-bed facility in Allegheny County, Pa., which disclosed widespread patient abuse and mismanagement of public funds.

In September and again in March we held hearings on the growing trend to dump patients from State mental hospitals into boarding homes. We examined the poor care in boarding homes and the associated ripoff of the supplemental security income program.

Last February we released our report dealing with fraud and abuse among clinical laboratories. In that investigation, conducted jointly with Chicago's Better Government Association, we learned that perhaps $1 out of every $5 paid for laboratory services is ripped of.

Since that time we have evaluated the performance of medicare's program integrity unit in a forthcoming report dealing with practitioner abuse of the medicare program. We have completed followup investigations into clinical laboratory, home health, pharmacy, and nursing home abuses. Some of these inquiries have been turned over to the General Accounting Office or other Federal and State authorities because we simply do not have the manpower to follow through properly on each one of these efforts.

In the near future we expect four reports from the General Accounting Office dealing with the handling of patients' funds in nursing homes, the required supplementation of medicaid money by families placing patients in nursing homes, a financial audit of Kane Hospital, and a closer look at the practices of factoring firms.

In short, today's report dealing with medicaid practitioners follows extensive investigations of the various aspects of the medicaid pro-

gram. Invariably, whatever part of the medicaid program we studied, we found substantial problems, mismanagement, waste, and fraud. Accordingly, it is important for everyone to understand that the judgments in today's report are based on the totality of our experience.

Medicaid Mills—Small For-Profit Welfare Clinics

In an effort to examine fraud and abuse among practitioners in the medicaid program we started with a list of doctors making more than $100,000 a year from the program. We soon learned that most of these practitioners worked out of medicaid mills—small for-profit welfare clinics which checker the ghettos of our major cities. We decided to examine such facilities a little closer. In the course of our clinical laboratory investigation we learned a great deal about their operations. In order to get a still closer look we examined the problem from three perspectives: patient, provider, and government.

We learned the government's point of view by interviewing local, State, and Federal officials and reading reports detailing program deficiencies. We learned the provider's point of view by interviewing doctors, by posing as businessmen pretending to buy medicaid mills. We learned about the quality of care in medicaid mills by posing as patients, making about 200 visits to clinics in 4 States.

When I heard from the staff about the blatant overutilization, unnecessary testing, the ping-ponging and referring patients to particular pharmacies, I decided to go to New York to see things for myself.

I put on the oldest clothes I could find. The U.S. attorney helped me obtain a valid medicaid card in my name. On June 7, accompanied by Pat Oriol, chief clerk of the Senate Committee on Aging, I entered the East Harlem Medical Center posing as a medicaid patient with a cold.

This facility was selected because three Senate staff members posing as patients had entered the facility and had been referred from practitioner to practitioner and given a full battery of unnecessary tests.

The physician gave me a brief cursory examination, took a quick medical history asking if I had high blood pressure, diabetes, or anything of the sort. Even though there was nothing wrong with me, he told me that I had a red throat and ordered blood and urine tests and X-rays. The doctor asked me if anything else troubled me and I said once in a while my neck is a little stiff. The doctor decided I needed to see Mr. Cohen, the chiropractor.

As there was no intercom in the facility, the nurse shouted up the stairs to warn the chiropractor I was coming. The doctor asked me some questions, twisted my neck and stated, "There, doesn't that feel better?" He stressed that the relief was only temporary and that he would have to get at the underlying causes for me to realize any permanent cure. He invited me back for treatment the next day and I was given a battery of X-rays. As I left, I was told to be sure to return the next day for more work and reminded to fill my prescriptions at the pharmacy next door.

I also visited the clinic at 164th Street and Morris Avenue in the Bronx. The shoppers who had entered this facility were greeted with

a 30-needle allergy test before they ever saw a doctor. Again the pattern of treatment was the same: a brief examination, extensive blood and lab work, and a number of referrals. I was given a number of tests and scheduled to come back for still more, and for possible referral to other practitioners. I was given a handful of prescriptions and told to fill them at the adjacent pharmacy. Directing a patient to a particular pharmacy, I might add, is a violation of State and Federal regulations.

ADDICTS' HAVEN

The third facility I visited was at 209 East 14th Street in New York's Lower East Side. The staff had been turned away on six previous attempts to seek treatment. The clinic was a haven for addicts. The staff was successful in taking movie film of some of the drug sales which took place on the street in front of the clinic.

I did not receive treatment in this facility but I did enter the adjacent pharmacy. The pharmacy was in the basement of what was really a small cellar partitioned in the middle by bulletproof glass which separated the pharmacist from the customers. A number of apparent addicts were milling about. Behind the glass a pharmacist stood filling prescriptions at random. Two months after my visit, the city health department closed the center, saying that the doctors who operated in this medicaid mill were essentially using their medical licenses to act as drug pushers.

From this experience I have some impressions of what it is like to be a welfare patient. They include:

If you are a medicaid patient, you can expect to be treated in a clinic located in a dilapidated part of the city.

The outside of these clinics, or medicaid mills, are garish. Most offer a brick facade. They may be brightly painted, with awnings, banners, and pennants attracting the eye. The front window lists an impressive array of services—everything from a psychiatrist to a podiatrist.

Inside the mill will be cramped and sparsely furnished. It will be dirty. Cleanliness is not prized in medicaid mills; it costs too much money. The floors look like they haven't been swept in a month and the restrooms are abominable.

As you enter a mill you will be greeted by a receptionist or someone who looks like a nurse. This is important because you never know for sure. This receptionist will ask for your medicaid card. She will xerox it a number of times. You may be asked who you want to see or what your medical problem is or you may not.

Now you wait for an hour, sometimes two. While you wait the receptionist or someone else may suggest that you should see Dr. So-and-so, the chiropractor, or Dr. XYZ, the podiatrist.

When you do get to see a practitioner, your visit will be brief—usually from 3 to 5 minutes—and the examinating room will be tiny.

You will be given a general examination no matter how specific your complaint. If blood pressure is taken or a stethoscope is used, the odds are it will be done through your clothing. It is likely that you will not be touched. Medicaid doctors don't like touching their patients.

At some point the doctor will take blood. The taking of blood confirms that treatment has been rendered to the patient but, perhaps just as important, samples presented to clinical laboratories will generate a return of $15 each from the laboratory.

In addition, you are going to be asked for a urine sample; you will be given a number of X-rays and perhaps a shot or two. You can count on receiving several prescriptions. In most cases you will be directed to a particular pharmacy to have your prescriptions filled.

If you're not sick, you won't be told you're not sick. If you are sick, the odds are you won't be helped. In the last analysis, the best description is the one given to us by a mill owner who said: "Medicaid isn't medicine, it's business. Curing patients is good medicine but bad business."

"I AM OUTRAGED"

I want to tell you that after this firsthand personal experience, I am outraged. I am angry that the money the Congress has appropriated for the care of the aged, the blind, and the disabled is going to line the pockets of a few businessmen and real estate operators. I am angry that 10 years after the enactment of the medicare program we find the resurrection of that abhorrent dual track of medical care which provides one standard of care for the rich or comfortable and another for the poor. I am angry that so much of the taxpayers' hard-earned dollars is lost to fraud and abuse. There are millions of people in my home State and across the Nation who work too hard for their money to be able to stomach the fraud and abuse, which by now must be evident to anyone who subjects the medicaid program to the slightest scrutiny.

I am not talking just about medicaid, mills. I am talking about the fraud and abuse we have discovered in nursing homes. I am talking about the recent disclosures of fraud and abuse in prepaid health plans. I am talking about the ripoffs among some for-profit home health agencies and hospitals that specialize in welfare patients. I am talking about clinical laboratories. I am talking about moving patients from State hospitals to nursing homes and boarding homes to take advantage of medicare and SSI. The day is long since past when we can tolerate the poor care and obvious fraud, waste, and abuse that exists in the medicaid program. It is time for an overhaul. I know that with the assistance of the Senators here today, we can move quickly to enact Senator Talmadge's bill, S. 3205. The enactment of this bill would do much to reduce the festering problems with which we have been grappling for too many years.

I apologize somewhat for the length of that statement but I think it will help to set the stage for what we expect to find in our hearings which we have detailed in this report which is released today on "Fraud and Abuse Among Practitioners Participating in the Medicaid Program."

[The statements of Senator Church and Senator Williams follow:]

STATEMENT BY SENATOR FRANK CHURCH

I wish to join in commending you, Mr. Chairman, and the two members of the Capitol Police force who performed outstanding services while assigned temporarily to the Senate Committee on Aging within recent months.

You are to be applauded, Mr. Chairman, for your tireless efforts to expose fraud and abuse in the medicaid program. It took a great deal of courage to go to New York and see things for yourself.

The two Capitol Hill policemen who participated in the investigation are Privates James A. Roberts, Jr., and Darrell R. McDew. At this point I would like to give my personal thanks to Police Chief James C. Powell and Senate Sergeant-at-Arms F. Nordy Hoffmann for making it possible to assign the two officers for this work. Privates Roberts and McDew visited more clinics than anyone else in the investigation, gave more blood for "tests," and bore up doggedly despite the wide number of illnesses diagnosed for them. I might add that they had received a complete physical and were pronounced physically fit before the shopping began.

As chairman of the Committee on Aging, I take a great deal of pride in the achievements which are being revealed to the American public this morning. I know the end result will be legislation to curb these widespread abuses. I pledge my best efforts in bringing about some improvements in the fiscal integrity of Government health care programs.

STATEMENT BY SENATOR HARRISON A. WILLIAMS, JR.

Mr. Chairman, I am pleased to address this hearing by the Subcommittee on Long-Term Care. The hearings conducted by this committee, chaired by Senator Moss, have been greatly informative. They have provided the Congress with valuable insights into fraud and abuse among nursing homes, clinical laboratories, and other providers in the medicaid program.

I expect today's hearings will serve the same end; that is, providing the Congress with the information it needs with which to legislate.

I am proud that my State of New Jersey has been, over the years, one of the most active in terms of preventing fraud and abuse in the entire Nation. According to HEW statistics, New Jersey is one of the three States with excellent fraud detection programs. I am glad to see that the New Jersey Special Commission on Investigation will testify today, sharing the results of their good work with this subcommittee and with the Nation.

I think now everyone knows my commitment to national health insurance and to expanding medicare and medicaid benefits for the aged, blind, and disabled. I am troubled that hundreds of people may be going without the health care they need. But I am just as troubled by the increasing reports of fraud and abuse in these programs. I am hoping that these hearings will help us to redirect Government money so as to eliminate waste and to provide greater benefits for the needy.

Senator Moss. Now I am very pleased to have with me a number of Senators. The ranking Republican member of the subcommittee is Senator Percy, of Illinois, who has been with us on so many of these hearings and has done valuable service in assembling the data that we now have before us. I would like to recognize Senator Percy.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Senator Moss, we welcome you back from the battlefield. It looks like in the reprocessing you have gone to Brooks Brothers this morning to get back here in good shape. I want to commend you and the members of the staff and certainly the Capitol Police that have cooperated with this subcommittee in learning firsthand how some of these programs are really carried out.

I think we learned as we went through a great many nursing homes that there is a great deal of difference between theory and practice. Too few times legislators legislate in a vacuum and don't actually follow up to see what happens. I would hope that those who feel you can wave a magic wand and create a national health insurance program; tack it onto the social security program; and obtain instant free medical assistance and health care for every man, woman, and child in this country with the same degree of efficiency that we offer health care today, would go out and actually see how some of these programs—which are minuscule compared to those that are actually implemented—are carried out.

We have a long way to go before we are ready to enact a total national universal health insurance plan in this country. There is a long gap between theory and practice, and I think you have helped bridge that gap in showing in these relatively modest programs the kind of abuse that is there. Yet we know that medicare and medicaid programs, as such, were desperately needed and we know that there is no substitute for them for some people. We know that some people in the practice carry them out according to the rules. Many people who are recipients do not abuse it, but the abuse is there and the potential for further abuse is there. I think it is now up to us to do something about it.

Since July 1969 this subcommittee has held 27 hearings on medicare-medicaid fraud and abuse. It appalls me that after 7 years of hearings, repeated investigations, and numerous reports we are still here today listening to testimony which identify and confirm the same types of fraudulent practices that have been plaguing the medicaid program since its enactment in 1966.

I would say that on behalf of all the members of the committee here this morning, all of whom are action-oriented, pragmatic, hard-hitting legislators, that the time for talking and for testifying about medicaid fraud and abuse is just about over; it is time now that we act and actually do something about these abuses.

After an 8-month investigation the subcommittee staff has completed a report entitled "Fraud and Abuse Among Practitioners Participating in the Medicaid Program" which gives firsthand evidence of rampant fraud, abuse, and maladministration in the medicaid program and a pattern of reprehensible exploitation of the sick and poor, not to mention the taxpayer who is paying the bill. The findings of the report indicate that as we talked, investigated, and held hearings, medicaid fraud and abuse actually increased in scale and sophistication.

ONE-THIRD OF FUNDS WASTED

The subcommittee report exposed medicaid mills that operate solely for the purpose of defrauding the medicaid system. The subcommittee staff concludes that as much as one-third, or over $1 billion, of New York's total medicaid and public assistance funds have been wasted.

It is my hope that these hearings will act as the catalyst to finally bring about needed legislative and administrative reform of the medicaid programs so that intended medicaid beneficiaries will receive quality health care at a reasonable cost.

The staff recommends that the fraud and abuse provisions of S. 3205, including establishing the Office of Inspector General in the Department of Health, Education, and Welfare, should be enacted immediately. I would like to point out that last week an amendment to the pending legislation in the Senate offered by Senator Nunn and myself was unanimously adopted. There we stamped out, I hope, abuse in the student loan program where we found $1 billion out of $8 billion in unpaid bills, and programs where there was simply inadequate follow through. I have strongly recommended that an Inspector General be installed for that purpose as well as this present scandal that we have involving administration in the Department of Health, Education, and Welfare.

As an original cosponsor of the Medicare-Medicaid Administrative and Reimbursement Reform Act, I trust that we will act immediately to expedite the enactment of that bill. Certainly we can act. We now know what needs to be done and these hearings, I hope, will put to rest the need for further hearings. The time for action is here.

Thank you.

Senator Moss. Thank you very much, Senator Percy.

As I explained at the beginning, Senator Talmadge had intended to be here this morning, but the conference on the tax bill has precluded this. He sent a very brief statement and asked that it be read into the record and I will do that at this time. This is the statement of Senator Talmadge who is chairman of the Health Subcommittee of the Senate Finance Committee.

[Reading:]

STATEMENT BY SENATOR HERMAN E. TALMADGE OF GEORGIA

At the outset I want to commend Senator Moss and this subcommittee for imaginative and innovative work in detecting and defining fraud and abuse in medicare and medicaid.

I have followed carefully the work of this subcommittee in the investigation and disclosure of what is clearly extensive abusive activity in nursing homes and laboratories. I have been briefed as to the areas which will be addressed at this hearing. What we will hear will shock millions of Americans just as it shocked me.

In a moment I will describe what some of us intend to do about these matters. Before doing so, it is highly appropriate to praise and commend the staff of this subcommittee, acting under the leadership of Senator Moss, for demonstrating to all of us that imagination and personal courage are not lacking in the Federal Government. The staff investigators undertook personal risk to develop the story which

will be unfolded today and tomorrow. In fact, in some instances they spent money out of their own pockets to avoid interruption of the investigation. These investigators are a credit to those who support responsible and efficient government.

Now to specifics. Recently the Committee on Finance which has legislative jurisdiction over medicare and medicaid held 5 days of hearings on my bill, S. 3205, the Medicare and Medicaid Administrative and Reimbursement Reform Act. That proposal, in which I was pleased to be joined by Senators Moss and Nunn, along with other Senators, contains a number of significant provisions designed to more effectively prevent, detect, and punish fraud under the Federal health financing programs. It was my expectation that we would act early in the next session to move the bill through the Congress. Howver, the situation is urgent.

I, therefore, have taken from S. 3205 the various antifraud sections, adding somewhat to some of them and improving upon others. It is my intention to introduce an antifraud bill by early next week. Senators Moss, Nunn, and others have been consulted during the work on this proposal and will join with me in introducing it. It is my hope that this antifraud measure can be added as an amendment to an appropriate House-passed bill this year.

Quite simply, we believe that we should not wait another 6 months to enact vitally needed antifraud legislation. We intend to do all we can to secure passage of these necessary reforms in this session of the Congress.

Again I want to commend Senator Moss for the fine public service he has rendered with this investigation and for the kind invitation to participate in this hearing with you.

[End of statement.]

Senator Moss. Senator Talmadge will join us tomorrow definitely and if he gets a break in that conference he will come in today.

As I announced earlier, Senator Nunn has joined us this morning. He is chairman of the Oversight Subcommittee of the Senate Government Operations Committee.

Senator Nunn, do you have any opening statement you would like to make?

STATEMENT BY SENATOR SAM NUNN OF GEORGIA

Senator NUNN. Very briefly, Mr. Chairman. I am very pleased to be here this morning. I would ask that my complete statement be put in the record as acting chairman of the Permanent Investigating Subcommittee.

I have had our staff looking into this overall area of medicare and medicaid fraud and abuse. I commend you and your staff for this extraordinary effort. I believe that it will give a major thrust to the Talmadge reform bill which I am cosponsoring. I hope that we will be able to take action on it this year.

Rather than taking more of the committee's time, I do thank you for letting me appear with you. I would ask you to place my full statement in the record.

Senator Moss. Without objection, it will be placed in the record in full.

[The prepared statement by Senator Nunn follows:]

PREPARED STATEMENT BY SENATOR SAM NUNN

I would like to join in commending Senator Moss and this Special Committee on Aging for their extraordinary and continuing oversight investigations into fraud and abuse in the medicare and medicaid programs.

I am acting chairman of the Permanent Subcommittee on Investigations, which is likewise conducting inquiries into fraud and abuse in the health and welfare industries. I know from our current investigations that what will be presented before this committee today and tomorrow are not isolated examples. Indeed, they are part of the actual conditions in the health care services industry.

They are so much a part of the industry that I believe they are major factors behind increasing program costs and the continuing escalation in national health expenditures. But more importantly, fraud and abuse of the health sector does not simply cost money. It can result in injury to and even deaths of patients who are given too many drugs, too many tests, too many surgeries.

The work of Senator Moss and the Special Committee on Aging in the areas of nursing homes, laboratories, and now the medicaid mills points Congress in an obvious direction. We must address the problems of fraud and abuse more specifically and more forcefully. I hope that Senator Talmadge's antifraud bill will clear the Congress this year. I support it and I am pleased to have worked with him on it.

As I said recently to the Senate Finance's Health Subcommittee, if somehow we could legislate that only men and women of good conscience should be involved in receiving and spending Government health and welfare funds, then we would have no need for systems to spot the culprits. But we cannot.

So we must continue to look for schemes and the schemers and respond immediately with legislative reform and encourage regulatory reform. It will require the continuing vigilance of Congress, the kind of vigilance shown by this special committee and its most capable staff to insure that the laws are sufficient to punish the criminals and to assure ourselves that those charged with administering the laws do so effectively.

Senator Moss. We do appreciate your sitting with us this morning and the cooperation that we have had with your committee as well as Senator Talmadge's committee. The interaction among the committees has been extraordinarily good.

I would just like to mention that Senator Percy is the ranking Republican member on the Nunn subcommittee as well as this subcommittee.

The Senator from Maryland, Senator Beall.

STATEMENT BY SENATOR J. GLENN BEALL, JR.

Senator BEALL. Yes, Mr. Chairman. I ask unanimous consent that my full prepared statement be included in the record.

I would like to take this opportunity to congratulate you and the staff of the committee and the investigators who cooperated in gathering the information for today's hearing. You have done a great service in helping to expose the shortcomings and the abuses of the present

system. I would point out also that the subcommittee investigators did an outstanding job, earlier this year, in bringing to light the fraud which has infiltrated many of the clinical laboratories which participate in the medicare and medicaid programs. I would note, Mr. Chairman, that those earlier hearings prompted me to offer an amendment to S. 1737—the Clinical Laboratories Improvement Act—which increased the criminal penalties for fraud and abuse in the delivery of laboratory services. The Senate passed S. 1737 on April 29, and I would hope that the House of Representatives would act on this important matter before the Congress terminates its activities early in October.

As the ranking minority member on the Labor and Public Welfare Committee's Subcommittee on Aging, I am continually interested in the problem of health care delivery to our senior citizens. Mr. Chairman, you and Senator Domenici, as members of the Budget Committee along with me, have been concerned about and wrestled with the problems of setting national priorities within the constraints of a fiscally responsible Federal budget. Medicare and medicaid are large programs which consume billions of State and Federal dollars each year. They are vital programs that provide medical services to the elderly and the poor who might not otherwise have access to medical care.

I think it is essential that the corruption that exists in these programs must not be tolerated because it drains away vitally needed but necessarily limited resources, thus depriving needy members of our society of the health services they need and deserve. In addition, it rips off the hard pressed American taxpayer, it undermines the public's confidence in the ability of Government to deliver services to our people in an efficient and effective manner, and it will tend to undercut public confidence in the medical profession.

As Senator Percy pointed out, we cannot begin to support a national health insurance plan unless we first have the program structured in such a way as to protect the public from the type of corruption and abuse that you and the subcommittee have turned up in this investigation. I would congratulate you on the work that has been done by the subcommittee and I hope that, as a result of these hearings, we can come up with meaningful legislation that will bring solutions to bear on these very important problems.

Senator Moss. Thank you very much. The full statement will be placed in the record.

[The prepared statement by Senator Beall follows:]

PREPARED STATEMENT BY SENATOR J. GLENN BEALL, JR.

Mr. Chairman, I am pleased to participate in this morning's hearing which will focus much needed attention on the serious problem of fraud in the medicaid/medicare programs. The Long-Term Care Subcommittee has, through its investigations and hearings, done much to expose the shortcomings and abuses of the present system.

The subcommittee's team of investigators did an outstanding job of bringing to light the fraud which has infiltrated many of the clinical laboratories which participate in the medicare/medicaid programs. I would note, Mr. Chairman, that those earlier hearings prompted me to offer an amendment to S. 1737, the Clinical Laboratories Improvement Act, which increased the criminal penalties for fraud and abuse in the delivery of laboratory services. The Senate passed S. 1737 on

April 29 and I would hope that the House of Representatives would act on this important matter before the 94th Congress adjourns.

As the ranking minority member on the Labor and Public Welfare Committee's Subcommittee on Aging, I have continually sought to improve the quality of life of our Nation's 22 million senior citizens. As members of the Senate Budget Committee, Senator Moss, Senator Domenici, and I have wrestled with the problems of setting national priorities within the constraints of a fiscally responsible Federal budget. Medicare and medicaid are large programs which consume billions of State and Federal dollars each year. They are vital programs that provide medical services to the elderly and the poor who might not otherwise have access to medicare care.

Corruption in these programs must not be tolerated because:

(1) It drains away vitally needed but necessarily limited resources, thus depriving needy members of our society of the health services they need and deserve.

(2) It rips off the hard-pressed American taxpayer.

(3) It undermines the public's confidence in the ability of government to deliver services to our people in an efficient and effective manner.

(4) It will tend to undercut public confidence in the medical profession.

I repeat Mr. Chairman, that we must not tolerate this kind of corruption. We must promptly root out any and all corruption from the medicare/medicaid programs and we must devise procedures and administrative structures that will prevent its reoccurrence. This is a difficult challenge but the Congress and the administration must meet and resolve this program before we can seriously consider massive new programs such as national health insurance.

In closing, I would note that I gave this matter a great deal of thought when I was drafting S. 2702, the long-term care amendments of 1975. That bill, which is pending in the Senate Finance Committee, would replace medicaid as the funding vehicle for a whole range of medical and nonmedical services delivered in institutional and noninstitutional settings for senior citizens. The mechanism contained in my bill that would hopefully prevent fraud and abuse is the community long-term care center. The community long-term care centers would have an elected governing board, of which a majority would be older persons. That local board and its professional staff would evaluate and certify the long-term needs of the individuals who reside in their service area. The funds would flow from the Federal Long-Term Care Trust Fund to the community long-term care centers by way of a State plan. The center would actually purchase or provide the needed services, such as home health services, homemaker services, nutrition services, long-term institutional care services, day care services, foster home services, and community mental health center outpatient services. The center would control the funds and carry on a continuous followup relationship with each individual receiving services under this program.

In drafting S. 2702, it was my hope that the creation of community long-term care centers would enable us to structure a responsive program with adequate safeguards against abuse, fraud, and/or misuse.

Mr. Chairman, I commend you for undertaking this investigation

and I hope that this series of hearings will help Congress and the executive branch to come to grips with this pressing problem.

Senator Moss. I do appreciate the fine work you have done in cooperating with this subcommittee and the staff as we develop these investigations.

The Senator from New Mexico, Senator Domenici.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. I will only take a moment if my statement can be made a part of the record. I do want to commend you and the staff, Senator Moss, for an excellent job. I did not personally visit the medicaid mills in New York, only in Chicago. I am delighted that a number of Senators from important committees of our U.S. Senate are actively involved in trying to help with this very serious problem. It is long overdue.

I personally don't know how we are going to solve the problem; it is an incredible new subculture delivery system that has grown up in the medical practice. It is not the average doctor, but rather just a strange new culture that almost ignores everything that we thought was right and needed by way of a delivery system. Whether or not we are going to solve the problem with fraud and abuse statutes, I don't know. I do wholeheartedly support such measures and I will join in trying to expedite their passage.

It is absolutely incredible when you go into a major American city, particularly the slum area, to see what has happened in the years since medicaid. I don't think anyone would have believed that a slum building would now become a storefront, well-advertised delivery system. The most pronounced act in all of them are the green cards. It is as if we are inviting people off the street to come in, promising care. Then when you get in many medicaid mills you find the paraphernalia that advertises what they have there to offer to our poor people is something again. This deception has created a new culture in America's medical delivery system. You would not believe what is imposed on these people.

Now you have yourself participated in that, Mr. Chairman, as have our staff. I assume that thousands of Americans have already experienced it and hundreds of millions of dollars have gone for naught. I have a word of caution or warning. I don't think laws are going to totally solve the nightmare, but I think the medical profession has a grave responsibility. Ninety-nine percent of them are not involved in this. Most of the involved doctors are foreign medical people, as you know, Mr. Chairman.

Somehow or another we need some help in terms of enforcing the standards of excellence that are delivered to most Americans by the medical practitioners. We need their help in seeing that those who deliver medical service to our poor people, basically in our slums, are also held at that standard also. I don't know how we can do that, but that fact is a must. I think this hearing and the others that will follow it must excite this institution, the Senate, but also the medical people, those who are involved in training our doctors, our medical schools. State and local authorities are just going to have to get concerned enough to join in a war of not only stopping it but also in an affirmative approach of finding a better way to do it.

Thank you, Mr. Chairman.

Senator Moss. Thank you, Senator. Your full statement will be inserted in the record.

[The prepared statement by Senator Domenici follows:]

PREPARED STATEMENT BY SENATOR PETE V. DOMENICI

Mr. Chairman and other members of the committee, I am anxious to proceed with the hearings today so I will say only a few words.

It is simply stunning that the abuses outlined by the subcommittee report and those that will be described personally today have been known by law enforcement officials for at least 10 years. Apparently to know is not enough. Apparently it has to take a public forum as this to force the appropriate remedial action.

I hope this hearing will capture the attention of the public, the entire Senate, and those abusing Federal programs such as medicaid and medicare, and be instrumental in ending these crimes. Perhaps now New York and other States will extend the effort necessary to truly sense their needy, rather than turning a program loose with crossed fingers and good intentions. It seems that the larger States with heavily populated cities are most vulnerable to the disgraces outlined in the subcommittee report. It appears that many of the larger States are most lax in their enforcement procedures. Certainly the Federal Government has also been lax in providing adequate enforcement procedures and proper guidelines.

Not only are a few made wealthy at the expense of all taxpayers, but even more abysmal is the fact that the elderly, the poor, and the disabled receive poor health care—if they actually receive it at all. The poor and elderly are the scapegoats in this dilemma and the situation must end, and end now.

The subcommittee report is an alarming commentary of a necessary Federal program gone astray. It is not enough to say these abuses occur only in larger communities. It is not enough to say that only a very small percentage of doctors and other health professionals are involved. Obviously good intentions are not enough when we in Congress or in the State legislatures fail to insure proper safeguards. Too often those we wish to help are forgotten once we enact the "saving" legislation.

Proper enforcement and monitoring procedures are possible as illustrated by the relatively successful operation in Michigan and some other States. The situation in Michigan is not perfect by any means, but it is light years ahead of New York's system.

I am pleased this subcommittee's members and staff have persisted to uncover and document the evidence. The report outlines seemingly unreal situations. How can certain individuals be so successful in abusing social programs directed to the less fortunate in our society? How has it evolved that the elderly and poor are so exploited? How have enforcement procedures become so lax? The facts are there for all to examine. The testimony today and tomorrow will add the personal documentation needed for a final realization that fraud of the worst type, that abuses of the most unreal dimensions exists.

I do not wish to take more of the subcommittee's time now. I wish only to extend my personal commitment in future efforts to eliminate these shocking problems.

Senator Moss. The Senator from Iowa, Senator Clark.

Senator CLARK. Mr. Chairman, I have no statement. I would like rather than making an opening statement to ask that there be inserted in the record at this point an article which appears in this week's Newsweek that is out this morning dated September 6, 1976, called "Inside the Medicaid Mills." I am not going to read the whole article, in fact just tantalizingly I am going to read the first sentence.

Senator Moss. I have not seen it yet so my curiosity is aroused.

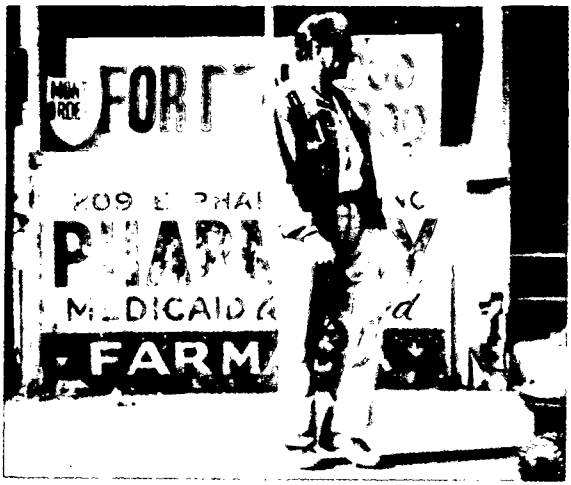
Senator CLARK. You will be interested in it then, Senator. It says, "F. Edward Moss is no ordinary sidewalk derelict." [Laughter]

Senator Moss. Now I believe it.

Senator CLARK. I would like that to be inserted in the record at this point if I may, Mr. Chairman.

Senator Moss. Thank you. That will be inserted in the record. Even though I have not had a chance to check the text yet, I will run that risk and place it in the record.

[The article follows:]



Val J. Halamandaris

Undercover man: Senator Moss visits a New York City storefront clinic in disguise

Inside the Medicaid Mills

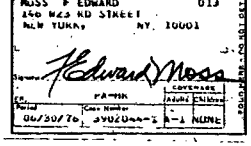
The haggard old-timer, dressed in a grungy denim jacket and Army fatigue pants, shuffled into a storefront clinic in New York's East Harlem one morning in June. He had a cold, the old man complained, as he produced a Medicaid card identifying him as "F. Edward Moss." He waited around for more than an hour before a doctor saw him, took a brief medical history and ordered a blood test, a urine test and a chest X-ray. Next the old man was given a prescription for three drugs and told to have it filled at "the pharmacy next door." When asked if he had any other ailments, the old man mentioned a stiff neck; he was sent to a chiropractor upstairs, who recommended additional X-rays.

F. Edward Moss is no ordinary sidewalk derelict. When not in disguise, he answers to the name Frank E. Moss and works as a U.S. senator from Utah. As a member of the Senate Special Committee on Aging and chairman of the subcommittee on long-term care, Moss took on his unusual undercover assignment for a personal look at Medicaid abuses. "I'm kind of a kick-the-tires man," says the 64-year-old Democrat. "The committee staff was giving me reports that were astounding. I thought I'd like to see for myself." What Moss and his investigators saw—and heard and felt—was a wide assortment of medical flimflams, all to be detailed in a 287-page report that will be made public at hearings in Washington this week.

The Medicaid program, enacted by Congress in 1965 and jointly funded by the Federal, state and local governments, helps to finance health services for the poor. But too often, committee investigators found, Medicaid money has become easy pickings for the unscrupulous. The staff report cites innumerable instances of phony bills for services that were unnecessary or never rendered. One investigator with perfect vision received three prescriptions for eyeglasses; another was X-rayed on a machine that had no film. "Some people are ripping off vast amounts of money by setting up these Medicaid mills and running people through like cattle," Moss told NEWSWEEK's Henry McGee last week. Of the more than $15 billion that will be spent on Medicaid this year, Moss estimates that fully 10 per cent—$1.5 billion—will be lost through fraud and abuse.

To gain first-hand insight into the malpractices, Moss and six committee staffers posed as Medicaid beneficiaries and made more than 200 visits to approximately 100 clinics in New York, New Jersey, Michigan and California. The investigators usually followed a set procedure: on entering a clinic, they made only

Moss's ID card: A doctored name



a general complaint ("I have a cold"), and they never sought referrals or suggested the need for medical treatment in any other way. Prior to their "shopping tours," the investigators were all in good health, the report said; nevertheless they were diagnosed in the Medicaid mills to be afflicted with everything from bronchitis to a severe infection of the urinary tract. Moss himself returned from his two-day undercover tour of New York City with a painful souvenir: his arm bore ugly purple blotches—a result of clumsily performed blood tests.

'Ping Ponging': Medicaid abuses, the investigators found, came in so many variations as to have a vocabulary of their own. Examples include "Ping Ponging" (referring patients to other doctors within the clinic even when there is no medical need to do so), "upgrading" (billing for additional services not provided), "steering" (sending patients to a particular pharmacy, usually one affiliated with the mill) and "shorting" (delivering fewer pills than prescribed). According to the report, Medicaid costs are further kited through cozy deals between doctors and landlords and between doctors and factors (who usually take over the doctors' accounts receivable and advance immediate payment less a 12-24 per cent service charge).

The report stresses that only a relative handful of doctors have abused the Medicaid program. But some among those few have apparently tapped a bonanza (in 1974, 365 physicians received $100,000 or more from the program). Sheer incompetence often goes hand in hand with greed. At a Los Angeles clinic, one investigator submitted a soap-and-cleanser concoction as a urine sample, which was tested as "normal." A New York facility proved to be little more than a haven for junkies. Committee staffers expressed special concern for the effect of Medicaid mills on the poor. As investigator Catherine Hawes put it: "It's bad enough they're ripping off the government, but they're not even providing minimum levels of medical care—and that's criminal."

To curb future abuses, the report backs legislation to establish an office of Inspector General in the Department of Health, Education and Welfare to police Medicaid (and medicare as well). It also recommends laws banning fee-splitting and shop rentals based on a percentage of income in Medicaid clinics (last week, HEW announced "a flat prohibition against the factoring of Medicaid accounts"). Finally, the report singled out New York City's Medicaid program for a special knock, asserting that Medicaid losses there over the past ten years "probably equal the $1 billion deficit which brought New York City to the brink of [financial] disaster." Had New York taken reasonable steps against Medicaid frauds, the report claims, the city conceivably could have avoided its fiscal crisis.

—DANIEL CHU with HENRY McGEE in Washington

Senator Moss. I certainly appreciate the attention given by all of my colleagues and their statements this morning. They indicate how serious this problem is and really how perplexed we still are as to how we are going to deal with it. We have the Talmadge bill which I am sure is a step in the right direction and I think all of us will want to press for its adoption but we don't know how hopeful we can be that that will resolve all of the problems.

Must Preserve Integrity

As the Senator from Illinois pointed out, as we expand in this field of providing health services for our people we have to find a way that the system can have its integrity preserved and cannot be abused by those who choose to do so and have been successfully doing it with medicare and medicaid as the hearings today I think will indicate.

Now reference has been made by others and I want to echo that reference to the exceptional work done by the staff of the Senate Committee on Aging and particularly those assigned to the subcommittee. They have exerted great imagination and penetration in finding ways to bring our attention to abuses that we will hear of this morning and which are detailed in this report. I have asked a number of those members of the staff and particularly those who went out and did the leg work, the investigation, to come here as a panel and sit and present their report on what they have to tell this subcommittee.

This investigation, as has been pointed out, has been going on for a long period of time and it has required great perseverence to continue to follow up day after day with the most limited of facilities, manpower and financial means that we have at our command and we therefore have entered into agreements with others like the Chicago Better Government Association who did such good work in Chicago.

We also had the good fortune to have two very able officers detailed to work with our committee as investigators who are members of the Capitol Police force and they will be with the panel this morning. I had a chance to be with them for a full day in New York and I can attest to the perception of these men and their real understanding of the problem and their dedication to the job. They did an excellent job.

I will ask Val Halamandaris who is the associate counsel for the Committee on Aging and who was in general charge of all of this investigation, Patricia G. Oriol who is chief clerk of the committee and, as you will see, a lovely lady who did the job of going into these clinics and shopping for services and then reporting on them, and then Darrel McDew and James Roberts, the two police officers to whom I have referred, and Catherine Haws who is an investigator for the committee, to come forward and we will ask for a presentation of their report and of course all of them will be open for questioning by the members.

Mr. Halamandaris. Mr. Chairman, I request that we be sworn.

Senator Moss. All right.

Raise your right hand. Do you and each of you solemnly swear the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

[All answered in the affirmative.]

Senator Moss. You may proceed, Mr. Halamandaris.

STATEMENT OF VAL J. HALAMANDARIS, ASSOCIATE COUNSEL, COMMITTEE ON AGING

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

On behalf of the staff I say thank you from the bottom of my heart for all the kind words that have been said about the work of the subcommittee staff.

I just would like to add this comment: Mention was made of the clinical lab investigation that we conducted in Chicago when you, Mr. Chairman, and others, went to Chicago to see for yourselves. You'll remember we had the invaluable assistance of the Better Government Association. I would like to acknowledge and credit the BGA for their good work.

There is another group that should be mentioned and that is CBS's "60 Minutes" with Mike Wallace. All of the investigations we have done here in 7 years did not have the impact of the single segment on "60 Minutes." I think CBS gave the American public the first graphic evidence of what is going on in the medicaid program.

I would like your permission, Mr. Chairman, to have inserted in the record at this point your statement in the Congressional Record on June 15, 1976, in which you compliment CBS President Richard Salant along with Mike Wallace and Producer Barry Lando for the excellent work they did in conjunction with that program called "The Clinic on Morris Avenue."

Senator Moss. Without objection, that will be in the record at this point.

[The statement follows:]

[From the Congressional Record, June 15, 1976]

"FRAUD AND ABUSE AMONG CLINICAL LABORATORIES"—SPECIAL REPORT OF THE COMMITTEE ON AGING—REPORT NO. 94-944

Mr. Moss. Mr. President, on behalf of the Subcommittee on Long-Term Care of the Senate Committee on Aging, I submit a report for publication and use by the Senate. The report is entitled "Fraud and Abuse Among Clinical Laboratories."

This report has been in so much demand that last Thursday the Senate agreed to the printing of 4,500 additional copies of it.

The report details the results of our 5-month investigation of fraud among clinical laboratories in six States, Pennsylvania, Illinois, New York, Michigan, New Jersey, and California. We concluded that $1 out of every $5 paid for medicaid laboratory services is fraudulent. The number of labs who cheat is small but their share of the $213 million in medicaid lab services is large.

The lawbreakers in our report have been brought to justice. In Illinois, 14 laboratories have been suspended. Indictments have been brought against laboratory operators in all six States we studied.

There has also been action on the legislative front. On April 29, the Senate passed S. 1737, the Clinical Laboratories Improvements Act which requires licensure of every lab. In addition, the act makes the offering or receipt of a kickback grounds for the revocation of a laboratory's license. Moreover, amendments were added on the Senate floor which make offering or receiving kickbacks a felony punishable by up to 3 years in jail, a $10,000 fine or both.

I am sure that this prompt action would not have been possible without related investigation by CBS "Sixty Minutes" entitled "The Clinic on Morse Avenue" and aired on February 15. I would like to compliment CBS for this excellent example of investigative reporting. I would compliment in particular, CBS President Richard Salant, Reporter Mike Wallace, and Producer Barry Lando.

The ACTING PRESIDENT pro tempore. The report will be received and printed.

Mr. HALAMANDARIS. Mr. Chairman, I would like to take just a few minutes to tell you what we did during the course of this investigation and to have the staff who participated tell you of their findings.

The investigation over the last 8 months consisted of about nine steps. The first thing we did was to examine about 100 reports that have been written concerning problems in the medicaid program. You will find that detailed in part 3 of our report.

Now if I can refer you to page 207, you will find the number of fraud cases reported to the Department of Health, Education, and Welfare by the States. On page 207 you will find that at any quarter during 1975 there were approximately 2,062 cases pending. Then there is a breakdown from the various States as you can see. Some States like California are very active. Massachusetts is very active. Then you look at the totals for the State of New York.

The bottom line is that the State of California, which accounts for some 13 percent of all medicaid moneys, referred 40 percent of the fraud cases to the HEW. On the other hand, the State of New York, which receives 23 percent of all medicaid funds, referred only one-tenth of 1 percent of all the medicaid cases to the Department of Health, Education, and Welfare. That, in a nutshell, gives you a view of the kind of performance New York has given. Historically the State of New York has not been living up to the responsibility, is not in conformance with the Federal regulation. It is our view that the State of New York should be a lot more aggressive than they have been. That summarizes one part of our report.

The last had to do with reviewing records; (1) in the New York City Department of Health; (2) in the office of the U.S. attorney, southern district of New York. We are very pleased with the cooperation we had from these groups, along with the New York Assistant Attorney General Charles J. Hynes.

The next thing we did was to manually evaluate the medical vendor statement, the so-called computer printout which has all the payments in New York State. When we asked for this printout, we requested what we had seen: A list that was alphabetized, a list that was in order by dollar amount. We wanted to learn how many physicians received how much medicaid moneys.

7 PERCENT RECEIVE 50 PERCENT OF MONEY

Subsequently we learned that 7 percent of the medicaid participating doctors earned 50 percent of the medicaid money. There is an incredible concentration of funds. Think about that—7 percent of the participating doctors received 50 percent of the medicaid dollars in New York City.

Now how did we learn that? That pile of papers you see at the end of the table is the computer printouts that they sent us. Now is it in some kind of order? Is it in order by alphabet? Is it in order by physician? Is it in order by dollar amount? The answer to that is

no. It is as if you told the computer to scramble the findings so as to confuse the Senate committee and its staff.

So we had to manually evaluate that pile of data, thanks to the people sitting behind me, we were able to do this. I would like to introduce to you at this point Arcole Perry, Suzanne Kaufmann, Stephanie Fidel, and Investigator Tom Cline. The staff has been working night and day going through the pile of computer printouts. We tried to find ways to run this through a computer. The Library of Congress was flabbergasted, they didn't know what to do with it. We had no alternative but to do our evaluations manually.

The next thing we did was to interview some 20 public officials. Thereafter, the chairman sent letters to every responsible public official in New York State. There were 30 public officials who received what may be called written interrogatories.

We also reviewed incorporated memoranda relating to the Illinois doctors we visited last January in conjunction with the subcommittee's report on clinical laboratory fraud. As the Senator from New Mexico knows, the doctors were very frank about their financial relationship, admitting receiving kickbacks of $1,000 a month or more from laboratories, in addition to receiving rentals of $1,000 a month from a pharmacy for an 8 by 10 foot room and $10,000 a month from the dentist for similar space.

Next we sent a questionnaire over the chairman's signature to 250 physicians in New York City who make between $75,000 and $785,000 from the medicaid program. The results of those questionnaires are just coming in. We have several physicians who are willing and anxious to testify before this committee with respect to various abuses.

Next the committee staff and the chairman, Senator Moss, posed as medicaid patients making some 200 visits to clinics in four States. About 120 of these visits occurred in New York City, the remainder occurred in the States of California, New Jersey, and Michigan. I would like to underline New Jersey because the Chairman of the Special Commission on Investigation, Mr. Rodriguez, is here today and he will present the results of his report and independent analysis of the medicaid mills.

The next step was monitoring the operation of the store front clinic established in Chicago last year.

Medicaid Mills for Sale

Lastly, we announced the establishment of a corporation to buy health care facilities. We simply answered advertisements in the New York Times. Every Sunday you will find three or four pages indicating medicaid mills for sale, along with invitations to physicians to join the medicaid mill and to make lots of money. We posed as businessmen trying to buy these facilities.

Essentially this is what we did in the course of this investigation. As the chairman pointed out in his remarks, perhaps our report has caused some confusion. The conclusions in this report deal with not only medicaid mills, but also with hospital and nursing home laboratories. It carries our conclusions, based on 7 years of dealing with the entire medicaid program.

At this point I would like to recognize the people who did most of the work in this investigation. On my right is Patricia Oriol, the

chief Clerk of the Senate Committee on Aging. I must say that we are indebted to Pat Oriol for a number of reasons. She is the chief clerk of the committee and keeps the committee on an even keel. In addition, she posed as a medicaid patient in some very dangerous neighborhoods. When we entered the 403d precinct, several policemen told us we were crazy. They told us that it is called Fort Apache, that nobody goes in there, but we were there, and Pat Oriol was right with us.

Another modest man who should be recognized is our staff director, Bill Oriol, to whom we are very much indebted for his assistance and guidance.

Next to Pat we have Mr. Darrell McDew of the U.S. Capitol Police force, Mr. James Roberts of the U.S. Capitol Police force and Catherine Hawes of the committee, who performed so admirably.

At this time with your permission I would like Mrs. Oriol to proceed and tell you what she found posing as a medicaid patient.

Senator Moss. Thank you, Val. Your full statement will be placed in the record.

[The prepared statement of Mr. Halamandaris follows:]

PREPARED STATEMENT OF VAL J. HALAMANDARIS, ASSOCIATE COUNSEL, SPECIAL COMMITTEE ON AGING

Mr. Chairman, we are pleased to be here this morning to present the results of our most recent investigation into Medicaid abuse. We focused on possible fraud by practitioners, including doctors and dentists and soon learned that most high-volume Medicaid practitioners work out of Medicaid mills. Consequently, Medicaid mills is the central topic of this report.

THE INVESTIGATION

In the course of this 8-month investigation Senate investigators attempted to test the Medicaid program from three perspectives: government, provider and patient. Specifically, the investigation involved:

(1) Examining in detail more than 100 major reports produced by Federal, State or local agencies detailing fraud, abuse, waste or inefficiency in Medicaid, with a particular emphasis on New York.

(2) Reviewing records in the New York City Department of Health, in the Office of the United States Attorney, Southern District of New York, in the Office of the District Attorney, County of New York, as well as offices of Michigan's Post Payment Surveillance Unit, the so-called "Fraud Squad."

(3) Manually evaluating the medical vendor statement, a computer print-out of all payments for 1974, compiled from records of the New York State Department of Social Services.

(4) Interviewing 20 public officials and sending written interrogatories to 30 additional public officials with present or past responsibility for the Medicaid program in New York.

(5) Interviewing more than 60 physicians; 50 of the interviews were conducted in Illinois last January in conjunction with the Subcommittee's report on clinical laboratory fraud.

(6) Sending questionnaires to 250 physicians in New York who were paid from $75,000 to $785,000 from Medicaid last year (1975).

(7) Committee staff and United States Senator Frank E. Moss, (see following), posed as Medicaid beneficiaries with valid Medicaid cards, presenting themselves for treatment more than 200 times. Some 120 of these visits were in New York City, the remainder were in California, New Jersey and Michigan.

(8) Announcing the establishing of a corporation for purposes of buying and operating health care facilities. Accompanied by cooperating physicians, investigators answered advertisements in the New York Times announcing "Medicaid mills" for sale in Brooklyn, Queens, the Bronx, and the lower East Side and East Harlem. This technique, along with the physician interviews, gave Senate investigators direct information as to the financial operation of numerous Medicaid mills.

(9) Monitoring the operation of a storefront "Medicaid mill" established last December by Chicago's Better Government Association.

Phase I of our work consisted of evaluating some 100 reports dealing with the operation of the Medicaid program particularly in New York. We found that the substantial problems have existed for some time. We then interviewed public officials and sent written interrogatories. We evaluated the results. Phase II was to incorporate the findings with respect to Medicaid mills which we learned in our examination of clinical labs last January in Illinois. Phase III related to our posing as patients and we would like to give you some detail on our experiences. Phase IV, which I will discuss in a few moments, related to our posing as businessmen answering ads in the *New York Times* ostensibly to buy Medicaid mills.

CONCLUSIONS

Maidcaid mills

Comparatively few physicians, (and other practitioners) the great majority of whom work in Medicand mills, are paid most of the money from the Medicaid program. However, because of complicated leasing arrangements, these doctors (mostly foreign trained practitioners) work essentially on commission and are allowed to keep only about 30 percent of the income they generate for Medicaid mill owners, generally businessmen and not medical practitioners.

Practitioners who work in Medicaid mills are under continual pressure to see more and more patients, to order more and more tests, and to spend less and less time with each patient. From personal experience Committee investigators and Senator Moss documented that the quality of care in Medicaid mills was poor in 90 percent of their visits.

As noted above, in national terms, about $2.2 billion may flow through such Medicaid mills. Some 70 percent of this amount is siphoned off by businessmen or real estate operators. Even allowing for overhead salary and other costs, the Committee staff concluded that $1 billion a year was being paid out unnecessarily to enterpreneurs who provide essentially no services.

Medicaid mill owners resort to many techniques to maximize the amount of income coming into the clinic, the first is billing for services not rendered (fraud) and the second most common is ordering unnecessary tests which is a form of over-utilization. However, in about 25 percent of the over-utilization cases experienced by the Committee staff, the efforts were so blatant, so calculated and purposeful, that the staff concluded they constituted intentional efforts to defraud the Medicaid program.

Medicaid mills: A box score

(1) $1 billion may be unnecessarily paid by Medicaid each year to businessmen and real estate speculators who own Medicaid mills. In the normal case, these men are not medical practitioners.

(2) Of the amount unnecessarily paid, the Committee staff estimates that $220 million (10 percent of all payments made to Medicaid mill practitioners or pharmacists) is outright fraud.

(3) Another $550 million of the $1 billion total (25 percent of all payments to Medicaid mill practitioners consists of purposeful over-utilization. The incentives under the present system encourage the ordering of repeated and unneeded tests and the provision of unwanted and unnecessary services.

(4) The quality of care in Medicaid mills in 90 percent of all cases is reprehensible.

NEW YORK

New York State, and particularly New York City has a historical problem of maladministration in its welfare (public assistance) and Medicaid programs (medical assistance) programs. The two are tied together because of eligibility for welfare automatically makes a client eligible for Medicaid as well. Studies by New York and federal officials continue to reveal high ineligibility rates and poor management. Despite repeated warnings from City, State and Federal officials in the form of over 100 reports (the best of which have been prepared by Comptroller Aurther Levitt), little action has followed. This is hardly news for New Yorkers who have read ad naseum about impropriety among New York nursing homes. This report suggests there is equal cause for alarm with respect to other Medicaid providers including some hospitals, clinical laboratories, and certain practitioners who work in Medicaid mills. The Committee staff used conservative estimates that $444 million is lost in New York State as a result of (a)

ineligibility, (b) fraud by all providers including nursing homes, hospitals and practitioners in Medicaid mills, and (c) overutilization of services. Most of the problem is centered in New York City which the Committee estimates loses $295 million in Medicaid funds to these three factors.

While noting these problems are critical and that New York has the worst managed Medicaid program in the Nation, the Committee staff was quick to point out that the problems were historical and not the responsibility of any one public official. On the contrary, the Senate staff had high praise for Governor Hugh Carey of New York who has taken aggressive action to stem the tide. The staff report notes a few of the positive steps taken by Governor Carey: (1) the appointment of a Special Prosecutor for Nursing Homes and more recently vesting him with authority to examine domicilliary care facilities. (One prime recommendation of the report is that the Special Prosecutor's position should be established in law and that he be given responsibility to investigate practitioner abuse in the Medicaid program as well as among institutional providers); (2) the establishment of a Moreland Act Commission to study nursing home problems; (3) the establishment of a commission to study Social Services laws and (4) proposing and then signing legislation to establish a sophisticated computer system called the MMIS (Medicaid Management Information System). It is projected that MMIS may cut Medicaid losses by as much as $160 million a year in New York.

MEDICAID FRAUD IN GENERAL

After having examined fraud and abuse among nursing homes (with more than 27 hearings), clinical laboratories, some home health agencies, a few hospitals that specialize in welfare patients, and now having taken an extensive look at Medicaid mills, Senator Moss and the Committee staff concluded Medicaid fraud is massive. "The 8 percent estimate given by HEW is too low. Fraud is at least 10 percent—$1.5 billion out of $15 billion total. More likely it is about 12 percent ($1.8 billion)," as you have said, Senator, "Adding overutilization, we may be talking about 25 percent on the entire program."

STATEMENT OF PATRICIA G. ORIOL, CHIEF CLERK, COMMITTEE ON AGING

Mrs. Oriol. Mr. Chairman, my name is Patricia Glidden Oriol. I am 53 years old. From 1959 through 1960 I was chief clerk of the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare. From 1961 through the present I have been chief clerk of the Senate Special Committee on Aging.

Through 1959 to 1965 we on the subcommittee and committee were of course deeply involved in efforts which helped make the case for enactment of medicare. We were troubled by the fact that day in and day out older persons and the younger members of their families stood in danger of financial wipeout caused by hospital or medical bills and a few of us wondered whether medicaid—enacted as a compromise theoretically to cover gaps left by medicare and to give help to low income persons in other age groups—would really do all that was hoped for it.

This is not the place or time to recite what has happened to medicare or medicaid since but I will say that at committee hearings around the country during the past year elderly witnesses said again and again that medicare was letting them down in important ways: It doesn't cover prescription drugs, it is overly restrictive on home health, it doesn't pay for eyeglasses or hearing aids, and so on. They were, in effect, repeating a complaint heard by the committee soon after medicare was enacted. It is an umbella with many holes. And when asked about medicaid, many witnesses expressed misgivings about what they regarded as a welfare program, complete with a means test and redtape.

It was natural, I think, that I wanted to see what was happening to tax dollars voted by the Congress to achieve the purposes set forth when medicare and medicaid were passed 11 years ago.

I volunteered, then, to become a "shopper" at medicaid mills partially for the reasons explained by Mr. Halamandaris: It was important for a woman to join the investigative group, especially one who was older than the other participants.

Mr. Halamandaris has already described our shopping methods.

In my case I decided that it would be wrong to dress shabbily. People—especially older women—don't go to the doctor in their worst clothing; they try to make the best appearance possible. And so I wore inexpensive, but neat, clothing. I'm glad I did; I found out that most other women in every waiting room, no matter how poor or tough the neighborhood, did the best they could. Being poor doesn't mean the lack of pride; the opposite is more often the case.

But despite the efforts and attitudes of the patients, personnel seemed to regard the patients as unworthy and unfeeling objects, rather than people. There must be some sort of rule against calling a person anything but the first name. One of my medical files just has "Ruth" and the patient number.

Many Dollars—Little Care

Mr. Chairman, I sat more than once as doctors discussed business plans for new medicaid mills. I was only a few feet away; they didn't see me or even care about me. And they were completely frank about their determination to make as many dollars as possible for as little care as possible.

As I sat in waiting room after waiting room, usually scared, I became angry as well.

Here I was, in cities where many older persons are in desperate need of health care, and yet they can't afford it. The medicare deductibles or coinsurance may be too high for them; or they can't afford even the monthly premiums. And so medicaid should come to their aid. But go to a medicaid mill? Many elderly people, I am sure, have heard from others who had tried the mills and they had been warned. And I think that they would resent being used so that people who didn't care about them could cheat them and the Government. I saw very few older Americans at medicaid mills, and yet I know that good care, given by caring personnel, would have been a blessing to them.

I thought of hearings at which older people tell our committee that they can't afford to buy the prescription drugs that medicare doesn't pay for. I would think of that testimony when, at a medicaid mill after a cursory examination, I would be given three or four different prescriptions for ailments I did not have. I would think of that kind of testimony when a person who called himself a doctor urged me to take a tranquilizer or shot I did not need, insisting that it would make "a new woman out of you in an hour." Or, another one, "Your cold will be cured in an hour."

I thought of that kind of testimony later when Dr. Capper, disturbed because I had already convinced his aide that I would not take the two shots, approached me with the two hypodermic needles and said, "You can have them either in your hip or your arm." I was terrified

because my partner cop had finished and was waiting outside and could not get back through that buzzer door even if I shouted for him. I told the doctor I would take any medicine he prescribed but please don't give me shots, that if the medicine didn't work that I would take the shots when I came back in 2 days for the rest of the tests. He insisted that the injections were not penicillin and he wanted me to take them. I finally decided that if all else failed I would put up my hand and say, "Stop, I'm an investigator for the U.S. Senate." But after giving blood and the time to this clinic, I didn't want to blow my cover. So I was very grateful when he relented. However, on top of the two injections I had refused, I was given five prescriptions for medicine.

This experience both angered me and broke my heart. If I had been the poor, single person burned out of her apartment that I was pretending to be, I would have had no defense against such treatment. I would have received the shots without a chance of refusal. I would have been trying to recover from taking seven different kinds of medicine for my runny nose. And I could only wonder how much profit did Dr. Capper receive. And how many other defenseless patients are enduring the same experience right now?

Prescription Drugs and Pharmacies Pushed

That incident occurred in Detroit, but in all four states in which I shopped I encountered "pushing" of prescription drugs and the pharmacies are often just a few steps away from the medicaid mills, or you have to exit from the clinic through the pharmacy next door in order to get to the street. In fact, in California, in a very large clinic—Rockridge Medical Care Center—the pharmacy couldn't be missed. A wide blue line of arrows had been painted down the center of the sidewalk, across the street and right into the pharmacy.

And so, my pile of prescriptions mounted. I would walk out of the final medicaid mill and pharmacy at the end of the day and bring back in my shopping bag a load of medications that would do me no good at all. In fact, if I had taken the drugs that were prescribed for me I would probably have become desperately ill.

Today everyone is conscious of the danger of additives in our food and here these people are absolutely polluting patients' systems for profit.

At another clinic in Detroit, by an assistant, I was asked trick questions such as, "If you climb four flights of stairs, are you out of breath?" And I would have to answer, "Well, yes, a little." So the complaint was written down: Short of breath. Then I was asked, "If you walk four or five blocks, are you tired?" I would have to answer again, "A little bit." And the entry was: Fatigue. When the doctor started to talk to me he asked, "How long have you been short of breath and fatigued?" This doctor, Dr. Goldberg, was much more curious about my address and why I happened to be in his office than he was about my ills. When I told him it was close to Chandler Park, he asked if that was north or south of Woodward Street. I managed to evade answering the question because I didn't know, but I learned later that Woodward runs north and south.

This was the way of the medicaid mill: A test of wits if the patient was anything but subservient and unquestioning.

In 80 Delancey Street—Delancey Street Medical Center—on the lower East Side of New York, which was a long way from the Bronx address on my medicaid card—I wasn't as frightened there as I was humiliated by the manner of treatment. This clinic is open 7 days a week and I was told that the technician works 7 days a week. Another technician told me that she works part time because she is going to medical school.

While I was being examined, the door was left open to the public corridor and waiting room, and a young man entered the room and emptied the large trash can. The expensively dressed doctor, Dr. Gupta, during his quick examination—without a word—banged a TB tine test on my arm, barely missing the other two I had received from earlier clinics. If I had been offered the chance I would have refused the test because I'm not sure how many you should receive. No explanation was given as to what it was—no circle was put on the test area, nor was I told what to watch for. The needles from my blood tests were thrown in the waste can without being broken in two.

Between receiving my X-ray and the electrocardiogram, I was forced to sit in the public waiting room in the briefest, cheapest paper gown very much embarrassed in front of my buddies.

Optician—Glasses for Everyone

In the same clinic I witnessed an optician who received an urgent call and had to leave to go home, so he asked agitatedly for the files, saying, "I'm going to measure everyone whether they need glasses or not!" He then raced around with his little ruler measuring everyone, pulling the glasses off of one woman walking by and measuring her, and even measured a young baby 6 or 7 months old!

This type of experience was completely new to me. I have never been involved in any kind of undercover or secret investigation, let alone anything so dangerous. Without our good cops here, there were many streets where I would not have ventured alone out of the van and many clinics I would have been apprehensive about visiting alone. Our other investigators who were monitoring outside often had a tough time waiting around unnoticed on the street for the long waiting periods we spent in the clinics, yet when we finally emerged from the clinic—often alone—we could feel confident that we were being protected by our buddies.

In New York our staff worked alone, also in California. In Michigan and New Jersey we worked with State people who helped provide security and direction in our investigation.

Throughout I felt that patients were just being used. The patients—or more to the point, their medicaid numbers—were just the necessary raw material for the production of profits.

What a bitter and terrible thing to happen to them, so many of whom are already on the verge of hopelessness or dull resignation. I hated every moment I spent in those medicaid mills. I am the mother of and have raised five sons and have seen a wide range of injuries and illness, but our family has always had the advantage of fine medical care from Group Health Association of Washington. I watched young families all around me in the clinics and worried about whether the visit there would do the sick youngsters and adults more harm than good.

I hope that this hearing and the reports which accompany it can help make the case for reform. It haunts me to think, as we sit in this hearing room today, that at this very moment other persons are enduring what we endured—or worse—and that their poor treatment is making others wealthy.

My experience already seems like a fading nightmare. For me, the memory recedes; for other, it is a harsh, everyday reality.

Senator Moss. Thank you, Pat. You have testified rather eloquently there and I appreciate it. It gives us the feeling of what it is to go into those clinics which the record will show you accompanied me when I went in there and I was glad to have you along because you were a veteran and I was a neophyte. You recognize the feeling of agitation and deep sadness as you sit there for an hour or two just looking at those people crowded in there, oftentimes not enough chairs for everybody to sit down and all going back and forth out through the little bathroom that is outside that is a public lavatory, taking their kids in and out. The place is not fit to enter. It really is a time of sadness.

I am sorry to interrupt you but it touched my memory.

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

We would like to have Officer McDew continue at this time.

Senator Moss. All right.

Glad to have you, Officer McDew. You were on hand all of the time just outside or inside and I appreciated your presence there in New York.

STATEMENT OF DARRELL R. McDEW, TEMPORARY INVESTIGATOR, COMMITTEE ON AGING

Mr. MCDEW. Good morning, Mr. Chairman and Members of the Senate. I am Darrell R. McDew. Starting on May 12, 1976, I began posing as a medicaid patient along with other members of the staff of the Committee on Aging.

Over the next few months, I and the other five members of the team made more than 200 visits to practitioners in medicaid mills in four States.

All of us began this assignment with mixed emotions. I didn't know quite what to expect. We had no conception of the quality of medicine that was being practiced and how it compared with our family physicians or other public health clinics. We had heard about various abuses allegedly practiced by some doctors but didn't really know what people were talking about.

After 3 months all of us were thoroughly educated in the terminology. For example, all of us personally experienced an abuse called ping-ponging. Ping-ponging is the practice of referring patients from practitioner to practitioner in the same facility irrespective of need.

In some facilities we entered, ping-ponging was obvious and apparent, a premeditated policy. I would like to tell you about a few of my experiences in a little more detail.

Imagine you are with me walking into the East Harlem Medical Center. I told the receptionist I wanted to see a doctor about my feet. After waiting a while I was ushered in to see what I thought was the

podiatrist. The man turned out to be a general practitioner, Clyde Weissbart. At no time did he examine my feet. Instead he asked a few questions about my medical history, checked my back with a stethoscope and asked me if I ever had any back trouble. He then prescribed three medications, and ordered urine and blood tests and X-rays. Dr. Weissbart asked me if I used any particular pharmacy and I told him no. He then asked if he could suggest one, and I told him he could. He told me that the pharmacy next door was a good one and that I should get my prescriptions filled there. He repeated this several times.

When he gave me my chart, he told me to go upstairs. Again, I assumed I would be seeing the podiatrist. However, when I got upstairs I discovered that I was in the waiting room of the chiropractor, Dr. Abbot Cohen. He asked me if I had any problems with my back and I said, "Not really." He examined me and said my spine was crooked, pressing his fingers on my back.

"Your back does hurt you here, doesn't it?" he said.

"Yes," I said: "With you pressing it, it does hurt, but it quits when you stop." [Laughter.]

"Well, I think with six or seven visits, I can straighten you out," he said, suggesting my first visit start the next day.

Feet Examined Visually

After this examination I was directed downstairs where I finally saw the podiatrist, Dr. Napoli, about my feet. I told him my feet hurt, particularly the soles. He had me sit on a bench and take off my shoes and stockings. At no time did he place his hands on my feet. He sat in his chair across the room with his arms folded. By just looking at my feet he announced his diagnosis—"ankle strain." "When you get up in the morning you feel like you're walking on eggs, don't you," he asked.

I said, "No, not really." [Laughter.]

He insisted I probably felt like I was walking on eggs each morning and that I had strained ankles. He wrote a prescription for one pair of ankle braces fitted to size. He never told me when to start wearing them or for how long, just to fill the prescription at a medical supply house down the street and to return in about a week

I think you can understand why the phrase "ping-pong" is accruate. All of us repeatedly were bounced through the medicaid mill. Always the visits were brief. About 45 percent of the visits resulted in at least one referral or "ping-pong."

Perhaps another example or two will further make the point. At the Riis-Wald Medical and Dental Center, I complained of a headache. The receptionist asked me if I wanted to see a podiatrist or a chiropractor. I said: "No, you didn't hear me. I said I have a headache."

She told me that because of my headaches I needed to see a chiropractor. "Maybe your headaches are caused by tension," she offered.

I saw the chiropractor, Dr. Diniz. He asked about my medical history, he examined me, gave me an "adjustment" on my back and ended by cracking my neck. He sent me back to the waiting room. Not long after this I was called in to see another practitioner. He was

a podiatrist, Dr. Jackowitz. He looked at my feet and said, "Your feet sweat." I looked down at my grubby tennis shoes and remembered that it was in the 90's outside. I didn't say anything as he gave me a medication which he claimed would decrease the sweating. After having me stand barefoot on the floor, he diagnosed flat feet and hammer toes. He placed small white pads in the arches of my tennis shoes. Here they are [indicating].

Senator Moss. It looks like about the size of a silver dollar.

Mr. McDew. After another trip to the waiting room, I was called in to see Dr. Ortez, an internist. He asked me how frequently I had headaches. He told me I have to have X-rays. I submitted to about 10 of them. I was scheduled to return for further tests but nobody told me why they were needed.

An interesting postscript to this visit illustrating the "ping-ponging" we received is the fact that I encountered Dr. Jackowitz, the podiatrist, about 1 week later. This second meeting took place at the Urban Medical Group in Harlem. I had asked to see a doctor without specifying a complaint. He asked what my problem was and I said nothing except maybe my feet hurt a little. The doctor was making an examination when another practitioner stuck his head through the curtains of the cubicle. He asked my name and I responded. He told me he was the optometrist and that I should be sure to see him before I left. Minutes later the podiatrist came in the room and I recognized him at once. It was Dr. Jackowitz.

He looked at me and then at my feet. While looking at my feet he asked me, "Haven't I seen you before?" I didn't say anything. He pulled out a little book and said, "Yes; I did see you on the lower east side a couple of weeks ago."

Glasses Prescribed—Vision 20/20

Looking at me he said: "Remember what you had before? Well, you've got it again." [Laughter.] He placed little white pads in the insoles of my oxfords. To finish the story, I did see the optometrist. He told me I needed glasses and prescribed a set for me. He gave me a choice of the two standard medicaid frames and noted that if I wanted to pay a few dollars extra, I could get special frames, wire rims or other kinds of metal frames.

I should add that my vision is 20/20 and my feet and body are completely healthy.

My overwhelming impression is one of gratitude. I am grateful my financial situation does not require me to depend on medicaid for my medical care. I honestly feel, and the other investigators who are testifying today will agree, that if I had a serious illness it would remain undetected or untreated. I am sad to think that there are many people who have not been as lucky as I. They must encounter on a daily basis the horrible conditions and treatment that I experienced during this investigation.

[The prepared statement of Mr. McDew follows:]

PREPARED STATEMENT OF DARRELL R. McDEW

I, Darrell R. McDew, private with the United States Capitol Police, was placed on temporary leave of absence by resignation in order to be hired by the Special Committee on Aging of the United States Senate on May 7, 1976. I

reported to the Committee on May 7, 1976, and was sworn in as a Senate Investigator. On this date, I was examined by the attending physician of the United States Capitol, Dr. Freeman H. Carey. Dr. Carey certified that I was in excellent health with no medical infirmities, at that time.

During the period of May 10 through July 16, 1976, I participated in an investigation evaluating the operation of the Medicaid programs in New York, Michigan and New Jersey, and the Medi-Cal program in California. I posed as a Medicaid beneficiary and presented a variety of possible illnesses to various doctors in facilities that accepted Medicaid patients. My complaints included those of a general nature, such as headaches, foot problems, back pains, eye problems, and common cold. During these 10 weeks, I was seen by internists, podiatrists, opticians, opthalmologists, optometrists, chiropractors, and general practitioners.

Of the many visits I made to these facilities, there were several instances in which I felt the treatment I received was worse than poor. There were times that I felt no more human than a dog as I was sent from doctor to doctor and test to test without so much as an explanation. Medications were prescribed liberally, and in most cases I was not told what type of medication I was supposed to take or the possible reactions I could experience due to intake. I hope the following illustrations will clarify the frustrations I felt as a Medicaid recipient.

When I entered East Harlem Medical Group in New York City, I requested to see a doctor about my feet. The receptionist took my Medicaid card and told me to take a seat. After waiting a while a doctor motioned me into an examining room. At that time, I assumed that this doctor was the podiatrist. However, at no time did this man examine my feet, and it was not until the conclusion of the examination that I learned his name and specialty. The man's name is Dr. Clyde Weissbart. He gave me a very brief examination consisting of checking my chest with a stethoscope and asking me if I was having problems with my back. He then prescribed three medications, ordered a urine sample and a chest x-ray, and scheduled me for blood work. Dr. Weissbart asked me if I used any particular pharmacy and I told him no. He asked if he could suggest one. I answered yes. He told me that the one next door was a good pharmacy and that I should get my prescription filled there. He repeated this to me several times.

When he gave me my chart, he told me to go upstairs. Again, I assumed I would be seeing the podiatrist. However, when I got upstairs I discovered that I was in the waiting room of the chiropractor, Dr. Abbot Cohen. While waiting to see Dr. Cohen, I opened my clinic folder and read the chart. I saw that Dr. Weissbart had noted that I had no allergies. However, Dr. Weissbart had never asked me if I had allergies. In fact, I do have one allergy, to horse serum.

My examination with Dr. Cohen lasted approximately 10-15 minutes. He asked me a few questions about problems I have had with my back. I said I haven't had any, only on very rare occasions, a strain or stiffness, but nothing serious. He had me take my shirt and undershirt off, and began to examine me. He told me that my back was in very bad shape. Dr. Cohen said that rather than being straight in the lower section, my spine pointed towards the front and right of my body. He pressed his finger against the lower part of my back and stated, "Your back does hurt you there, doesn't it?" I said, "Yes with you pressing as you are, it does hurt, but other than that, it doesn't." Then he said, "Well, I think in maybe six or seven visits with me, I can straighten you out." He suggested that the first visit be the following day.

After this examination, I went back downstairs to the waiting room and finally saw the podiatrist, Dr. Napoli. When asked what my problem was, I complained of pain in the soles of my feet and in the back of my calves. He told me to take my shoes and socks off and sit on the bench. At no time did he ever place his hands on my feet. He sat in a chair about three feet way, with his arms folded, and just looked at them, saying that there was something wrong with my ankle. He called it ankle strain. He said, "When you get up in the morning don't you feel like you're walking on eggs?" I replied, "No, not really." He still insisted that I probably felt like I was walking on eggs in the morning and told me once more that I had strained ankles. At this time he began writing out a Medical Service Order for one pair of ankle braces fitted to size. He never told me how long to wear them, nor when I should start wearing them. He did tell me to come back in a week.

PING-PONGING PRACTICED

My experience at Riis-Wald Medical and Dental Center provides another example of the practice of ping-pong, being sent from one doctor to the next regardless of a patient's initial complaint. I went in this facility and complained of headaches. The receptionist was very courteous and nice. The place as a whole was very clean and seemed to have been well organized.

The receptionist asked for my Medicaid card and I presented it to her. She said, "Have a seat and then I'll call you back." I assumed that during this time she had run off copies of my card, since when she called me back, I looked down and saw she had a folder in which there were two copies of it. She asked me if I wanted to see a podiatrist or a chiropractor. She said, "Because of the headaches you may need a chiropractor. Maybe your headaches are due to tension." I said, "Well, I'm not sure, but you think I need to see him, okay." She replied, "I think it might be a good idea." Then she asked if I was having problems with my feet and I said, "Well, not really." She asked, "Well, do you want to see a podiatrist?" I just shrugged my shoulders and said, "Well, I'm not sure." She said, "Well, I'll put you down to see one."

While I was waiting to see the doctor about my headaches, I was called in to see the podiatrist, Dr. Jackowitz. The doctor examined between my toes and said, "It seems like your feet sweat." He gave me a prescription for some kind of medication which he claimed would decrease the sweating. Then Dr. Jackowitz requested that I stand barefoot on the floor. He glanced briefly at my feet and diagnosed flatfeet and hammer toes. He placed small white pads in the arches of my tennis shoes and said, "I'll put these little pads in your shoes and you see how that feels." I noticed no difference with or without the pads. The entire examination with Dr. Jackowitz lasted approximately six or seven minutes.

I returned to the waiting room for a short period of time, after which I was called in to see Dr. Ortez. He apparently was the doctor that I was to see about my headaches. First I saw someone whom I assumed to be his nurse. She took a fairly complete medical history, including questions concerning asthma, epilepsy, paresis, high blood pressure, sugar diabetes, and my drinking habits in regards to alcohol, coffee, and water. She also checked my blood pressure. Then I waited for the doctor. He came in, asked me a few questions, took my blood pressure, reached inside my shirt and felt around my chest and back area with stethoscope. He asked me how frequently I had headaches, and how long had I had them. Then he questioned me about my sleeping patterns. After he had finished the examination he told me he wanted to have x-rays taken. I submitted to about 10 of them. I was also scheduled to return for further tests but no explanation was given as to why I needed them.

Once again, I returned to the waiting room and was summoned in to see Dr. Diniz, the chiropractor. He took my blood pressure, listened to my chest area with his stethoscope and felt around my spine from the base of my skull to my waistline. He asked me how I felt, did he hurt me at anytime during the examination? I said no. Then, he had me lie face down on the examining table and applied little pressure on my lower back and asked if he was hurting me. He had me turn my head to the right, and pressed down on it around my neck area, and he asked me if that hurt. Then he repeated the same thing to the left side. Finally, he said, "Well, you seem to be tense. Are you tense or nervous about anything?" I answered no to all his questions. He said, "Well, it feels like you are very tense." He then cracked my neck a couple of times. After what seemed to be a very long time, I left the clinic.

On May 25, I entered the Urban Medical Group, less than two weeks after having visited Riis-Wald Medical and Dental Center. Upon entering, I asked to see a doctor without specifying my problem. The receptionist told me to take a number and have a seat. After a while, I was called back to the desk where the receptionist requested my Medicaid card. She made approximately 8–10 copies of my card.

I was called into an examining room and a person, whom I assumed to be a doctor, came in. He never identified himself by name and began asking me some brief questions about my medical history. Finally, he asked me what my problem was, and I told him that I was having problems with my feet—that they were hurting all the time around the sole area. At this time, he told me to take off my shoes and socks and sit on the examining table. He felt the pulse in my feet and said it felt good. He mentioned that he probably would want to run a test to see if I had sugar diabetes or anything of that nature.

PODIATRIST SPLITS TIME BETWEEN MILLS

At this time, Dr. Jackowitz, the podiatrist who had examined me at the Riis-Wald Medical and Dental Center, happened to stop by the cubicle. The other doctor asked Dr. Jackowitz to take a look at my feet. He told me to stand on the floor barefoot. Dr. Jackowitz said, "This man's problem is just the fact that he has flat feet and there's nothing more." The first doctor mentioned, "Well, do you think it's necessary for me to run any tests?", at which time the podiatrist said, "No, his only problem is flat feet."

Dr. Jackowitz told me to follow him into his examining room where he checked my feet a little closer and put some padding in the arch area of my shoes. He then mentioned to me that he recalled seeing my face and told me that my voice sounded familiar. He asked me if I was sure I had not been to a medical center on Avenue D. I told him that to the best of my recollection I had not. Then, he looked at my chart and noted that the symptoms I had were also very familiar to him. He asked me if I had been in the service and I said, "Yes, I was in the Navy." At this point, he was even more sure that he had seen me and said, "Hold on a minute, "I'll check." He looked into a notebook filled with a list of names and found the name Tomas Feliciano. Then he remembered seeing me at Riis-Wald Medical and Dental Center, earlier that month.

While I was in the podiatrist's office, the optometrist stepped into the office and said to me, "Come and see me when you're finished here. I'm the optometrist."

After the podiatrist finished putting the pads in my shoes he told me to come back and see him next Thursday.

Then I went into the optometrist's office and he examined my eyes. He had me read the eye chart without the aid of any lenses. Then he used a machine and had me read the chart again while switching different lenses back and forth. Everytime he chanked the lenses, he would ask me if I could see better or worse. Finally, he said to me, "Generally, your eyes are pretty good, but you do need reading glasses." He asked me if I wanted to pay for special frames, or make do with Medicaid frames.

At Avenue C Medical Group, located on the Lower East Side, I walked in and asked to see a doctor. The receptionist asked me my complaint and I told her I was having headaches. She asked for my Medicaid card and told me to have a seat.

I waited for what seemed to be a long time. Then, she called me back to the desk and asked me if I wanted to see an optometrist. I replied, "I don't know." She said, "Well, you may be straining your eyes and that may be one of the reasons that you are having headaches. You may need glasses." I just shrugged my shoulders. She said, "Well, I will fix it up that way. You will see the doctor and then see the optometrist." She told me to have a seat again. Once more the receptionist called me back and told me that the first doctor I was originally supposed to see was out to lunch, so I would be sent in to see Dr. Barron, the optometrist first.

The first thing he asked me to do was read the eye chart. Next, the doctor held various lenses with one hand in front of my eyes, while he directed a light through the lenses into my eyes with his other hand. At no point during this part of the examination did he ask me to read the chart. Finally, he placed two lenses into a frame, put them over my eyes, and had me read the chart. He stated, "Your eyes are a little bit off here and there. You need glasses, so I'm going to write up a prescription. You can get plain glasses through Medicaid, but I suggest that you get tinted glasses. This will cost you a little more, but where I'm going to send you, the guy is pretty fair. For a few extra dollars he can fit you with some tinted glasses." I was told to come back to see a Dr. Larry.

I did return on the scheduled day to see a Mr. or a Dr. Larry to be fitted for eye glass frames. He showed me frames of various kinds and colors. I asked him if it was possible to get metal frames, and he stated that Medicaid does not pay for them. So, I chose a brown colored frame. He then wrote up a work order on that particular set of frames, and stated that I was to come back in a few days to pick up my glasses. I obtained these glasses and they have been refracted and are secured in a safe in the offices of the Committee on Aging.

I would like to make note that, to my knowledge, I have 20–20 vision. My last eye examination was prior to going on the U.S. Capitol Police Force in January of 1974. At that time, I was told that I needed no visual aid.

After Dr. Barron's examination, I returned to the waiting room and was eventually called in to see Dr. Markowski, an internist. He took my blood pressure,

my temperature, checked my throat, and asked me if I was allergic to anything. I told him that I was allergic to pencillin. He suggested that I have a B–12 shot and I told him I didn't want it because I don't like needles.

TESTS PUSHED

He also scheduled me for tests later on in the day. From what I saw on the doctor's invoice, he had about nine items listed. I returned later that day and gave a urine sample and three vials of my blood were drawn. I was also scheduled for an EKG, but I did not have it.

At Universal Medical Group my complaint was "achey" feet. Dr. Feldman, the podiatrist, examined my feet, felt around my ankles, toes, and calves. He asked if I had sugar diabetes, anemia or heart trouble. He x-rayed my feet in a flat position and also at an angle. He stated that my feet were in pretty good shape, but I needed arch supports. He took a plain sheet of paper and placed it on the floor, tracing my right foot on one side of the paper, and the left foot on the reverse side. He made two small marks on the paper at the point where the toes begin. He said the x-rays would substantiate the need for foot molds. He asked me if I had a phone and I answered no. So, he told me that he would send me a letter when the molds arrived and to be sure to come back to see him.

I entered the 164th Street Medical Group and again complained of headaches. I was seen by Dr. Enrique Davis who gave me a brief examination using a stethoscope on my back and chest and asking brief medical history. He took my height and weight. I was given an allergy test, vials of blood were drawn, and I gave a urine sample. I was scheduled for x-rays and an EKG, which I did not have since the clinic was about to close and I was told to return the next day. The clinc was very large, clean and well situated and the staff seemed to be well trained.

On my second visit to this clinic, a week and a half later, the atmosphere had changed. I noticed that there were a number of people who seemed to be addicts hanging around inside and outside the clinic. Again, my complaint was headaches and inability to sleep. Dr. Davis read over my chart from the first visit and told me that the results from my tests were okay. However, he went ahead and prescribed three medications and at this point, he still had not told me what he thought to be the cause of my headaches.

At the Willis Professional Group I again complained of headaches. I was throughly examined by a doctor by the name of Wallace. She took my blood pressure, checked my eyes, ears, nose and throat and listened to my chest and back area with a stethoscope. She felt around my abdominal area, ankles, calves, and throat. She had her assistant take my weight and height, and also had me read the eye chart. She determined I had 20/20 vision. Dr. Wallace told me that she could not see any physical reason for my headaches. She asked what I usually do when I have these headaches and I told her I take Excedrin and drink coffee. She told me she would not prescribe any medication, but to continue as I had been. She told me to return if I experienced any blurred vision or nausea. She said the headaches were probably due to tension and nothing more.

Dr. Wallace was efficient and took her time examining me. She seemed interested in me as an individual rather than as a nameless face. Of all the doctors that I visited throughout the investigation, she was the only one to give me a diagnosis with concurred with my true physical state.

Probably the most frustrating experience of the entire "shopping" venture was the endless waiting I endured in order to receive treatment. In one facility I sat for at least three and a half hours after which time I became so angry, I left. I watched as doctors walked around the clinics socializing with the receptionists and nurses instead of taking care of patients.

The filth and stench in a large majority of the facilities I visited was disgusting. I found it very upsetting to see cockroaches crawling on the floor of a medical office. The walls were dirty, cigarette butts littered the floor, and ashtrays were overflowing. Where there were stairs, they were so rickety that I had to be extremely careful when walking up or down them. The lighting in the waiting rooms was so inadequate that it made the waiting rooms appear even more dismal and depressing than they already were. One doctor's fingernails were so filthy it seemed like he had just come from changing the oil in his car.

In most instances when doctors prescribed medications for me, I was not told what kind they were nor how to take them. Nor was I told what to do if I experienced any type of reaction.

I would like to conclude by saying that I feel extremely grateful that I am not in a situation which requires me to depend on Medicaid for my medical care. I honestly feel that if I had a serious illness, it would remain undetected and untreated. I am saddened to think of the many people who have to endure the kinds of treatment and conditions that I experienced during this investigation.

Senator BEALL. When you had the 10 X-rays for the headaches, what part of the body was X-rayed?

Mr. MCDEW. The 10 X-rays consisted of four skull X-rays, chest and back and also of my feet.

Senator BEALL. Your feet?

Mr. MCDEW. Yes.

Senator BEALL. Thank you.

Senator MOSS. Thanks very much.

Mr. HALAMANDARIS. Officer Roberts.

STATEMENT OF JAMES A. ROBERTS, JR., TEMPORARY INVESTIGATOR, COMMITTEE ON AGING

Mr. ROBERTS. Good morning, Mr. Chairman and Members of the Senate. I am James A. Roberts. Starting on May 12, 1976, I began posing as a medicaid patient along with other members of the staff of the Committee on Aging.

Our investigation carried us from the lower East Side of Manhattan all the way to sunny Oakland, Calif. Yet, no matter what State we were in, there was always one thing that was consistent and that one thing is that these "medicaid mills" were always located in pockets of poverty. They were as strategically placed as sentries around the White House. Common logic would dictate that competition for patient load would be fierce, since there were so many clinics in any one small area. Continuing with that line of reasoning one would think then that the personnel would try to provide high quality care to attract the patients. Unfortunately, we did not find this to be so. If anything, our treatment demonstrated that we were thought of as being expendable.

A medicaid patient is almost always forced to surrender his rights as an individual to the clinic personnel. Officer McDew described the practice of ping-ponging, a practice which we all experienced. The purpose of ping-ponging is to bolster the clinic revenues and not, in my experience, to provide preventive health care. I would like to describe a related treatment mode. I refer to the ordering of medical and laboratory tests, many of which are unnecessary, poorly administered, and occasionally even dangerous to a person's health. These tests also appear to be done only to increase clinic profits, not to improve patient care.

I would like to give you a few examples which illustrate these points.

I entered the Gouverneur Medical Clinic in Manhattan complaining of a burning feeling when I passed water. During the examination, which was only from the waist up, the doctor told me that she detected a slight heart murmur. She told me that I would have to have an EKG to confirm her findings. As I was lying on my back, with the EKG test in progress, the doctor without warning jabbed my outstretched arm with a series of needles in what is called a Tine test for TB. I am sure that this shock had an effect on the EKG

tracing; however, the doctor dismissed my concern by telling me that this procedure was required by the Health Department for all new medicaid patients. The doctor circled the area with her ball point pen but I was given no further instruction as to what I should look for.

The important point is that two other investigators entered the same clinic. They, too, were told that they had heart murmurs, given EKGs and a battery of other tests. I found out later that an EKG is not standard procedure to verify a heart murmur. Since we were all healthy the entire procedure, including the finding of the heart murmur, was not medically indicated; rather, it was obviously a way of increasing income to the clinic from medicaid.

Tests, but No Results

A similar incident occurred at the 164th Street Medical Group on Morris Avenue in the Bronx. I presented a complaint of an earache and a cold. I was told that since this was my first clinic visit, I would need to have an allergy test. Even before I had seen a physician, I found myself again being jabbed with needles. This time there were 30 needles on a board in 3 rows of 10. The attendant took one drop from each bottle on her tray and placed it on each of the punctures. In a few minutes she wiped my arm clean.

I was never told the results of this allergy test. In fact, none of the clinic doctors or any of the clinic personnel so much as looked at my arm for a reaction.

At the same clinic I was given a test which measures hearing loss and told that this procedure was required since I complained of an earache. I was never told the results of this test either.

At the Riis-Wald Clinic in Lower Manhattan I complained of a burning feeling when I passed water. The receptionist directed me to the chiropractor. The chiropractor told me that full body X-rays were necessary. In his words, "Sometimes one appears to be healthy on the outside but X-rays are necessary to get a picture of what is going on in the bones."

The podiatrists I saw were also prone to order X-rays for questionable reasons. One told me that I had a bunion on the big toe of my right foot. Another told me that I had a bunion on the big toe of my left foot. Both said that they had to take X-rays to make sure.

If I can offer a few generalizations:

(1) A wide variety of tests were ordered on most visits. Blood was almost universally asked for.

(2) Quite often the tests had nothing to do with the symptoms that we presented. When I asked one doctor what the correlation was between an earache and a blood sample, he became visibly upset. He said that I had to give him blood or he would not treat me.

(3) The tests were usually rushed and at times haphazardly given. We were given EKGs over stockings and our blood pressures were taken over our shirt sleeves. When listening to our chests and back, often the doctors didn't bother to have us remove our shirts.

(4) Rarely were we given the results of the tests we received.

The psychological trauma of this 3 month experience was severe. In the back of my mind I always knew that I was not dependent

on these horrible clinics for my regular medical care but I am still troubled and saddened when I think of all the people in this country who really don't have any other alternatives.

[The prepared statement of Mr. Roberts follows:]

PREPARED STATEMENT OF JAMES A. ROBERTS, JR.

Mr. Chairman, my name is James A. Roberts, Jr. I am a Private in the United States Capitol Police. Our investigation carried us from Manhattan's Lower East Side all the way to sunny Oakland, California. Yet no matter what State we were in one thing was always consistent. That one thing is that these "Medicaid mills" were always located in pockets of poverty. They were as strategically located as sentries about the White House. Common logic would dictate that with such a number of clinics there ought to have been some competition among the centers for patient load. If a person's actions are indicative of his thoughts, then that thought is as far removed from their minds as a cat swimming in the Atlantic Ocean, because they treated us as though we were expendables.

I think that the best way to illustrate the conditions we encountered in our investigation, is by giving a number of illustrations of what transpired during the visits.

When I went to the Gouveneur Medical and Dental Group, I asked to see a medical doctor. The receptionist asked me what my problem was and I told her that I had a burning feeling when I passed water. She then asked for my Medicaid card—no identification—and made at least two copies of it.

I was given a dental clinic card even though I never asked for it and was there to see a medical doctor. Then there was a short wait—probably about ten minutes—before I was directed to an examining room and to a Dr. DeJesus. Dr. DeJesus asked me what my reason was for being there, and I told her that I had a slight burning sensation when I passed water. She then asked me if I was certain that there wasn't any discharge and I said yes. She asked if I was allergic to any medication and I told her that I was allergic to penicillin. She was writing on the chart the whole time that she was speaking to me. She then asked me to pull up my shirt and undershirt. She took a blood pressure reading which she said was normal. She then listened to my chest and heart. While listening to my heart, she said that she detected a "slight murmur," and I would have to have an EKG test to verify her findings. I was taken into a room where there was an examining table, and an assistant who applied the creams and began the EKG exam.

While I was on the table, and the EKG test had just started, Dr. DeJesus came into the room and without any warning, she popped me with a Tine TB test on my outstretched wired arm. I asked her what that was because it surprised me. She responded that it was a "TB test that was required by the Health Department of all new Medicaid patients." So I did not object because I did not have a chance to do so.

She circled the test area on my arm with a ball point pen, but she did not give me a specific time to return to have it read. I was not given any instructions as to what to watch for, nor was I told to report any changes to her.

After the EKG test was over, the technician told me to get dressed. Then she came back into the room and gave me a cup for a urine sample. I remembered hearing Dr. DeJesus telling the technician that she wanted me to have a urine test and that I was supposed to come back the next Saturday for a reading of the urine specimen.

When I gave the sample to the technician, she said that Dr. DeJesus said that my EKG was normal, but as I was leaving, Dr. DeJesus stopped me at the reception desk.

She seemed rather interested in my skin. She kept looking at my face and saying that there was something wrong with my skin because it looked scaly to her. I just told her that I didn't put any lotion on it that day, that I had just gotten up off of the street and come in.

After the receptionist told me to have the prescriptions filled at the pharmacy next door, I then left the clinic.

The next office (if you can call it an office) I went into was at 209 East 14th Street. From the street the place looked to be a door leading to nowhere that you would ever want to go. Yet there was a large blue awning stretched

out front that said "14th Street Medical Center." When you entered the office, you found that it was very dimly lit. The furnishings look as if they were taken directly from a junk yard. Somewhere from behind the partition came a voice that asked me what I wanted. I later found out that the voice belonged to a man dressed in a white uniform. When I told him that I had a burning feeling when I urinated he promptly referred me to the City Health Department Clinic. This, I might guess, was the best treatment that one could possibly get from this clinic. So, heeding his expert suggestion I turned and left. I got the same treatment on two return visits.

I wouldn't send a dying dog into that place. This was one of the worst looking places that I saw in all of my "shopping experiences."

EXAMINATION: 30 SECONDS

At the Third Avenue Medical Office, I received the fastest exam of my eyes, ears, nose and throat that I have ever experienced. I was complaining of an earache—that I had some mucous draining—and that I had been suffering for a day or two.

The doctor that I saw here was named Bernard. He asked me very general medical questions, about my medical history and the medical history of my family. I responded negatively to all of his questions, but I did tell him that I had an aunt who had diabetes. It wasn't until after he had taken my blood pressure that he got around to asking me why I was there.

He then took an instrument and looked into my eyes, ears, nose and throat, covering all of these areas in about thirty seconds. And that is a generous estimate; it may be more like ten seconds on the outside. This particular exam was the fastest one that I have ever had.

He next instructed me to lie up on the examining table. Dr. Bernard took his hand and ran it across my left and right ankle, just touching them. He asked me to unbuckle my pants, and he pressed around my abdominal area. He visually examined my chest area, and then told me that I could stand up.

I fastened my clothes and sat down in the chair next to him. He took my temperature, and reported it to be 99.4, even though I do not believe that I had a fever at that time. I was not feeling flushed, feverish, or any other discomfort.

It was at this point that he brought out two test tubes and a syringe so that he could take a blood sample. I refused to take the blood test and the doctor became visibly upset. He said that he didn't want to continue treating me, since he would not be able to tell what was wrong with me, unless he had a blood sample. I questioned him about the correlation between a blood test and an earache, and he said that the blood test was to determine whether or not I had diabetes. He said that since I had an aunt that had diabetes, I had a history of the disease in my family. He also rattled off other reasons for having a blood test, that I couldn't fully understand because of this thick accent. But again I refused to have the test, despite his insistence, because I did not trust him or appreciate his rough manner.

He offered to give me a prescription to relieve the pain and discomfort in my ear but he told me that I would have to be referred to another doctor or hospital. He refused to accept any liability for what may have been wrong with me, and with that, began to write furiously all over the chart. I think that he spent more time writing on my chart than actually examining me! He filled in every conceivable space that was on the examination chart, and when he finally finished, he wrote out a prescription for two medications which he placed in my folder. I was ushered back to the reception area, where the receptionist filled out the top of the prescription forms, and gave them to me. After that, I left the office.

The 164th Street Medical Group at 95 Morris Avenue was a new facility that still wore banners announcing its grand opening, like a used car lot. However, it seemed to have the full range of practitioners from surgeons to chiropractors, hearing specialists, psychiatrists, allergists, podiatrists, internists, dermatologists, and radiologists.

I entered the clinic and was greeted by a man in a white smock. He asked me why I was there and I said that I wanted to see a doctor. He asked if I had been there before and when I responded negatively, he said that he would start a file on me. This included taking my Medicaid card and making six copies of it.

After that, he said that since this was my first visit, the first thing would have to be done would be an allergy test. After a brief wait, an assistant took me

into the nurses' station and gave me the test. First she washed the underside of my forearm with alcohol. Next, she took a device that had about thirty needles on it and ran it into my skin causing multiple penetrations. Then she took one drop from each of the thirty bottles on her tray and went over the skin pricks that she had made and let it sit for a while.

I would like to make note here that after the technician wiped the drops off of my arms, no one ever took any real notice of what the reaction was, if any, that I had to the scratch test,

When she was finished with the allergy test, the technician took me into the medical examining room where I was seen by Dr. Enrique Davis.

He asked me why I was there and I repeated what I had told the male receptionist, that I had an earache the day before and that I had a mucous problem.

The physical exam itself was very brief. Dr. Davis asked me questions about my medical history and about my family's medical history. At this point, Dr. Davis stopped writing and looked me in the eye and asked me where I came from. I responded by giving him the same address that was on my Medicaid card. That answer was not what he was looking for as he asked me where I was really from. I was frightened, swallowed hard, and told him that I was born in Newark, New Jersey, but had moved to New York about five years ago. Dr. Davis slowly turned his pen in his hand as he thought about my response. By that time, my palms were sweaty and my heart was beating a little bit faster. But that answer seemed to suffice.

Many Tests—Poor Care

His assistant continued the examination. She weighed me, measured my height, and then directed me to sit on the table and to remove my shirt. She took a blood pressure reading and told her findings to Dr. Davis. He said that was an extremely high pressure reading and questioned me about any history of high blood pressure. He took my blood pressure in both arms, and decided that it wasn't high after all. Next he took his stethoscope and listened to my chest and back. He concluded his examination by pressing around my stomach a couple of times and then he went back to his desk and started to write. I was still on the table when his assistant came over and drew two vials of blood.

Dr. Davis told me that I had a viral infection in my throat and ears and that he would prescribe some medication. He wanted me to have an ear test, an EKG, and a chest x-ray. I was also to come back at ten o'clock the next Friday to be examined by the ear, nose and throat specialist.

My visit to Morris Avenue ended after I had a diagnostic hearing exam, administered by an assistant. As per the allergy test, I was never told the result of this exam either.

The overall impression that was given by the staff of the clinic, and reinforced by the way that my examination was conducted, was that the facility was there strictly as a money making operation. If the patient care was good, that was merely a secondary aspect.

One of the other more flagrant examples of "Ping-ponging" came when I entered the Riis-Wald Clinic at Avenue D and asked to see a doctor. A receptionist took my Medicaid card, made three copies of it, and then asked me what was wrong. I told her that I had a burning feeling when I passed water. I was told that I would have to wait to see a medical doctor, but that there was a podiatrist and a chiropractor that were available immediately. I declined to see the podiatrist, because I still had some dye on my foot from a previous visit with a podiatrist. She persisted, and said that since this was my first visit, I should have a complete physical which included seeing all the physicians that were available. Again I declined and she continued to press, stressing the need for a complete case history, which could only be built by seeing all of the physicians. Finally, I conceded that maybe at a later date, I would see the podiatrist. I agreed to see the chiropractor that day.

Dr. Diniz, the chiropractor, was the first practitioner that I saw. He asked me many of the general medical history questions that are usually asked by the physician. He pressed on my spine and massaged my muscles. He told me that I should return in one week, because that was when a specialist would be in, and then I could get a thorough examination. He indicated that an x-ray examination would be necessary, since "sometimes you may appear to be healthy on the outside, but full body x-rays are necessary to get a picture of what is going on in your bones." After he finished his examination and made another appointment for me, I was ushered back into the waiting room.

After about fifteen minutes, a woman in white came into the waiting room and took me back to the examining room. She asked for a complete rundown on any medical disorders that were in my family. She took my temperature and asked me what the reason was that I had come to the clinic. Shortly thereafter, Dr. Ortez entered the examining room and gave me a superficial examination. He, too, asked me what the problem was and again I repeated it. Then he asked me when I last had sex, so I assumed that he was thinking that it might be some kind of veneral disease. Then he took a swab for a culture.

Even though I complained of a burning sensation when I urinated, he did not request a urine sample. My visit with the doctor lasted approximately ten minutes.

He gave me a prescription for an antibiotic, instructed me on how to take it, and told me to return in about a week for the results of the swab test.

Upon entering the East Harlem Medical Group I was directed upstairs by the receptionist for the dentist, when I asked to see a medical doctor. My doubts about this office began when I had to ascend a flight of rickety and worn, dirty stairs.

UNTOUCHED DURING EXAMINATION

When I entered the dirty cramped waiting room I asked to see a doctor. The receptionist took my Medicaid card and made copies of it. She then made out a folder for me and told me to have a seat. After waiting for a while, I was seen by a Dr. Clyde H. Weissbart. Dr. Weissbart asked me why I was there, and I told him that I was depressed, I didn't feel well, and I couldn't sleep well at night. I requested to be given something to help me sleep at night and something to help curb my appetite. Dr. Weissbart gave me a very brief examination. It consisted of his sitting in his chair and asking me if I had had pneumonia recently, been in the hospital or had any other serious ailments. I answered no to all these questions. (The closest he came to me was when I stood on a scale and he took my weight. He did not touch me during the course of the entire examination.)

He then told me that he could see that I was depressed and something was bothering me. He directed me to return the next day to see the psychiatrist. He prescribed medication for me in the meantime. In addition, he directed his assistants to give me an x-ray and to draw blood from me. I also gave a urine sample. Dr. Weissbart then asked me "Do you know where the pharmacies are in the area?" I said, "No, I don't." He said," "There's one across the street on both corners, and there is one downstairs. It might be easier for you to fill these prescriptions downstairs." Dr. Weissbart then asked if I were having any trouble with my feet. I said no, not that I knew of. Nevertheless, he suggested that I see the podiatrist for a routine examination.

After a wait I was examined very briefly by a Dr. Napoil. He told me to take off my shoes. He looked at the tops and bottom of my feet, but not between my toes; had he looked he might have discovered that I had a mild case of athlete's foot. After looking at my feet he decided I had a bunion on my right foot. This is the reason he ordered x-rays of both feet. I was later instructed to return in a week for further examination and to get results of today's testing.

On the following day, I went to the Family Health Professional Office at 2369 Second Avenue, New York. At this center, I saw a podiatrist named Luckower. Dr. Luckower examined my feet and told me he thought I had the beginnings of a bunion on my left foot. He told me the great toe of my left foot was pushing too far to the left. He too took an x-ray of my feet. His method of x-raying was unique of all the x-rays I have had. Dr. Luckower directed me to put my feet on a large yellow envelope while he positioned what appeared to be a dental x-ray machine above my feet. He then took the cord attached to the machine and stepped back into the hallway and operated the x-ray machine from there.

In conclusion, I must say I found it astonishing that Dr. Napoli could think I might have a bunion on my right foot and Dr. Luckower believe the same condition existed on the opposite foot.

Senator MOSS. Thank you, Jimmy. Very good.

Mr. HALAMANDARIS. Mr. Chairman, we are very pleased to have Catherine Hawes, an investigator of the Committee on Aging. Miss Hawes has done a lot of research in the nursing field, and we were very fortunate to have her participate as an investigator and do some shopping for us.

Senator MOSS. Thank you.

STATEMENT OF M. CATHERINE HAWES, INVESTIGATOR, COMMITTEE ON AGING

Miss HAWES. Good morning, Mr. Chairman and members of the Senate. I am Catherine Hawes. Starting on June 14, 1976, I began posing as a medicaid patient along with other members of the staff of the Committee on Aging.

Like Privates McDew and Roberts and Mrs. Oriol, I am troubled and offended by the conditions I discovered during this investigation of the health care available to the aged and others utilizing medicare and medicaid.

The practices described by Privates McDew and Roberts such as ping-ponging and overutilization of diagnostic tests are terrible drains on the public purse. I often wonder how many people are deprived of desperately needed services because Government funds are wasted by the kinds of medical practices we encountered in many clinics.

But if the waste of a few million dollars does not outrage you, then the destruction of the health of millions of aged and poor individuals should, for these clinics fail abysmally to provide even adequate health care to these people. We believe this failure is the most important issue.

It is our conclusion that 90 percent of the examinations we received are inadequate Our standard of comparison emerges not only from personal experience but also from discussion with professors of medicine and health sciences at George Washington University and at Georgetown University. We asked these medical men what we could reasonably expect by way of examinations for the various symptoms we presented. In the great majority of cases, the examinations we received were deficient in one or more respects. For example:

We have been given EKG's when the tapes were not marked and dated.

We had allergy tests that were not read.

We had TB Tine tests where the area was not circled—as is standard medical practice—nor were we told what reaction to watch for or what to do in case of a reaction.

We had EKG's taken with the electrodes placed over our stockings.

In many instances when a stethoscope was used, it was placed over our clothing.

We have seen used urine sample bottles returned to the shelf for use after thay have been rinsed only once with water.

We have seen clinics with only one thermometer.

In all the time we spent in medicaid mills we never had anything approaching an adequate medical history taken.

We rarely spent more than 4 minutes with any particular practitioner having a physical exam made.

We saw X-rays being given to us without plates in the machine. We had numerous X-rays given without changing plates, and we had chest and feet X-rays with dental X-ray equipment.

QUALITY OF CARE "HORRIFYING"

Clearly the magnitude of this mistreatment is astounding and horrifying. What is even sadder is the fact that the sloppy medical practice which causes such errors is commonplace in too many medic-

aid mills, as our own experience indicate. I found the quality of care provided to me as a medicaid patient in New York, New Jersey, and California to be horrendous.

My experience at 43 Avenue C Medical Group in the lower East Side of New York, though hardly isolated, is a classic case of such treatment. In some sense, the treatment here typifies every evil I found in the clinics I visited—ping-ponging, long waits in filthy, roach-infested waiting rooms, perfunctory physical examinations, sloppy medical practice and unneeded tests, prescriptions written to be filled at an affiliated pharmacy.

In this clinic I asked the receptionist for an appointment with a medical doctor, telling her that I had a cold. Yet she suggested that I also see the foot doctor and the eye doctor, too. I replied that really all I had was a cold, but she insisted, explaining that the medical doctor was busy and would be for a while. She said that I could see the others while I waited.

After 15 or 20 minutes I was directed to the podiatrist's office. He asked me what was wrong and I said that I had a cold. Despite this he told me to sit down, and he proceeded to examine my feet. He told me that I should come in monthly to have dead skin trimmed from my feet, offering the explanation that if I did it, I might cut too deeply and hurt myself.

He inadvertently demonstrated this danger by then slicing quite deeply into my toe. Hastily, he slapped on a bandage without even applying any antiseptic. I assume he was hoping that I wouldn't notice the damage, but the toe bled on and off for 3 days.

He was about to do some more unnecessary carving on my feet, but realizing this I told him I thought I was going to throw up. He immediately said my feet were fine and quickly sent me back to the waiting room. All of this took no more than 3 minutes.

After a long wait while watching roaches wander leisurely around the room, I was shown back to the office of the medical practitioner. He asked what my problem was and I responded again that I thought I had a cold. He told me to sit on an examining table and took my blood pressure over my rolled up sleeve, then listened to my breathing and heart with his stethoscope just under my collarbone and on my back over my shirt and T-shirt. He asked no questions about mine or my family's history but did ask if I was allergic to any medications. Then he wrote out two prescriptions, without offering any explanation or instructions on their usage. During the 3 minutes I was with him in his office I don't think he ever really looked at me or considered me as an individual. I honestly felt like a siphon, a nonentity.

Eye Examiner Not Qualified

I fared no better during the cursory exam I received from a person I presumed to be the "eye doctor." Although he did seem to use the proper equipment, he took only 3 or 4 minutes to arrive at the prescription for glasses. Thus when he wanted to do a glaucoma test which, according to him, required that he put anesthetic drops in my eyes, I refused.

He insisted that I had to have the test, trying to convince me by stating that his examination had disclosed that I had "deep cups," a condition of the optic nerve which is frequently a symptom of glau-

coma. He was quite forceful in his insistence that I had to have this test, implying that I was being ignorant and childish to refuse. I told him that I didn't have to do anything, so he reluctantly agreed to let me off without the drops and test but scheduled me for an appointment a few days later with the optometrist. This was the first time I knew that the man examining my eyes was not the real "eye doctor."

Thus I had entered Avenue C Medical Group complaining of a cold I did not really have. I not only got treated and received prescriptions for this nonexistent illness, I also came out with a prescription for glasses and foot powder—outgrowths of medical treatment I did not request and did not want. To make matters worse, my foot now actually did need medical attention and I was afraid that I might have a serious eye disease. In short, I came out of this medical facility in much worse condition than I entered it.

I, however, am fortunate enough to have good alternative medical care available. I was able to go to my regular ophthalmologist 2 weeks later and find that, like most nearsighted individuals who do not have glaucoma, I have shallow cups, not deep ones.

I kept thinking to myself—suppose that like most of the other patients we encountered during our investigation, we were dependent for care on clinics like these. For instance, our other investigators received equally serious middiagnoses, ranging from heart murmurs, hypertension and chest spasms, to kidney and bladder infections. Then we, too, could have been subjected to costly and plainful mistreatment. I remember this every time I think of a woman I met in a New Jersey clinic who had been told she had a lump in her breast.

Unfortunately, in terms of the quality of medical care, the clinics in New Jersey and California provided no evidence to me of markedly better care. At the Inter-Med Clinic in Los Angeles, I received what seemed to me to be the most thorough physical examination I had had in all of the clinics, yet the doctor prescribed medication for a sore throat I did not have. In addition, the nurse recorded my height as 2 inches shorter than it actually is, and she replaced on the shelf an unsterile urine sample bottle.

Yet the worst thing I saw in terms of quality of care occurred in a clinic in Brooklyn when a woman rushed into the clinic holding a little boy in her arms. His foot was cut and bleeding profusely, yet the receptionist told her that the doctor was busy and would not see her son for an hour. In fact, the doctor had spent much of the last hour in conference with a well-dressed man who was not a patient.

Clinics Only Available Medical Care

I think about what it would have been like if I had been that woman and if the boy had been my child—if I had been unable to get desperately needed health care. The point is, as investigators, we could leave those places. But for people who live in those areas, what we received in the weeks of our investigation is, for practical purposes, all they have available for everyday medical care.

Even all I have said, however, can't convey what it's like in these clinics, what it's like to get medical treatment in conditions so unsterile

that roaches roam the floors freely, to know that what the majority of medicaid facilities I visited provide is costly billing for the Government and callous care for the sick, poor of this Nation.

[The prepared statement of Miss Hawes follows:]

PREPARED STATEMENT OF CATHERINE HAWES

Mr. Chairman, Members of the Senate, my name is Catherine Hawes, and I am currently employed as an investigator for the United States Senate Subcommittee on Long-Term Care of the Special Committee on Aging. Under the auspices of the Committee, I was involved in an evaluation of the health care available to the aged and others dependent on Medicare and Medicaid. Like Privates McDew and Roberts and Mrs. Oriol, I am troubled and offended by the conditions I discovered during this investigation.

The practices we encountered such as "ping-ponging" of patients from one clinic physician to another and the overutilization of diagnostic tests are terrible drains on the public purse. The waste of tax money engendered by this kind of fraud and abuse, of necessity, limits the funds available for other public programs. I often wonder how many other people are deprived of desperately needed services because government funds are wasted by the kinds of medical practices we encountered in many clinics.

But if the waste of a few million dollars does not outrage you, then the destruction of the health of millions of aged and poor people should, for these clinics fail abysmally to provide even adequate health care to these individuals. I found the quality of care provided to me as a Medicaid patient in these clinics to be horrendous.

In some sense Avenue C Medical Group in the Lower East Side of New York typifies everything I found wrong with the health care available to the elderly poor and other medically indigent individuals in this country—ping-ponging of patients from one doctor in the clinic to another, long waits in filthy, roach-infested waiting rooms, perfunctory physical examinations, sloppy medical practice and unneeded tests, prescriptions written to be filled at an affiliated pharmacy.

In this clinic I asked the receptionist for an appointment with a medical doctor, telling her that I had a cold. Yet she immediately suggested that I see the foot doctor and the eye doctor, too. I replied that really all I had was a cold, but she insisted, explaining that the medical doctor was busy and would be for a while. She said that I could see the others while I waited.

After 15 or 20 minutes, I was directed to the podiatrist's office. He asked me what was wrong, and I said that I had a cold and had come to see the medical doctor. Despite this, he told me to sit down and proceeded to examine my feet. Then he told me that I should come in to see him monthly to have the dead skin trimmed from my feet, offering the explanation that I might cut too deeply into a callous and hurt myself—something he inadvertently demonstrated by slicing quite deeply into my toe. He hastily slapped on a bandage without ever applying any antiseptic. I assume he was hoping I wouldn't notice the damage, but the toe bled on and off for three days after I removed his bandage. He also stated that I seemed to have a problem with excessively sweaty feet—something even my best friends and worst enemies have never suggested—and wrote out a prescription for a foot powder and fungicide. He was about to do some more unnecessary carving on my feet, but realizing this I told him I felt sick to my stomach. He immediately said my feet were fine and sent me back to the waiting room. All of this took no more than three minutes.

After a long wait while watching roaches wander leisurely around the room—I was shown back to the office of the medical practitioner. He asked what my problem was, and I responded that I thought I had a cold. He told me to sit on an examining table and took my blood pressure over my rolled-up sleeve, then listened to my breathing and heart with his stethoscope on my collar bone and on my back over my shirt. He asked no questions about mine or my family's medical history but did ask if I was allergic to any medications, and then he wrote out two prescriptions. During the three minutes I was with him in his office, I don't think he ever really looked at me or considered me as an individual. I honestly felt like a cipher, a nonentity.

MONEY, NOT CARE, IS MAJOR CONCERN

Again I was sent back to the waiting room. As I sat there, I observed a heated argument between the receptionist and one of the clinic physicians, from all evidence, a foreign medical doctor. This doctor was complaining bitterly that the owner wasn't paying him quickly enough for the patients he treated. The receptionist pointed out that some of those patients were on Supplemental Security Income and that their bills hadn't yet been paid. Therefore, according to her, the doctor couldn't receive his percentage until the bills were paid. The doctor shouted that he didn't see why he should be working if he wasn't getting paid, complained about his hours, and stalked back down the hall. During this same time there was another shouting match in another of the clinic's halls. Someone was literally screaming about the $1000 a week he was paying and asking what his "one percent" was going for. Unfortunately for me, a child started crying during this last argument, and I was unable to hear the entire discussion.

But this kind of dissention among the doctors and the staff serve to highlight what I believe are their major concerns—how much money they can make rather than how much good medical service they can provide to the community. My belief in this was heightened by the cursory eye exam I received from a person I presumed to be the eye doctor. Although he did seem to use the proper equipment, he took only 3 or 4 minutes to arrive at the prescription for my glasses. Thus, when he wanted to do a glaucoma test which, according to him, required that he put anesthetic drops in my eyes, I refused. He insisted that I had to have the test, trying to convince me by stating that his examination had disclosed that I had "deep cups," a condition of the optic nerve which is frequently a symptom of glaucoma. He was quite forceful in his insistence that I had to have this test, implying that I was being ignorant and childish to refuse. I told him that I didn't have to do anything, so he reluctantly agreed to let me off without the drops and test and scheduled me for an appointment a few days later with the eye doctor. This was the first time I knew that the man examining me was not the real eye doctor.

Thus I entered Avenue C Medical complaining of a cold I did not have. I not only got treated and received prescriptions for this non-existent illness, I also emerged with a prescription for glasses and for foot powder—outgrowths of medical treatment I did not request and did not want. To make matters worse, my foot now actually did need medical attention, and I was afraid that I might have a serious eye disease. In short, I came out of this medical facility in much worse condition than I entered it.

I, however, am fortunate enough to have good alternative medical care available. I was able to go to my regular ophthamologist two weeks later and find that, like most nearsighted individuals who do not have glaucoma, I have shallow cups, not deep ones.

I keep asking myself—suppose that like of the other patients we encountered during this investigation, we were dependent for care on clinics like these. Our other investigators, for instance, received equally serious misdiagnoses, ranging from heart murmurs, hypertension, and chest spasms, to kidney and bladder infections. Then we too could have been involved in costly and painful mistreatment.

While this treatment at the 43 Avenue C Medical Group typifies the evils I witnessed, it is not alone. At Midwood Medical Center in Brooklyn, for instance, I received archetypical treatment—a long wait in a grimy waiting room in order to have a medical practitioner spend only 1½ to 2 minutes on a physical examination. Actually I was amazed at his speed—in that time he used a stethoscope to listen to my breathing, glanced into my ears, nose and throat, using a flashlight, and placed the back of his hand against my forehead to see if I had a fever. Then offering no explanation or instruction on proper usage, he wrote out his prescription for medication and dismissed me.

Of course, occasionally a doctor would spend more than two minutes with me. At Grand Humboldt Medical Center in Brooklyn, a doctor spent nearly 15 minutes with me, some of it on the physical exam but most of it asking me about my problems in raising children in this area of the city. While he seemed nice and concerned about me as an individual patient, he could afford to be leisurely with me since I was the only patient in the clinic, aside from investigator Darrell McDew. Actually I began to wish that I hadn't received quite so much personal attention from the doctor. After he put a tourniquet around my arm in preparation for drawing a blood sample, the doctor then spent so much time waiting for the nurse to bring a disposable syringe, that my entire lower arm temporarily

lost all feeling. Here too, as at most of the clinics I visited in New York and New Jersey, some member of the medical staff of the clinic directed me to have my prescriptions filled at a specified pharmacy.

AVERAGE EXAMINATION, 3 MINUTES

People's Medical Center in Brooklyn presented a fairly typical physical setting for the clinics I visited in New York, except that it was incredibly crowded. When I arrived around 11:30 a.m., there were already 12 or 13 people in the waiting room, and by the time I got "treated," almost two hours later, there were at least 25 adults and 10 to 15 children sitting and standing in the waiting room and on the sidewalk outside the entrance. No doctors were in the clinic until 1:00 when the podiatrist arrived. The gynecologist and internist were in attendance by 1:30. The line in the waiting room was quickly reduced in as much as the internist spent less than 3 minutes with each of his patients, including the Medicare recipient who preceded me, an elderly black man with a baseball-sized tumor on his head.

The internist took about the same amount of time with me, spending most of it filling out a second billing form. The only things he did which even approached a physical examination were to look in my throat with a pencil flashlight and listen to my breathing with his stethoscope placed outside my shirt and T-shirt. He did take the time to prescribe Valium for me when I replied "Yes" to his question, "Do you ever get nervous?" He also took the time to "ping-pong" me to the podiatrist when I asked him for a band-aid for a blister on my heel, after seeing a box of band-aids on his desk. He told me that he couldn't do anything for my feet—that I'd have to see the podiatrist. I repeated that I only wanted a band-aid, but he insisted that I see the podiatrist for it. He also ordered a blood test for me.

One of the unhappy aspects of treatment in these clinics is the rough manner of the clinic personnel. For instance, when the nurse came to draw the blood sample, we had a slight argument over which arm she would draw it from. I insisted that she take it from my left arm, since I knew I had a bruise on my right arm from a sample taken at another clinic. Finally she took the blood from my left arm. By the following day, I had bruises on both arms, just another indicator of sloppy health practice.

The podiatrist, whom I saw next, was a very friendly man, who chatted with me about what good feet I have while he trimmed some dead skin off the bottoms of my feet. I asked him not to do that, since I had to walk quite a bit more that day and stating again that all I came in for was a band-aid. He assured me that his trimming wouldn't make my feet tender at all—which turned out to be false. Walking was painful for at least 2 days. He assured me that he would "fix (my) feet right up," and then he clipped two toe-nails on my left foot. After that he said that I would have no more pain from the "turned-in" nail, as he called it. I replied that I never had had any pain or discomfort from it, and he responded, "Well, you certainly won't have any trouble with it now."

While still telling me that I had good feet and saying that "we should just make sure," he slid an 8½'' by 11'' manilla folder with "KODAK" printed on it under my feet and pulled what appeared to be a Ritter dental x-ray machine down over my feet. He then moved to the corner of the room—approximately 8 feet away—and pressed a button at the end of a long cord. After putting another KODAK folder under my feet and turning my feet slightly so they rested on their sides, he repeated the procedure. But the podiatrist also took an interest in other aspects of my health. He suggested that I see the clinic's gynecologist. He even went out to the desk and made an appointment for me, and he recommended the clinic's pediatrician to me for my children. All of this I got for the complaint of a common cold which I didn't have.

I found the situation in New Jersey Medicaid facilities to be much the same as in New York. At Park Medico Center in Paterson, for instance, the doctor listened to my breathing and heart and took my blood pressure over my clothing. As a matter of fact, during the entire investigation, I was never directed to remove any article of clothing other than my shoes and socks. Most of the time, the doctors would take blood pressure and place their stethoscopes over clothing. Occasionally they would pull my shirt to the side or up in back to place their stethoscopes properly, but in general, their main concern seemed to be to get the billing form filled out and to get rid of me as a patient quickly, expending the least amount of effort and time as possible.

It's hard to realize now just how horrible the filth in those clinics is, but I was particularly struck with this realization during one weekend. I had returned

to my home here in Washington and on Sunday afternoon was in a laundromat. A woman who worked there was sweeping the floor. With a start I realized that the floor of this laundromat—even before she swept it—was cleaner than any medical clinic I'd visited for treatment in the previous two weeks.

PATIENTS DEPRIVED OF PRIVACY

The Broad Street Medical Clinic in Newark, New Jersey, is another classic of its kind. I entered the clinic complaining of a sore throat. After half an hour in the waiting room. I was called by the nurse into an examining room. An elderly black woman was still in the examining room and despite my presence, the nurse proceeded to discuss details of the woman's treatment with her and to belittle her ability to follow the doctor's instructions. The nurse exhibited a noticeable impatience with the woman and with her questions about her medical condition, displaying an attitude I found extremely objectionable even to observe. But the elderly patient evidently found this to be standard treatment, in as much as she exhibited no surprise at being so addressed in front of a stranger or at being deprived of privacy.

After that patient was dismissed, the nurse turned to me and proceeded to ask questions about my medical history and to weigh me, measure my height, and take my temperature. She also extolled the virtues of this clinic and of being treated by "specialists," assuring me that they could take care of all my health needs. The nurse asked me when I had had my last Pap Smear. Fearing any contact with a gynecologist in this clinic, I answered that it had been just two months. Nevertheless, the nurse asserted that I should really have another and signed me up for an unsolicited appointment with the clinic's gynecologist. The nurse then asked if I had any trouble with my skin. I said I didn't, but she persisted, and I admitted that I do have some wrinkles. Peering at me she replied, "Yes, I can see that," mumbled something about "those blemishes" and said I should see the clinic's dermatologist. Again she made an appointment for me. At this point, I wanted to rush to a mirror to see if I'd suddenly developed a horrible case of acne; but before I could leave, the nurse suggested that I see the clinic's podiatrist to have my feet taken care of, despite my assertion that I had no problem. After this—but before I had seen *any* physician—the nurse scheduled me for blood and urine tests and for chest x-rays, despite my pleas that I really didn't have enough time for all of that today and promised that I would have those tests when I returned for my other appointments. My unwillingness had no effect, however, on the nurse. It was at this same clinic that this nurse in the presence of the doctor, told me that he could prescribe some pills for me that would "make a new woman" of me. She noted that unfortunately Medicaid would not pay for such pills, but she suggested that I give up smoking and use the money saved to buy the pills. I hastily replied that I had never smoked and thus couldn't save money by quitting and that I had no extra money for pills.

It was also at this clinic that I witnessed one of the incidents which has caused me the most sadness. While I was in the waiting room, I struck up an acquaintance with a woman and her child who were also waiting to see one of the clinic physicians. Because long waits were usual and reading material was rarely available in the clinics, I carried yarn with me. I was crocheting while I waited, and the child wanted me to teach her how to crochet. While I did, her mother and I had a very pleasant conversation about children and family. Later, as I was sitting in the examining room, this woman walked by on the street outside and we waved at one another through the window. By way of extolling the virtues of the clinic doctors, the nurse said, "Oh, you know her? She has a lump in her breast, you know, and she's being treated by one of our specialists." I still remember that woman's gentle face and am horrified to think of her being dependent for diagnosis and treatment by people such as many of the ones we encountered on this investigation. I despair when thinking of what this woman and many like her must endure at the hands of those physicians who are more intent on profits than on care.

In my opinion, California differed in some respects from the picture of Medicaid mills in New York and New Jersey. For instance, in my investigation, I found no evidence of "ping-ponging of patients from one 'specialist'" in the clinic to another, but while Medi-Cal rules may have reduced or altered this kind of monetary fraud and abuse, I have no evidence that the program is providing better medical care than that found in the other State programs we investigated.

It was in San Francisco, for instance, at the Geary Street Medical Office, that

I went in complaining of a sore throat and was examined only by a nurse. I never even saw the doctor. However, it was also in California that I got what I personally feel was the most adequate exam.

At the Inter-Med Clinic in Los Angeles, I received what seemed to be the most thorough physical examination I had in all of the clinics I visited. Nevertheless, he prescribed medication for a sore throat I did not have. Furthermore, the nurse provided a glaring example of poor health practice.

SOAPY "URINE" SAMPLE "NORMAL"

It seemed sloppy enough that the nurse measured me and recorded my height as two inches shorter than it actually is, but then the nurse handed me a smudged urine sample bottle and directed me to the bathroom. Because the place itself was grimy and because it was my second and third exam of the day, I filled the urine cup with a mixture of water and green liquid soap I found in the bathroom. The nurse not only accepted this offering, she tested it with a dip stix and announced that the four colored tabs indicated no abnormality in my urine. I was really relieved that I hadn't actually used the urine cup as ordered, since the nurse emptied the contents into the sink and then merely ran water over the bottle, rinsing it out only once with water, before returning it to the shelf with the rest of the "clean" bottles, ready to be used again on some other unsuspecting patient.

Yet the worst thing I saw happened in a clinic in Brooklyn. Ten to twelve women and as many children crowded into the waiting room which was made grimier and noiser by the continual coming and going of workmen and their equipment into the space being added onto the clinic. Although the office roster listed six doctors, only one was on duty that morning, and he was seeing patients only sporadically, spending much of the first hour in the clinic in discussion with someone who appeared to be a drug and equipment salesman. Soon after the salesman's departure, a woman rushed into the clinic, holding a little boy in her arms. His foot was cut and bleeding profusely, and she was clearly upset as she asked the receptionist to see a doctor. But the receptionist said that it would be at least an hour before the doctor could see the child and suggested the woman go down the street to another clinic. She went out, still carrying the child, looking for help, but evidently she didn't get it at the other clinic either, because I saw her a few minutes later coming back down the street from the direction of the other clinic, and the boy was still untreated, still bleeding.

I keep thinking about what it would have been like if I had been that woman and if that had been my child—if I had been unable to get desperately needed health care. The point is, as investigators we could leave those places behind. But for the people in these areas, what we received in the weeks of our investigation is, for practical purposes, all they have available for everyday medical care. As a Medicare or Medicaid patient you can expect long waits in dirty waiting rooms and exams so cursory that the medical personnel don't even bother to have you remove your clothing when taking blood pressure or listening to your heart or breathing. You can expect bathrooms that would shame the worst service station you've ever been in, unsterilized urine sample cups and disposable syringes that aren't broken after being used to draw blood. You can expect blood tests to be given so clumsily that your arms are badly bruised, hardly ever having your arm swabbed before they jab the needle in, rarely being told why tests are being made and what the results are. You can expect to be treated in a demeaning manner by medical personnel who exhibit little regard for your right to be informed or for privacy. Many times I shared an examining room with another patient while one or both of us was subjected to tests or was having our medical history taken, and on at least one occasion, the other patient was male. Rarely are you told by the physician what his or her diagnosis is or what or how many bills he or she is submitting. In most clinics, outside California, the receptionist has photocopied your Medicaid card one or more times, and as a patient you have no responsibility or authority to review or sign the billing form. Even after you are told to go to what is probably an affiliated pharmacy—you are required to sign a blank billing form before your prescription is filled. Yet even all of this can't begin to convey what it's like in these clinics, what it's like to get medical treatment in conditions so unsterile that roaches roam the floors freely, to know that what the majority of Medicaid facilities I visited provide is costly billing for the government and callous care for the sick, poor of this Nation.

Senator Moss. Thank you very much for your good testimony.

Mr. HALAMANDARIS. At this point, Mr. Chairman, may we bring in the medications which the six healthy Senate investigators received in this brief period of time? These are the medications that we received while posing as patients. Keep in mind that the Senate investigators were perfectly healthy.

Senator MOSS. Are my prescriptions included in there?

Mr. HALAMANDARIS. Yes, sir. Some of the drugs are presently being analyzed by the Food and Drug Administration.

Senator PERCY. That is enough to kill all of us.

Senator BEALL. Was there an average cost associated with this?

PRESCRIPTIONS CHECKED BY FDA

Mr. HALAMANDARIS. We are trying to establish that, Senator Beall. As I indicated, the Food and Drug Administration is finding some substitutions, some illegal contraband. When the Food and Drug Administration is through, we will have some interesting results.

Senator MOSS. That is what I acquired in two visits.

Senator BEALL. You have not told us whether you were healthy before you went there.

Senator MOSS. I will defer that to Dr. Carey. He gave me a clean bill of health.

Senator PERCY. How have you been feeling since you came back?

Senator MOSS. Pretty lousy.

Senator BEALL. Is that one visit?

Senator MOSS. No; two clinics to get this, and all I complained of is I thought I had a cold.

Senator BEALL. What is it?

Senator MOSS. You can read on it. I cannot tell you what they are all for.

Senator PERCY. Family pharmacy.

Do you want to try some?

Senator BEALL. No; thank you.

Senator MOSS. Have a swig on me.

Well, I think the staff has made the point very dramatically.

None of the people that entered any of these clinics had any real medical problem, is that correct?

Mr. HALAMANDARIS. That is correct.

I would like to make a couple of points. The medications that are on the table obviously are all marked. This is going to be evidence in whatever criminal trials progress as a result of our investigation and findings that have been turned over to the U.S. attorneys in Michigan and New York.

The billings are just starting to come in. That is going to be the real story of this investigation in my judgment. I want to discuss that; I think I would like to take about 4 more minutes wrap up and clarify some remaining misconceptions.

Senator MOSS. Go ahead.

Mr. HALAMANDARIS. I would like to refer you to page 48 of the report, if I may. On that page there is yet another chart which we constructed after conferring with the U.S. attorney on the court records that he had dealings with eight medicaid clinics. As we indicate, the principals, two doctors, received $2,222,000 from the medicaid program. There is a breakdown where the money goes.

The first 12 percent off the top goes to the factoring firm, $10,000, and with a kickback it comes back to the principals—25 percent of the gross, of the roughly $2 million, is rent which is then paid to the principals. Then we have the remainder which is divided 50–50 between the owners of the clinics and the practitioners which also means that we are talking about another $700,000 which goes to the principals. To this amount you add in whatever amounts the principals received as kickbacks, and in this particular case they have a 30-percent kickback from the clinics which amounts to about $217,000. So the grand total that the two principals in these eight clinics made is about $1.5 million from the clinics that they owned out of the $2 million that the clinics received.

Businessmen Receive 70 Percent of Money

Now the point is this: This distribution of funds is a common industry practice among medicaid mills. The landowners take about 70 percent of the money that is paid to medicaid mills. Only 30 percent goes to the doctors who do the work. We think this is one of the most egregious practices we found.

The common industry practice is for the businessman, who essentially does nothing more than own the building or own the lease to receive roughly 70 percent of the money that flows through medicaid mills. We think there is something wrong with this. We don't think this is what the Congress had in mind when they appropriated medicaid funds.

How large is the problem of medicaid mills? Let's talk about national figures. Medicaid in 1975 was at the $15 billion level. Of this amount, roughly $3 billion was paid to physicians and dentists and chiropractors and podiatrists, pharmacies, and clinical laboratories.

We estimate that about $1 billion a year flows through medicaid mills. As much as 50 percent of this may be unnecessarily paid.

This has nothing to do with any estimates of fraud, it is simply our judgment that this is money that need not be paid. New York figures are more problematic because of the condition of the New York data. Nevertheless in New York the best we could find out, $3.2 billion to the medicaid program, about $320 million in New York State goes to dentists and physicians and pharmacists and clinical laboratories and approximately $240 million is our projection of the amount that goes to medicaid mills of the entire State, not to be confused in New York City. In short, about $168 million is paid to practitioners, medicaid mill entrepreneurs. Our estimate is that $112 million is paid out unnecessarily.

I would like to generalize a little bit more and summarize and say 90 percent of the care that we found was substandard, and I think Miss Hawes was very eloquent in giving the standards of comparison that we used. When you say that you have a cold and the doctor does not look down your throat, we think that is substandard care. When you say you have a cold and the doctor looks down your throat with a normal flashlight 5 feet away, we think that is inadequate care. When the doctor does not look at your ears, when he does not check your eyes, when he does not take your blood pressure, when he takes your blood pressure over your sleeve, when he tries to put a stethoscope on your chest and does not ask you to take your jacket off, we think there is

something wrong. It is our estimate that 90 percent of the care is substandard.

In approximately 70 percent of our visits we found some unnecessary testing going on. In about 45 percent of the cases we got a referral of some kind to another practitioner. About 25 percent of the time we encountered blatant ping-ponging or, that is to say, obvious overutilization. The exact figures for outright fraud as opposed to overutilization is difficult to compute at this point because we have only received about 40 billings back. However, we can make one statement with certainty. Every one of the 40 bills that has been received has justified payment to medicaid by indicating the diagnosis of some disease that we didn't have.

Again let me repeat that. Everyone of the some 40 statements or billings that have been presented to medicaid indicate as a justification for payment, a disease that none of us had.

Now there are more blatant cases. If you want to talk about the extreme cases, I'll tell you of my experience when I went into a medicaid mill on the Grand Concourse in the Bronx. I saw a general practitioner for 4 minutes. The billing that came back to the U.S. attorney indicated that I not only had seen the general practitioner but that I also saw a psychiatrist and podiatrist. Interestingly enough, this podiatrist also billed for seeing Officer McDew and Officer Roberts. In fact, the podiatrist didn't see any of the three of us.

You noticed in today's paper that the State Department of Social Services is calling in about a thousand doctors to discuss this problem, so we are delighted to see that action.

I would like to close by asking your consent, Mr. Chairman, to have entered in the record the New York Times article from August 12 which indicates that excess payments, overutilization, and ping-ponging were also found in so-called nonprofit clinics in New York as distinguished from the for-profit medicaid mills which were the subject of our investigation.

Senator Moss. Is that this year?

Mr. HALAMANDARIS. Yes, sir. They estimated an $18 million loss and they project an overutilization as distinguished from the for-profit medicaid mills we visited.

Senator Moss. Without objection, that will be placed in the record at this point.

[The article follows:]

[From the New York Times, Aug. 12, 1976]

EXCESS PAYMENTS FOUND IN CLINICS

MEDICAID AUDIT OF NONPROFIT UNITS IN NEW YORK PUTS TOTAL AT $18 MILLION

(By David Bird)

As much as $18 million in overpayments for Medicaid patients may have gone to private nonprofit clinics here last year, according to a preliminary audit released yesterday by the New York City Health Department.

The audit showed that as much as 12.8 percent of the $140 million paid in 1975 to the nonprofit clinics, including those in some of the most noted teaching hospitals in the city, might not have been justified.

Medicaid, which pays medical bills for the poor, is financed 50 percent by the Federal Government and 25 per cent each by the city and state.

PRACTICE FOUND WIDER

Previously the Health Department, with limited staff, had concentrated on auditing the private, profit-making so-called "Medicaid mills," where excessive and illegal Medicaid billing had been found.

Now the same pattern is being found, according to the Health Department, in the private nonprofit (voluntary) hospital clinics and other clinics operated by charitable organizations.

"Abuses such as overutilization of services, ping-ponging of patients and poor documentation of services, which previously had been thought to be exclusively a practice of 'Medicaid mills' have been documented in almost all voluntary hospitals and free standing clinics studied," said a statement from the Health Department.

Pingponging is the term applied to the practice of sending a patient from one specialist to another, whether he needs the attention or not, and collecting a fee for each visit.

So far, more than a dozen of the nonprofit institutions have been studied, according to Dr. Martin Paris, associate commissioner of health and executive medical director of Medicaid.

The sample covers a wide spectrum of the nonprofit institutions, from the smaller to the largest, Dr. Paris said, and is a strong indication of what is happening in the entire system.

Dr. Paris said that, as a result of the audit, Mount Sinai Hospital already had returned $67,000 for billing irregularities noted in its dental clinic.

MANY VISITS MADE

Dental clinics showed signficant abuses, according to the Health Department.

"We have seen cases of patients returning 40 and 50 times to a clinic for routine dental services, generating costs of over $2,000," said Dr. Thomas Travers, director of the Health Department's Division of Institutional Ambulatory Care. "In private practice, these services would require less than five visits and cost less than $300."

At Mount Sinai, Dr. S. David Pomrise, the executive vice president, issued the following reply to the audit:

"The services in question were performed by the dental clinic. The patients had been identified as Medicaid eligible but prior authorization, as required by Medicaid regulations, had not been received."

The Health Department said "Boys Club of New York Inc., which operates dental clinics has similarly refunded $11,000 for billing irregularities."

FRAUD IS DENIED

Anthony Siste, controller of Boy's Club which operates dental clinics in its clubhouse for 5,000 boys, said:

"No fraud was involved. One of our dental clerks just misinterpreted their regulations."

The Health Department said that lack of adequate controls, rather than the greed that motivated at least some Medicaid mills, apparently was the reason for excessive payments to nonprofit institutions.

"The outpatient clinics have always been considered the stepchild at hospitals, which are concerned primarily about inpatients," Dr. Paris said. "They don't care about the out-patient system, don't have administrative control systems and, since nobody's watching, the system goes wrong. Maybe it's not the same motivation as at the Medicaid mills, but the result is the same."

In addition to the dental audits, the Health Department has completed an audit of a wide range of ambulatory services at a sample of 12 voluntary institutions. It estimates that as much as $6.7 million of the $29 million in Medicaid bills from these institutions are questionable.

The institutions are: Long Island College Hospital, Bronx Lebanon Hospital, Methodist Hospital of Brooklyn, Misericordia Hospital, Unity Hospital, Lyndon Baines Johnson Family Health Center, St. Luke's Hospital, Maimonides Hospital, Long Island Jewish-Hillside Medical Center, Hospital for Joint Diseases, Arthur C. Logan Memorial Hospital and St. John's Episcopal Hospital.

COOPERATION CITED

Dr. Paris praised the involved institutions and the Greater New York Hospital Association for their cooperation in the investigation.

For its part, the association expressed confidence through its executive vice president, Dr. John V. Connorton, that the Health Department's statements "will prove to have grossly overstated the problem."

Some of the abuses charged by the Health Department included double-billing where doctors services were charged for twice, billing for appointments that patients did not keep and multiple billing for different clinic visits on the same day, violation of the law allowing only one clinic bill per patient in one day.

Of the more than $420 million paid for outpatient care for Medicaid patients here last year, about $120 million went to private practitioners, $140 to nonprofit organizations and $160 to municipal hospital clinics and emergency rooms.

Mr. HALAMANDARIS. In short, Mr. Chairman. on the basis of this examination into medicaid mills and on the basis of our examination into nursing homes and clinical laboratories, we are concluding that, there is massive fraud in the program. A conservative estimate would be 10 percent of the total. If it is $15 billion total, then we estimate that approximately $1.5 billion of the $15 billion is ripped off and the figure could be as high as 12 or 15 percent. These are only ball park estimates and I think we will know a lot better when the Department of Health, Education, and Welfare complete their investigation in a number of States.

I thank you very much for your attention. We appreciate the opportunity to work with all of you; it is a pleasure.

Senator Moss. Well, as I said in the beginning, the whole investigation carried on over such a long period of time has been remarkably well handled and you are to be commended for your direction on all of these people and others who participated certainly are to be commended for their sensitive attention to the very difficult job. I had only 1 day and I had enough people around me that I guess I should not have felt apprehensive at all but I did feel apprehensive at going into those clinics and I was pleased to have people along who had been through it before and therefore bolstered me.

Mr. HALAMANDARIS. I guess that is the point. When we were describing what we saw to you, I remember the look of shock and disbelief on your face when we first told you what we had found. You have to experience it yourself to realize what it is like, otherwise it is like trying to describe red to a blind man. I am glad that you went through it. Mr. Chairman, so that you could talk about it.

Senator Moss. Thank you.

Has New York begun any kind of program to remedy some of these glaring oversights in the supervision and detection of fraud?

SPECIAL PROSECUTOR FOR NURSING HOMES

Mr. HALAMANDARIS. Yes, sir, Mr. Chairman. It is a pleasure to know that Governor Carey has taken a number of initiatives, one of them being an appointment of a special prosecutor for nursing homes. Recently, at your request, he has given him authority to look into boarding homes and now is considering giving him jurisdiction over medicaid mills. That is one step.

The second step relates to funding by the legislature. At Governor Carey's request, the medicaid management and information system,

which they estmiate in New York will save $160 million, was funded. As you know, the New York Times today said the department of social services has cracked down on physicians; we are delighted to see their action.

Senator BEALL. On that point, do I gather that even though the States, including New York, pay about 50 percent of the cost of medicaid and they have had to cut back on the services because of a lack of funds, it is just now that we are taking steps to police the program?

Mr. HALAMANDARIS. Well, actually, sir, the initiative started in January 1975. Governor Carey came into office at the same time that a major nursing home investigation was underway.

Senator BEALL. But they had no ongoing oversight connected with this program in their department of social services?

Mr. HALAMANDARIS. Yes, sir, that is correct. It is my impression that there is a man named Dr. Martin Paris in the city who has been working very hard on the medicaid abuse, but he has only been in his position now for about 3 or 4 months and I think he would like to do a lot more. We should say that there were efforts promulgated by the city regulating medicaid mills, but their regulations were essentially shot down by vested interests. I think it is important to bring that out. Some people have been trying to do the job.

Senator BEALL. Another question comes to mind that is very disturbing. All of these services are being rendered by licensed physicians, what steps, if any, have been taken by the licensing authorities in the State or by the professional groups in the State to police their own people? Obviously there is unscrupulous activity taking place from what you said here today.

Mr. HALAMANDARIS. That is correct, Senator. We wrote to the professional societies. It is interesting to note that Senator Moss received notice that the State board of education is issuing regulations effective tomorrow, August 31, which would bar the percentage leases we are talking about. Thus it will be illegal to hire a doctor on commission, allowing him to keep 30 percent of the money he is paid with the entrepreneur keeping 70 percent.

Senator BEALL. How about the State medical society?

Mr. HALAMANDARIS. They have done precious little, to be frank.

Senator BEALL. How about the PSRO's? Are the PSRO's doing anything?

ASSOCIATIONS AND SOCIETIES "INACTIVE"

Mr. HALAMANDARIS. They are concerned with the quality of service offered by institutional providers and not necessarily with fraud. So they are not involved basically.

Senator BEALL. But this is the delivery of care.

Mr. HALAMANDARIS. I would agree. I would be in favor of giving them the authority to enable them to jump in and take hold of this problem but there has been no action to date.

Senator BEALL. The professional associations and societies have been very inactive in this whole thing.

Mr. HALAMANDARIS. With one exception and that is in Illinois. The Illinois Medical Society and the Illinois Physicians Union came to us and gave us the original evidence that we had on medicaid mills. Mr. Roger White and his colleagues told us essentially everything that we have reported to you today.

Senator Moss. The Senator from Illinois.

Senator PERCY. I think we probably all ought to note for the record that, whereas we pointed out briefly that the nursing homes should always try to put it back in perspective, the whole system has not gone rotten just because of a few bad apples in the barrel and for every single abuse that we point out there are a dozen that are honorable and carry on their work in a fine way.

Since 1969, while looking into medicaid fraud and abuse, we have pointed out nursing home operators, pharmacists, medical laboratories, medicaid administrators, vendors, physicians, dentists. Is there any group that touches this program that has not in some way been implicated in fraud and abuse?

Mr. HALAMANDARIS. I would like to come in the back door on the question and refer people to page 204 of the report. One thing we found which was most interesting was looking at the number of audits in the medicaid area conducted by the HEW audit agency. We found that the HEW audit agency has conducted 264 audits. You will note that an audit generally can deal with one or more audit areas. There is a total of 12 areas so there have been about 264 audits issued and 740 areas audited.

As noted in the italic type, 3 percent related to hospitals. If there is any area of the medicaid field that has not been investigated to any extent, it is hospitals. Neither this committee and not any other that I know of have investigated hospital fraud. It is my feeling that when we begin to do so we are going to find the same sort of abuses. I believe the entire medicaid system is faulty.

Senator PERCY. When we have gone into other fields where there has been abuse, generally there is a trade association or some group that pulls them together that has some degree of responsibility, particularly in the professional field. In investigating hearing aid problems we went into the hearing aid industry and their association and asked for their assistance and help.

RESPONSIBILITY NEEDED IN MEDICAL PROFESSION

We have found abuse in New York and Chicago involving the medical profession. What is the position of the American medical profession in this regard? Do they accept the degree of responsibility? Do they feel that this is a blight on their house that they themselves must somehow deal with and can't leave everything to the Government to handle? You have got to have some need within the industry so that we get after this rather than through Government investigation.

Mr. HALAMANDARIS. I would agree. It is refreshing to note that the American Medical Association has a canon which makes professional leasing unethical. They have no power to enforce the standard but their position is on the record. As Senator Domenici pointed out, they are in the rather peculiar position that most of the physicians that work in medicaid mills are foreign trained that essentially work on commission. The money is not going to the physicians; it is going to the entrepreneurs that own the clinics. You will find in our report in appendix A a list of doctors making over $100,000 from the medicaid program but when you trace it back you find out that these people

are merely conduits and the money is going into the hands of the businessmen.

Senator PERCY. Can you give us any further, specific examples of how medicaid fraud and abuse activities have grown in scale and in sophistication or has your testimony been pretty comprehensive?

Mr. HALAMANDARIS. I think the problem of fraud is pretty pervasive, Senator. Senator Moss has a memorandum which indicates not only the investigations we have done, but those we just have not been able to follow up on. For example, in the area of home health care we found substantial amounts of fraud, particularly among for-profit providers. The memorandum indicates a substantial amount of fraud continues among the clinical laboratories we have investigated.

The chairman has a GAO audit of 30 nursing homes which indicates every single one of them had problems associated with the handling of patients' funds. The problem is massive.

Senator PERCY. Have you heard of medicaid mills in States other than New York and Illinois? Do they exist in other States?

Mr. HALAMANDARIS. Yes, sir, they do. Let's analyze the list of high volume doctors and you can see exactly where they are. If you refer to the State of Texas, you are going to find that most of them are in San Antonio. If you refer to the State of California, you trace the addresses as we did and you find most of the high volume providers have mills in Los Angeles. High volume providers in Michigan as we indicated also practice out of Detroit medicaid mills. It's a general pattern.

Senator PERCY. We discovered that nursing homes became a new growth industry and you can buy stock in them on Wall Street. Is this a new growth industry that is springing up?

Mr. HALAMANDARIS. I think so.

Senator PERCY. Medicare mills.

Have you found medicare mills also?

MEDICARE MILLS IN FLORIDA

Mr. HALAMANDARIS. Yes, sir. I think the problem is just beginning. As you know, we did find medicare mills in Florida. In fact, one of the gentlemen that we interviewed in the course of pretending that we were businessmen from Chicago wanting to buy medicaid mills indicated that he had six or eight of them in Florida. Florida is one State that has a very low medicaid commitment. However, they have a substantial number of medicare beneficiaries down there. He said, "We play the same game in Florida but we don't call it medicaid down there, we call it medicare." He said, "There is no dental business down there but we do a hell of a lot of EKG's."

Senator PERCY. Will you describe how you actually went about setting up a dummy corporation to purchase medicaid mills?

Mr. HALAMANDARIS. It is not very difficult. Some of our investigators cooperated. We simply incorporated in the State of Delaware and paid our $44. I would like not to disclose the name of the corporation. We listed the purpose of the corporation: the buying and selling of health care facilities. It was just a precaution in case somebody checked us out. An answering service was hired in Chicago and we had a post office box, all by way of providing us with a cover.

Senator PERCY. Did you contact, during the course of the investigation, officials of the State and local officials in Illinois, New York, Michigan, and California and ask for their assistance and help. What degree of cooperation did you get from them?

Mr. HALAMANDARIS. We received great cooperation. In New York we also worked with Mr. Charles Hynes, special prosecutor for nursing homes. We worked with George Wilson, assistant U.S. attorney who advised us every step of the way. We worked very closely with the Special Commission on Investigation in New Jersey, the Michigan Fraud Squad, and in California our contact was the Joint Legislative Audit Committee and they have received our results. We wanted some criminal prosecutions to result from this rather than just putting on a show. Our main purpose however is legislation.

Senator PERCY. Mr. Chairman, I join with you in commending our staff who were temporarily assigned to this work. I don't think anyone can sit in this room and not have a feeling that you have an absolute necessity to find ways to correct this problem. You cannot go through what you just did, Ted, and not have a feeling that something has to be done.

Now the bottom line is where we go from here. We are not a legislative committee or subcommittee and it is for this reason that some time ago I contacted the Finance Committee, wrote them officially, asked them if they would undertake this burden of responsibility and I suggested that they go right to the State of Illinois, my own State, and investigate the situation that we simply knew ourselves required a legislative remedy.

S. 3205 has been introduced. Senator Moss and myself are cosponsors of that bill and I know it is going to have the full support and backing of Senator Beall. I would like to just pick a few things out of that as typical of the kinds of things we are going after and ask you for your appraisal as to whether or not these changes of the Finance Committee in this legislation would be of assistance and help to us.

BILL CONSOLIDATES FINANCING

First of all it seemed to me we did have a proliferation of departments and agencies within HEW and the bill combined the medicare and medicaid office of nursing home affairs and the bureau of quality assurance agencies into a single administration for health care financing. That consolidation focused the intention right into one area where there is no place they can pass the buck, and you are responsible for that. Would that organization help in HEW?

Mr. HALAMANDARIS. It is my feeling that it would, Senator. There are other provisions that I liked even better, that is the creation of the Office of Inspector General.

Senator PERCY. Now we have, I am sure, representatives of HEW sitting in the room and they have a degree of devotion to their job as we have to ours. I make my observation, excluding the Secretary, who is a very pragmatic and very hard hitting fellow, and I think he has been shocked at some of this. There is a naivete in HEW that really is almost rampant. They feel, well it is almost an attitude, that no one would ever dare defraud them in the fields of health, education, and welfare.

When Senator Nunn and I tried to discover why there was $1 billion defaulted on student loans, they had an investigator that came to the school and found there was a man who had declared himself dead so his wife would not be able to find him, and he is running a school dealing with very large sums of Federal funds. He just wanted to make money, he was not interested in education. There was money to be made in education and he made it.

I think HEW must reconize they have a tremendous internal responsibility. It is far too late when we get into the job or when U.S. attorneys do. By then the crime has been committed. So this legislation that we are proposing and Senator Talmadge is offering would create an essential fraud and abuse unit right within an agency. Now would that help?

Mr. HALAMANDARIS. It is my feeling that it would, sir, particularly if the agency is headed by an Inspector General. We have been discussing these problems informally on a staff level. We have come to the agreement that the Talmadge bill would solve many of the problems we face.

Senator PERCY. Mr. Halamandaris, would you assume that an agency that spends 1 out of 4 of our Federal dollars should have an Inspector General?

Mr. HALAMANDARIS. Absolutely.

Senator PERCY. Are you rather shocked that they don't have an Inspector General?

Mr. HALAMANDARIS. I am, sir. I am shocked that the Senate has passed the bill two or three times but the House has never acted.

Senator PERCY. Under the provisions of this bill, S. 3205, the Inspector General then would take over the direction of an essential fraud and abuse unit and also the general counsel of HEW would be authorized to prosecute directly civil fraud cases where U.S. attorneys have not acted in a timely fashion. Do you think that will help?

Mr. HALAMANDARIS. Absolutely.

Senator PERCY. Give them some of the clout to followup the sense of responsibility that they should have. They are the ones that are responsible for seeing that it is spent without fraud.

SAMPLING FINDS 15 PERCENT FRAUD

Mr. HALAMANDARIS. Yes, absolutely. I add one word from Dr. Keith Weikel who is sensitized to this issue. As he reported to the Finance Committee last Thursday, they were finding about 15 percent fraud in their sampling in New York State which makes our estimates of 8 and 10 percent very conservative.

Senator PERCY. Now, finally, getting into some of the implications on how we make payments it seems to me that percentage arrangements are just that. I am always suspicious of percentage arrangements, I would rather have a flat fee. I don't want them to have an incentive to find ways to spend money. Now don't you think these percentage arrangements ought to be illegal and no reimbursement paid to contractors, employees or related organizations and not have them recognized if there is a percentage arrangement involved?

Mr. HALAMANDARIS. Yes, sir.

Senator PERCY. I think that, alone, would remove one of the administrative problems that we have and that the Secretary's determination of the reasonableness of cost or charges would include consideration of the relationship between the direct and indirect overhead costs or charges in the direct cost of the provision of service. In other words, they would have to see what this superstructure is that has been established so that they would have to find some way to get behind it.

Now don't you think it would be desirable for a provider or an agent, when requested by the Secretary or the Comptroller General of the United States, to provide a full financial disclosure as to the arrangements? Who owns them? How much they are getting in rent? Who is skimming off the cream on the top? Who is making the money on this operation? There is no reason, as long as it is public money, why that should not be provided as information basic to the establishment of the treatment.

Mr. HALAMANDARIES. I could not agree more.

Senator PERCY. Then, finally, the closing of loopholes in the law. We have found some loopholes particularly in the payment of medicare and medicaid reimbursement to anyone other than the billing physician or hospital.

Lastly, I am really shocked to find that fraud under medicaid and medicare is now statutorily a misdemeanor. This bill would change it. The fraud will be punishable as a felony with penalties up to 2 years imprisonment and a $10,000 fine.

Now that is the exact same mechanism we used last year in a bill we unanimously adopted to really try to stamp out fraud in these student loan programs. I think these people realize they are going to go to jail and they are going to pay heavily and it is a crime, it is a felony, and not just a misdemeanor, for them to be robbing, stealing the public blind and taking advantage of the kind of people that all of us represent.

PEOPLE BARTERED LIKE PROPERTY

You can imagine the attitude of people when they sit and listen to them being bartered like a piece of property as to how doctors can actually make money, and what attitude do they have toward society and their Government when you see it going on right under their own noses? The experience that you have had, I am sure, is hardened. Maybe there is cause for a lot of crime in the ghetto level where people figure there is just no way to beat the system—the system is set up for those who are benefiting from it, not us, we are just being taken advantage of. I think you performed a truly remarkable service.

Senator, I just want to say once again to you, to be able to take your shirt off and get in there and put those coveralls on—you are going to have religion like no one has had it—no one is going to be able to stand up to you on the floor and say this bill is not really necessary.

Senator Moss. Thank you.

Senator Beall.

Senator BEALL. I agree with Senator Percy's analysis of this legislation and the need for an inspector general certainly.

I ought to point out that about a year or two ago, Secretary Weinberger included the request for a team of fraud investigators in the HEW budget request and the Senate Appropriations Committee cut that request out of the budget. As a matter of fact, it subjected the

Secretary to a great deal of abuse during the hearing process, accusing him of trying to set up a "plumber" type operation. I think some previous Secretaries have also raised the need to establish a fraud investigation unit of some type.

Mr. Halamandaris, do you associate the difficulties in controlling medicaid with the fact there is joint control between the Federal Government and the State?

Mr. HALAMANDARIS. I do, sir, definitely, jurisdiction is split between the Federal Government and State government and in some cases with local jurisdictions as well. It's like Abbot and Costello playing baseball—I have got it, you take it. The responsibility seems to fall between the cracks.

Senator BEALL. Some States are doing a good job and some States aren't.

Mr. HALAMANDARIS. Correct, sir, the better States include California, Michigan, and New Jersey.

Senator BEALL. What about Maryland?

Mr. HALAMANDARIS. Maryland is one of the better States.

Senator BEALL. Second, would the illustration you point to come from large urban areas?

Mr. HALAMANDARIS. That is right.

Senator BEALL. We have just passed health manpower legislation through the Senate as you know. Is it true that most of these situations occur in areas where there is not an adequate supply of primary care physicians and probably results from the maldistribution of health personnel across the country?

Mr. HALAMANDARIS. I believe that is a fact, yes, sir.

Senator BEALL. Do you find these abuses in rural areas, too?

ABUSES FOUND IN HIGH DENSITY AREAS

Mr. HALAMANDARIS. We have not found abuses in the rural areas. The mills exist in high density urban areas. If you travel to Chicago or to Los Angeles, you'll see them dotting the landscape almost like the pornographic book stores.

Senator BEALL. There is no available alternative for people who are sick? There is no other facility to be used other than this store front operation?

Mr. HALAMANDARIS. That is the best thing that can be said about medicaid mills, they are located in the ghetto. But so many people told us: "We don't go there if we're really sick. If we're really sick, we go to the hospital emergency room."

Senator BEALL. Thank you.

Senator Moss. Thank you very much.

In New York the responsibility financially is 50 percent Federal, 25 percent State and 25 percent in the city, is that right?

Mr. HALAMANDARIS. That is right, sir.

Senator Moss. So that is a three tiered financial responsibility which leads, as you say, to the scrambled lines and the failure to take full responsibility for audit and inspection and policing and so on.

Well, I want to say again how much I appreciate the work done by this staff. It must be realized that we are simply a subcommittee of the special committee and we don't have a lot of manpower or a lot of facilities to carry on this kind of investigation and it was because of

the pressing needs of this that the staff has devoted itself so wholeheartedly to this matter.

While I am speaking about that, calling on the Capitol Police force to suppy some manpower and some assistance to us was an innovative thing to do and certainly the two men who were assigned did an exceptionally fine job. I have here this morning a letter that Senator Church who is chairman of the full committee executed and I want to give this to each of those men for the outstanding work that they did. Their devotion was great indeed as it was for the entire staff in this matter.

The report that has been prepared is an excellent one. It covers an area of great importance to us.

I think we are going to have to involve other committees of the Congress as we are doing now with the Finance Committee and others to supply the added manpower we need to make sure we have got this thing in hand.

Is there anything further to be offered?

Mr. HALAMANDARIS. No, sir.

Senator Moss. Let me thank you all very much.

Let me ask Private McDew and Private Roberts if they would come up here and let me give them each a letter.

[Letters presented to Private McDew and Private Roberts.]

Senator Moss. We will now hear from Dr. Bruce P. Reiter from the city of New York.

Dr. Reiter, will you come forward, please.

We welcome you before this committee. We appreciate your cooperation and your willingness to come and we would be glad to receive your testimony at this point.

STATEMENT OF BRUCE P. REITER, M.D., NEW YORK CITY

Dr. REITER. Good morning, Mr. Chairman and Members of the Senate.

My name is B. P. Reiter, and I am a physician. I am a graduate of the Albert Einstein College of Medicine in New York City. I trained at Metropolitan Hospital, the Kingsbridge VA Hospital, and at Bellevue. In 1975 I was certified by the American Board of Radiology as a specialist in radiology.

I am a physician, and I also do a bit of writing. If you will indulge me, I will read a few things that I wrote in New York Magazine some while ago.

Once I finished medical school, I figured I would go out and get rich. Not superrich, but rich enough to move out of my one-room apartment. I also wanted to buy a new motorcycle, and perhaps pay off a few of the constellation of loans I had collected in medical school.

I could do none of these things. It turned out I had an M.D., but I had no license. You need at least a year of internship in order to get a license to practice medicine. I went and did an internship. A lot of interesting things happened; but I survived. And I got my license.

Well, I thought, now I'm going to go out and get rich.

"What are you talking about?" my friends said. "You have to specialize."

"I do not want to specialize," I said, "I want to get a job."

"You can't get a good job unless you specialize in something."

I specialized in something. Three years later I had my M.D., my license, and my specialty. I'm not going to talk to anybody this time, I thought. I'm just going to go out and get rich. I planned to open an X-ray office.

I called the X-ray equipment company and said, "hello; I'm a young radiologist and I'd like to open an office." The X-ray equipment company said no problem, they could set me up, on a modest scale of course, for about $220,000. "Oh," I said.

I didn't have $220,000. If I'd had $220,000, I wouldn't have opened an office. I would have closed the office and gone to Jamaica fishing.

Well, I figured, maybe I can find a job in the New York Times. What with the doctor shortage and everything, there ought to be a job some place for a radiologist.

Indeed, there was a whole string of ads in the Sunday Times. "Medicaid Clinics! Serve the community! No overhead, no investment, high volume. All types of doctors needed. Should speak a little English."

I speak a little English, I said to myself. I called up one of the clinics.

"I'm a radiologist," I said, "and I was wondering . . ."

Medicaid Mills Hard to Miss

"Come in," they said. "Come in and see us!" I drove to Brooklyn the next day and found the place. It was hard to miss—there was a gigantic, multilingual sign out front advertising medical care, dental care, chiropractic care, any kind of care you wanted. Everything but topless waitresses. Right next door, a similar, slightly smaller sign identified a conveniently located pharmacy. Also gladly accepting medicaid.

I went inside. There was a small waiting room, with a very big guard standing in the corner. I walked up to the little glass window.

"Hello," I said, "I have an appointment here."

"What?" the woman on the other side said through an intercom thing.

"I have an appointment. I am a doctor."

The piece of plate glass between us was about 3 inches thick, and she couldn't hear anything. It was like a checkcashing place on the Bowery. "What?" she said again.

"I said I'm a doctor," I yelled. "I've got an appointment!"

The guard came over and shook his stick at me. "Sit down and be quiet," he said to me, "or you won't get your methadone."

"I don't want any methadone," I said. "I'm a doctor and I have an appointment about a job here."

"Sit down and be quiet," the guard said, looking nasty. He was twice as big as I was and I sat down.

I looked around the little waiting room. This was a high volume operation all right, no question. I had to take a seat way in the back, but there was another great big sign up front with an illuminated, moving message. It was certainly big enough and bright enough not to be missed, even from the cheap seats.

"V.D. Tests," it announced in several languages. "Pregnancy Tests, Pap Tests, Road Test, Learners Permits, Auto Insurance, Life Insurance, Personal Loans—Low Rates."

"What am I doing in this place?" I said to myself. Two gentlemen dressed up in long white coats appeared from behind the armored window and came hurrying over to me.

"Are you the doctor who called up yesterday?" the smaller one said. "The radiologist?"

I admitted I was the radiologist.

"Wonderful, wonderful," he said. "This is my partner. Come with us, doctor."

We went inside. The guard did not frisk me but he looked like he wanted to.

The three of us sat down in a plasterboard office that had padlocks on everything.

"Would you like a cigar, doctor?" the little one said.

"No, thank you," I said. "I'd like a job. I finished my residency last June and I'm pretty well trained in general radiology, isotopes and angiography."

Furnish Everything for 70 Percent

"That's very nice," he said. "We take 70 percent."

"Pardon me?"

"You give us 70 percent of your billing."

"I don't understand," I said.

"Let's say you become our radiologist," the little one said with a kindly look on his face. "We handle everything for you. We take care of all the equipment, we buy the film, we pay the technician. All you have to do is read the films."

"I see. Well, who supervises the technician's work?"

"Oh, we do," the big one said. "We watch him very closely."

"Yes," the little one said, "you don't have to worry about anything. All you have to do is read the films and give us 70 percent of your billing."

"Seventy percent? You're kidding."

"This is a wonderful opportunity for a young doctor like you," the little one said enthusiastically. "Do you know how much that equipment costs?"

I knew. "Well, I'm not sure," I said. "I mean, that doesn't leave very much for me."

"Look at it this way. This is a very high volume clinic. Let's say you have $1,000 worth of billing. That's $300 a week for you right there. By the way, have you ever done any medicaid work before?"

"No. This is my first job."

"Well, there's one more thing," the big one interjected. "We like to get paid right away."

"Yes," the little one said, "that's true. We have a lot of overhead."

"What do you mean?" I asked innocently.

"It works like this. Let's say there's $1,000 worth of billing for 1 week. You come in and read the films, you pick up the invoices, and you give us a check for $700. For our overhead."

"You mean I have to pay you to work here?"

They both chuckled. "No, no, doctor," the big one said. "You're looking at it the wrong way. You send the invoices to medicaid and they pay you the $1,000. And you've got $300 free and clear."

"How long does that take?"

"Oh," the little one said casually, "not more than 4 months."

"Wow," I said "You mean every week I give you $700 and 4 months later I get it back from medicaid?"

"Well, more or less. You know, we have to meet our overhead here."

"I'm sorry," I said, getting up. "I don't have any money. That's why I was looking for a job."

"Sit down, sit down," they both said, still extremely genial. "No problem, doctor. We'll take care of everything, don't worry. We factor."

"Oh," I said. "What's that?"

Factoring Covers 4 Months Wait

"We'll help you out. We have a company that loans money to young doctors. You know, just until the bureaucrats at medicaid get around to sending out your checks. That 4 months can be a long time."

I was learning. "How much?" I said.

"Just 10 percent. We try to help our doctors along."

"You're joking," I said "That's 30 percent a year. How much do I keep? Eleven dollars?"

The two of them chuckled again. "You'll do very well," the big one said, "don't worry. It just takes a while for a young fellow like you to get started."

"You mean," I summed up, "you loan me money at 30 percent a year, and I lend the same money back to you for nothing? That's crazy."

"You're looking at it the wrong way, doctor," the little one said.

"I don't think I can afford to work here," I said.

They changed the subject. "Say, would you mind looking at a case for us? Our last radiologist got discouraged and left. This patient's been waiting weeks for his results."

I love to look at films. I examined their case for them, holding the films up to the window and squinting at them. It was an oral cholecystogram.

"Where are the rest of the films?" I asked. "This is a very incomplete study."

"Well," the little one said, "things have been kind of slow. The technician tries to save us a little money sometimes—the film is expensive. We've got a lot of overhead, you know."

"Yeah," I said, "you must have some electric bill for all those signs out there."

I inspected the films again and made a learned discussion about adenomyomatosis and cholesterolosis. The little one looked at me absoluately blankly.

"What?" he said.

I figured maybe he was a psychiatrist or something and he had been away from clinical medicine for a while. "What's your specialty, doctor?" I asked politely.

He thrust his hands into the pockets of his white coat and leaned back in his swivel chair."Oh, I'm not a doctor," he said.

"Well, who are you?" I asked.

"I'm the executive administrator," he said. "My partner is the doctor."

I turned to the bigger one. "What was your feeling about this case?" I inquired.

"Me?" he said. I'm a chiropractor. We have a different concept of disease, you know."

"Oh boy," I said.

A family with a large number of children wandered into the office. "Excuse me," the mother said, "is this where we find out about the apartment that's for rent?"

"No, no," the chiropractor said, hustling them out, "that's down in the basement. Go back downstairs."

He came back in looking annoyed. "I don't know how they got past the guard," he muttered.

"Oh yes, there's one more thing, doctor," the chiropractor said. "Some of the patients don't have medicaid or medicare, so you read those films for free."

"You mean like for indigent patients?" I said. "Sure, that's okay."

The chiropractor looked at me oddly. "We have no indigent patients," he said. "I mean for private patients."

"I don't understand. Why don't you bill the private patients?"

"Oh, we bill the private patients," the chiropractor said. "You don't bill them.It's sort of a service you provide for us."

"I still don't understand," I said. "Why do you get paid if I read the films?"

"Well," the chiropractor said, "with cash changing hands and everything, it's just easier. Ask around, all the medicaid clinics work that way."

"Yeah," I said, "I bet they do."

Diagnosis Never Normal

It was the executive administrator's turn. "There's just one more thing," he said, holding up an invoice. "See where it says 'diagnosis'? Never put down 'normal,' no matter what."

"But suppose that the films are normal?" I said. "Don't you ever ever get any normals?"

"Oh, yeah," he said, "all of them are normal, just about."

"Well, what am I supposed to put down?" I asked.

"It doesn't matter what you put down," he said, "as long as you don't put down 'normal.'"

"You mean you want me to make things up? I can't do that."

"No, no, of course not," the executive administrator said, beginning to look impatient. "Just use the referring doctor's diagnosis."

"This is getting kind of tricky," I said. "Is this legal?"

"Would we break the law?" the executive administrator said. "Let's go downstairs, and we'll show you."

We all went back downstairs. The chiropractor had to go and reprimand a patient who was kicking the soda machine. The executive administrator led me to a tiny examining cubicle with "Dr. So-and-so, Doctor of Chiropractic" on the door.

"This is Dr. So-and-so," he said. "Dr. So-and-so, this is the new radiologist. He needs some help in learning how to fill out the invoices."

The chiropractor was crowded into the little room with a young, hulking, very healthy-looking patient. There were a couple of view-boxes on the wall and this chiropractor was looking at some curvical spine films. Parenthetically, upside down. He stood up.

"Glad to meet you," he said. "The invoices are a snap to fill out." He gestured at the X-rays. "This young man, for instance, is suffering from a cervical radiculopathy."

"A what?" I said.

"A cervical radiculopathy. Look at the films."

I went over and, as casually as I could, turned the films right side up. "Where?" I said. "I don't see anything."

"Right there," the chiropractor said, pointing. "Look at those spurs."

"Those little osteophytes? Everybody has them. That's practically normal."

The chiropractor gave me a very hostile look and motioned me out into the corridor. He closed the door on the patient.

"What's the matter with you?" he said. "Do you want the patient to hear you?"

Film Shots Held to Minimum

"But there's nothing wrong with him on those films," I said. "Besides, if he's got neurological symptoms you've got to look at the neural foramina. You can't even see those on the lateral films. Where are the oblique films?"

"All you M.D.'s think you're so smart," the chiropractor said, retreating back into the examining cubicle. "You guys give me a pain in the ass." He slammed the door.

The executive administrator took me by the arm. "We don't take that many obliques here," he said. "We find we don't really need them. Don't worry, you'll catch on. Where are you parked?"

"Right out front."

"Come on, I'll walk you out to your car," he said expansively.

"Is the interview over?"

"Sure, sure," he said, lighting up a large cigar. "All these details are simple. Don't worry about them. You know, we're opening a new place in Queens next month. You might be interested in doing some work for us out there, too. We're going to have a real empire. You're pretty lucky—you can get in on the ground floor."

We walked out into the street. "Oh, that's too bad," he said, looking at my ancient Volkswagen—about 10 or 15 years old. "You've got M.D. plates on your car."

"What's wrong with that?" I said.

"Well, nothing. Just keep changing your schedule. You know, don't show up at the same time every day. Otherwise you might get jumped."

"Me?" I said. "Why would anybody want to take me off? I don't have any money."

The executive administrator looked tolerant and amused. "The methadone. They'll think you've got the methadone. See you Monday."

This is not fiction, as I am sure you are aware by now; this is just the beginning, as a matter of fact. What makes a medicaid mill like this, a reprehensible place like this, possible? Why do they spring up? Legislation was passed that provided money to help take care of older people, of poor people. What happened?

This is an opinion, on my part. I think a couple of things happened. First of all, an enormous amount of regulations, guidelines, and rules spewed forth, from a number of different agencies. I don't own a medicaid center, I am just on the list of what they called "vendors." This is some of the stuff that I got, telling me what to do, when to do it, when not to do it. [Holds up large pile of forms.]

These two sheets, with single-spaced typing on both sides, with some pictures, two of these sheets deal exclusively with the medicaid ID card. When you can't treat patients or when you can treat them. The rules and the guidelines and the regulations and the forms all keep changing, keep altering, and when you comply with them, they are followed by silence. When you treat a patient and you then want to get paid for it, it takes 3 months, 4 months, 6 months, 8 months to get paid. When you get paid, if you do, you get paid almost at random, it seems to me. You get "reduced," which means patients' names come back with code numbers on them. You call medicaid, and they hang up on you. You call again, and they hang up. You call the third time and you say, "Don't hang up, don't hang up, I just want to get the forms to get paid."

"Oh, sure, we will send them right out." They never do.

Structure Promotes Abuses

Then, when you do get paid by medicaid you really don't get paid particularly much. There is a bad effect from these things. What happens, I think, is that this structure—of papers, of forms, of changing rules—tends to disgust those people who are there to deliver health care, those people who are there to take care of sick people. It selects out against those doctors who simply want to take care of sick people, and selects into the process those people who are willing to sit down with their lawyer, and their accountant, and figure out just what the latest medicaid form says and what it does not say, and, more to the point, figure out how to outwit the very regulations that are supposed to contain the kinds of abuses they commit.

One of the reasons for this happening is that, to sit down and open a medicaid mill, you don't have to be a physician, or dentist, or podiatrist, or even a chiropractor. All you have to do is get a big sign that says "medicaid clinic," and you are in business. For the people who own medicaid mills, taking care of sick patients is something that they have to live with, just like income tax or overhead. It is something for them to do as cheaply and as efficiently and as quickly as possible. To be gotten out of the way, so they can attend to the business that they are there for—which is to make money and generate profits.

Now, I am not against profits. I would very much like to make some profit myself—to get a haircut, maybe get a new motorcycle.

But my concept of medicine is a doctor, in an office, with a patient, and my concept of medicine is not some guy who has never even considered what it means to be sick, or frightened of dying, or getting old. I think it is disgusting that a businessman, an individual who is just a young hustler, a guy that is younger than me, can sit there with his lawyer and accountant and figure out how to generate money out of people's illnesses.

Thank you.

Senator Moss. Thank you, Dr. Reiter. Your rather humorous recitation carries through the bitter disillusionment that came to you and reflects to us. To have you come back and explain, perhaps trying to be sure that the proper steps were taken and real attention given to the whole thing which is bogged down with a long list of forms and outline and a lot of material impedes rather than enhances the delivery of the medical care that people need.

Like you, I am frustrated in knowing how we get between these two. How do we get people who are trained as doctors in various specialties to care for their patients and to appropriately reward them for those services and not fall off on either side?

We constantly feel the necessity of pointing out that we still have great faith in the medical profession and most of them, the vast majority of them, want to serve. That is the reason they took all that training and went into that field. Others have been able to abuse the system and we need some way to try to single them out.

Care for Poor and Old As Real Purpose

Your experience is—unfortunately I guess it occurs to others who find themselves one way or another introduced into this system. Hopefully we will find a way because we are anxious to see that care is given to the poor and the old and those who are unable to go in the regular channels that most of us can go when we need medical care. That is the purpose of this whole hearing.

I cannot tell you how grateful we are to have you come and put this thing down clearly on a personal basis before us so that we can look at it and see if we know the way, and maybe we don't, but we have to try and struggle to try to find a way to make the system work out and enable people to get the medical care that they need and to which they are entitled. So I want to thank you.

Are you practicing alone, Doctor, or what kind of practice do you carry on?

Dr. Reiter. I am a writer. I have just finished a novel, "The Saturday Night Knife and Gun Club."

Senator Moss. You just write now, you are not actually practicing?

Dr. Reiter. I still don't have $220,000 to open an X-ray office.

Senator Moss. I can understand.

Dr. Reiter. If I could add another parenthetical remark about that. To open a private X-ray office, one does need a quarter of a million dollars. The one medicaid clinic, for example—although this is quite common—that I spoke of here, which collected 70 percent of the fees from the radiologist's work—supposedly for the service of providing this very expensive X-ray and the X-ray technician—outfitted their X-ray facilities for $8,000. Secondhand equipment, that cost them $8,000.

Senator Moss. Cost $8,000.

Dr. Reiter. Now, keeping in mind that about a quarter of a million dollars worth of stuff is needed to set up an adequate and competent office, which has the equipment to do the proper kinds of examinations and procedures, and only $8,000 these fellows shell out, you can imagine what kind of stuff they are working with there. That is routine, too.

Senator Moss. Yes. As you may have heard some of the other shoppers report being given X-rays, sometimes not even plates and sometimes the dental X-ray equipment to take X-rays of feet and things of that sort indicating the absolute ludicrous lack of equipment that is used simply again to generate dollars.

Dr. REITER. If I could indulge in one tiny bit of propaganda. The question was posed before about organized medicine. What, if anything, have the medical societies done? I belong to the State medical society and in fairness to them, there is a little note which I have got here that points out that last spring the New York State Medical Society sent a delegation to Albany to specifically request that the percentage leasing arrangement—which seems to be one of the linchpins of these medicaid mills—be made against the law or against the regulations or against something. The board of regents, which I think received that request by the State Medical Society in New York, has recently declared that such an arrangement is "unprofessional conduct"—which means that one's license can be taken away upon conviction for that charge. This may have some effect on the leased-space facilities where the rent is calculated on a percentage basis and the practitioner frequently receives only a small part of the fee paid. I think some credit should perhaps be given to the medical society there. They did move.

HELP FURNISHED BY MEDICAL SOCIETY

Senator Moss. I am glad to have you point that out. I think there is some movement and I expect more yet will be done by the medical society. Perhaps it is slow to move but I think they will move now in a lot of this area.

The Senator from Illinois.

Senator PERCY. Doctor, how many were in your graduating class? Where did you graduate for medical school?

Dr. REITER. I went to the Albert Einstein Medical College in the Bronx, New York.

Senator PERCY. How many were in your class?

Dr. REITER. We graduated something over 100. This is a guess. Between 105 and 110.

Senator PERCY. Did they all go on to specialize?

Dr. REITER. Heavily, yes. I would say that, yes.

Senator PERCY. In your own specialty, how many were in that class when you got your degree?

Dr. REITER. Well, at the stage we graduated we had not yet specialized. We all took a year of general internship, or did at that time, and then subsequently went on to specialty training. This is off the top of my head, but I estimate 8 percent, 9 percent, something in that range, of my class entered radiology.

In terms of how many of our people went into, let's say, internal medicine, family practice, pediatrics and gynecology, which is more or less the group of primary physicians that patients first come to see, I am really guessing now—58 percent in 1974.

Senator PERCY. Do you know any members of your graduating class that have actually gone to work in a medicaid mill or have they all gone into hospitals, private practice, perfectly legitimate pursuits of their vocation?

Dr. REITER. To my knowledge I am the only individual from my class who had the distinction of working with the medicaid mills. Generally speaking, these kinds of operations don't attract American graduates of American schools. As was pointed out previously, they kind of tend to prey on the doctors, as well as on the patients, and they single out a lot of doctors from other countries who don't have that good a grasp of the language to begin with, who are overwhelmed by the idea of setting up a practice, and attracting patients and all the associated complexities. That is an intimidating situation to be in, and can be taken advantage of.

Senator PERCY. From the very fact that in the ad you commented, some knowledge of English was necessary, wouldn't the assumption be that essentially they are trying to attract the foreign born and trained doctors who for one reason or another possibly can't get a license to practice in this country and therefore would be eligible to work in a medicaid mill but not other places? Is that generally the kind of person that ends up there? How would you describe the kind of people that you have met who end up in the medicaid mills?

FOREIGN-TRAINED PHYSICIANS IN MILLS

Dr. REITER. Well, as I understand it, one has to have a license to be reimbursed by medicaid—I am not 100 percent sure of this, but I am fairly certain. If that is the case, then obviously they are licensed. But again, there are all kinds of licenses. Someone who is a perfectly competent physician in his own language, may have adequate credentials elsewhere, and have gotten an equivalency license in this country, and still be overwhelmed by the unfamiliar situation of a new culture. I would agree with you, and with the speakers who were here today, that the medicaid mill physicians seem to be foreign-trained.

Senator PERCY. You said that you started out with the intention, honestly stated, of making some money and getting rich. Now when an opportunity was offered to you to make some money, and possibly get rich, why did you turn it down?

Dr. REITER. I didn't go to medical school for that.

Senator PERCY. You didn't what?

Dr. REITER. I didn't go to medical school for that. I went to medical school to be a doctor. Even though there is a problem with bad apples, I think there is still quite a selection process that goes on, starting at the point when you apply to medical school in this country. I would like to think that the bulk of our people come out of medical school with pretty much the same ideals that they took with them when they went in. I think to a large degree that is true. I hope it is true.

Senator PERCY. By your testimony you said, once you finished school you figured you would go out and get rich, not super rich but rich enough to move out of your one room apartment and buy a motorcycle.

Dr. REITER. Yes.

Senator PERCY. In other words, the association here simply was not the kind that you were willing to connect yourself to though it did involve making money?

Dr. REITER. I want to practice medicine; I am a physician. These medicaid mills people are not doctors. The people who run these places are not there to provide medical care. This is not like going to a bunch of doctors and saying, "What can you give to your community" and joining their group and seeing patients. This is just a scheme for grabbing a lot of Government dollars; it has nothing to do with practicing medicine.

Senator PERCY. How did you come to the attention of our subcommittee staff?

Dr. REITER. Mr. Bill Halamandaris called me. Apparently he looked at the article I had published, which I quoted to you, in New York magazine last summer. He asked me to come down.

Senator PERCY. You were aware of the work of this subcommittee and the interest that we had in this field?

Dr. REITER. Not in detail, but yes.

Senator PERCY. Thank you very much.

Dr. REITER. My pleasure.

Senator MOSS. Thank you very much, Dr. Reiter. We surely appreciate your coming and adding to our hearing record.

We have now Joseph Rodriguez who is chairman of the New Jersey Commission of Investigation. He will be accompanied by Anthony Dickson who is counsel to the commission.

We made some reference to New Jersey earlier and what they have done so we are very pleased to have Mr. Rodriguez here. He also has a report that I understand he will present and if he does that, we will make that report part of our record.

STATEMENT OF JOSEPH H. RODRIGUEZ, CHAIRMAN, NEW JERSEY COMMISSION OF INVESTIGATION, ACCOMPANIED BY ANTHONY G. DICKSON, COUNSEL

Mr. RODRIGUEZ. Thank you.

Mr. Chairman and distinguished members of the committee, on behalf of the New Jersey State Commission of Investigation, known as the SCI in New Jersey, I would like to thank you for this opportunity to appear before you and testify about the commission's investigation of the practices and procedures of practitioner groups receiving State and Federal moneys under the medicaid program. I understand that this committee is currently considering regulatory and statutory reforms on the Federal level to correct certain harmful abuses in, and exploitation of, the practitioner component of this well-intentioned program. By a report first made public here today and by our testimony we are prepared to share with you our insights concerning the operation of the medicaid program and our suggestions concerning its reform and improvement.

By way of background, let me briefly tell you something about the New Jersey SCI and the manner in which this particular investigation of practitioner groups receiving medicaid funds and the report [1] which we release here today were developed. At the outset I wish to make it clear to you that the New Jersey State Commission of Investigation has no role in the administration of the medicaid program. Our

[1] See appendix, p. 599.

investigative staff of less than 25 is charged with the responsibility of advising the State legislature and the public of problems of organized crime, official corruption and any other matter affecting the public trust. We have no prosecutorial powers but like the Ervin Committee we do have the obligation to fully investigate particular problem areas, report our findings to the public and recommend a course of curative action to the legislature.

Early in 1975 the commission began an evaluation probe of the entire medicaid program in New Jersey at the request of our Governor, Brendan T. Byrne. The SCI proceeded to set up three investigative teams to look into three principal medicaid cost areas—nursing homes, hospitals, and other purveyors of services, including independent clinical laboratories, professional practitioner groups and pharmacies. The commission has held public hearings and issued reports in many of these areas and more are shortly forthcoming. We have testified before several congressional bodies—including this distinguished committee—concerning the results and recommendations which stemmed from our investigation. Our probe into medicaid ripoffs by independent clinical laboratories was the subject of a national television network's documentary aired in April of this year.

In this investigation the commission centered scrutiny upon the practices and procedures on a sample of relatively large dental and physician groups, their relationships with other providers of medical care and services—especially pharmacies—and the adequacy of existing regulations and integrity monitoring methods utilized by the State body administering the medicaid program, the Division of Medical Assistance and Health Services.

Investigation Focused on "Professional Centers"

The commission focused upon practitioners associated together in professional groups, "professional centers" housing various unassociated tenant practitioners and offices of single practitioners in which other physicians would regularly share space in either an employee or independent contractor capacity. More than 12 facilities located in welfare project highrise buildings, converted stores, warehouses and tenements in impacted areas across the State—each having at least a 75-percent volume of welfare patients and bringing in substantial medicaid moneys yearly—were examined.

The commission received valuable and full cooperation from the Division of Medical Assistance in this investigation and established a working relationship with Val Halamandaris and other staff members of this committee. Books and records were subpoenaed and reviewed, facilities were visited by investigators of the SCI and the Select Senate Committee on Aging who posed as patients, and sworn testimony was taken from practitioners, facility employees, medicaid recipients and State program administrators.

The facilities which we examined typically were divided into a reception area for patients equipped with rows of theater-type seats and several smaller compartments used for patient examination, X-ray services and laboratory services. Several locations also contained in-house pharmacies. Each facility had an owner or equivalent of a business manager to supervise the day-to-day running of the operation, take on and terminate medical, nursing, and clerical staff, and

arrange liaison with out-of-house specialists and suppliers of goods and services. In many cases, the owner or business manager was a layman.

Through examination of books and records and sworn witness testimony, the commission was able to discern the financial arrangements between the staff or tenants of the facilities and their owner/operators. In early years of the medicaid program many facilities paid associated physicians a salary, which in some cases amounted only to $15 per hour. The facilities received all fee for service medicaid moneys accruing because of these practitioners and, in many instances, the amount could be hundreds of dollars per hour. We strongly doubt that the drafters of the medicaid program or professional groups which loaned their support to it envisioned such practices.

Nor do we believe legislative draftsmen on the Federal and State level foresaw the rise of percentage arrangements between professional practitioners and facility owner/operators whereby the practitioner would keep from as little as 30 percent to as much as 70 percent less $100 monthly of the fees for service paid by medicaid. The Commission identified several such relationships and on the average practitioners were required to turn over 50 percent of the taxpayers' money they received to facility operators or landlords. For their 50 percent operators and landlords provide space, telephone, nursing and clerical service. This latter "service" usually consisted of the presence of the operator's secretary to keep accurate tabs for the owner/operator of amounts billed by the practitioner.

Percentage Arrangement Unrealistic

The Commission recognizes that certain expenses are indeed borne by the facility but suggests that economies of scale accruing to large facilities should lessen the necessity of high percentage arrangements. We believe that these percentage arrangements should be outlawed. As our report indicates, they are incompatible with the goal of providing necessary quality care to recipients at reasonable cost to taxpayers. Such arrangements foster overutilization. It is unrealistic to expect program providers to practice fiscal restraint when the amount they earn at a facility directly depends upon the amount billed.

Percentage arrangements also incite "ping-ponging" which was defined here today, and our report also defines what we found in New Jersey as "family ganging"—a practice which we define as requiring a patient to return without medical justification to the facility for billable visits. They receive one medicaid patient and then require that the entire family go in for medical care. They call that family ganging.

The Commission received sworn testimony from physicians and facility staff indicating that owner/operators—very often lay owner/operators—would leave instructions for patients to be referred amongst the various in-house specialists and pressured physicians to follow instructions. Your own investigators can tell you how they were scheduled by clerical personnel to return to facilities for visits to dermatologists, radiologists, podiatrists and other specialists prior to being examined or even seen by a physician. They also can tell you of the brief amounts of time spent upon them by examining physicians

and you can review for yourselves the office visit charges in excess of $30 for the visit.

You can compare the statements of your own investigators with bills which your investigators were required to sign in blank and which were submitted by New Jersey physicians and find requests for payment for blood which was not drawn, injections which were not given and urinalysis and tine tests which were not performed, and even drugs billed for patients who had been dead for weeks. We know of cases where lay owner/operators have themselves steered patients into the house pharmacy or contacted the associated drugstore by direct phone link to have prescriptions filled and even a case where a lay facility administrator examined and prescribed medication for a female recipient. Our report also outlines the X-ray abuse for charging each time when the eye focuses rather than when the shutter snaps.

Dangerous Corner Cutting

We also found that facility owner/operators try to decrease their own expenses wherever possible. Your own investigators who visited several facilities in New Jersey with our staff will tell you of the filthy premises they often encountered. Our investigative record, which we leave here with you today, will demonstrate instances of potentially dangerous corner cutting through the use of untrained clerical personnel to administer injections and physical therapy treatments which were billed as if physicians actually performed the service.

Medicaid moneys were received unjustly by practitioners who billed the program for office visits when recipients telephoned for prescription renewals. Testimony indicates the decision to renew particular medication was often made by clerical personnel. Practitioners also billed medicaid and insurance companies for services rendered to recipients involved in accidents. In these instances the public paid twice—first in higher insurance premiums and second with tax dollars assigned to medicaid.

One facility and pharmacy in New Jersey which is contained in our report were involved with others in an ingenious scheme designed to maximize personal property. A lay entrepreneur who owned property banded together with a relatively small group of physicians, pharmacists and clinical laboratory operators to form a company which would arrange for laboratory tests to be performed, and repackaged and resold relatively inexpensively generic drugs under its own name. Stockholders included the physicians who would write prescriptions for their corporation's products and lay medical facility owners. For these prescription sales, stockholder equity in the corporation increased. Questions of product quality aside, such a situation raises grave questions of conflict of interest and temptation to overutilize scant medicaid program funds.

One product so administered to that corporation was a tonic which one doctor described as having as much alcohol as Old Grand Dad. Certainly this practice represents a blatant conflict of interest and should be prohibited.

We have also brought along with us a modest example of the prescriptions which were prescribed for your so-called healthy investiga-

tors who visited the State of New Jersey. We brought a modest sampling with us, yet they were billed for many and the prescriptions were never filled.

We have purposefully covered the names of the pharmacies that are involved because we intend to submit our report to the law enforcement agencies of the State of New Jersey for possible criminal prosecution and we thought for the purposes of this hearing we would have the pharmacies' names blanked out. This is a modest example of so-called healthy people being prescribed for medication.

We wish to point out that many of the abuses outlined here today—extensive use of paramedical and even lay personnel for duties which are reimbursable only to physicians, double billing, ping-ponging and family ganging—can be and are being detected by the State Division of Medical Assistance and Health Services through the use of sophisticated computer screens and the time studies. We commend the Division and specifically the Bureau of Medical Care Surveillance for the effectiveness of current methodology. Existing computer program comparison procedures, however, do not uncover abusive practices in each and every case but only when certain factors are present.

Undercover Agents Effective

To further protect the integrity of the program, we recommend that New Jersey and all other States obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. The Commission found that the use of such agents provided a quick, reliable, and efficient method of uncovering practices inconsistent with the aims of the medicaid program. Evidence gathered by such investigators could and should be aggressively used in suspension hearings or passed along for the review of appropriate law enforcement agencies.

At this point I would like to personally thank the members of the Capitol Police and investigators from this committee who assisted our investigators in obtaining some of this information. I would, if I may, take the personal privilege of pointing out that we affectionately call the following—runny nosed Oriol, earache McDew, sneezy Roberts and a-choo Hawes—and thank them for their heroic services in obtaining this medical care when it was not needed and incurring the risk many times of potential overradiation when X-rays were required in a haphazard manner.

We additionally recommend that facilities performing substantial amounts of medicaid work be annually inspected and registered. As a part of the registration procedure, facilities should disclose to administering agencies the names and positions of employees. This information which, of course, should be updated periodically, will prove helpful in detecting use of paraprofessionals in place of physicians. We would also suggest that the administering agencies consider legitimatizing the use of qualified medical paraprofessionals in certain instances. Services rendered by such individuals, however, should be paid at a rate lower than that now designated for physicians.

We also recommend that administering agencies consider the possibility of contracting with an insurance clearing house. Our own experience indicates this to be an effective step in obtaining reliable in-

formation on the presence of sources of medical payments other than the medicaid program.

Lastly, we urge that steps be taken to insure that recipients be made aware of services billed to medicaid on their behalf and be given an opportunity to challenge the accuracy of physician requests for reimbursement. At the very least, a procedure should be instituted and strictly followed requiring recipients to sign only completed, itemized claim forms. We further recommend that recipients be advised of services billed on their behalf, either by a State compiled listing of billings periodically through the year or simply by adding a copy claim form to be given to the recipient by the physician at the time of service as a receipt. We anticipate that costs incurred as a result of the adoption of either of these proposals would be offset by savings realized from more truthful billings. Either procedure would build a sorely needed check and balance into the existing system.

With respect to pharmacies, the Commission is pleased to point out that a major step in reducing program costs was taken by the medicaid division during the pendency of our probe. Under present regulations, generic rather than brand drugs should be prescribed and dispensed whenever possible. Additional steps can be taken to further reduce abuse and unnecessary expenditure of limited program moneys.

Computer Information Needed

The State currently has the computer capability to develop a prescriber profile on medicaid program physicians. This program would analyze prescribing patterns of physicians and display questionable or abusive practices. Unfortunately, the profile is not effectively used because program providers choose not to supply necessary information on claim forms. We recommend that the State assume a tough stance on this issue and reject for payment any claims not containing relevant information.

To facilitate the gathering of information relevant to program integrity, we suggest that a standard medicaid multicopy prescription/claim form be developed. The name of the prescribing physician could be prestamped on the form. The physician should list the medication desired and draw a line immediately under the last item prescribed and personally sign the form. Space can also be provided for the physician to list a substantiating diagnosis. A copy can be kept for the physician's record and the balance forwarded to the pharmacy via the patient for use as a description of drugs to be dispensed and the pharmacist's billing invoice.

Existing program regulations prohibiting the referral of patients to a particular pharmacy by physicians should be broadened to encompass all facility employees and stringently enforced. It should be made clear to all that the physician may not require nor may he recommend that a prescription be filled by a particular pharmacy; nor may his receptionist or any employee do so. Patients who ask must be reminded of their free choice of pharmacy. Any liaison—including direct telephonic connection and common entranceway—between physician and pharmacist should at the very least create a presumption of impropriety and such relationships should be subjected to special scrutiny as to pharmaceutical utilization.

Landlord tenant relationships present perhaps the greatest temptation to over utilize pharmacy services. Even without direct steering by facility staff, patients are usually required to pass the pharmacy entrance to pick up coats or children before arriving at the public street. The in-house pharmacy truly has a captive audience. For this reason, the common entranceway should be prohibited. Moreover, when a physician or landlord owns a pharmacy or has a pharmacy for a tenant, he is induced to take whatever steps are necessary to see that the pharmacy succeeds. Inhouse pharmacies also present opportunity for profit based upon the precise nature of inventory kept and the ability to obtain volume discounts on drugs. We recommend that the State take these savings into consideration along with the fact that inhouse pharmacies primarily—if not exclusively—service patients of the facility and reimburse these pharmacies at a lower institutional pharmacy medicaid rate.

Mr. Chairman and distinguished members of the committee, thank you for your cooperation with the New Jersey State Commission of Investigation in its own probe of the medicaid program and for listening to me today. I will now attempt to answer any questions you may have.

Senator Moss. Thank you very much, Mr. Rodriguez, for your testimony and also for the report that you have provided for the committee, and it is being released just today. This report will be included in our record.[1] This is a very significant document that gives us a viewpoint of what is being done in New Jersey.

How large a staff do you have on S.C.I.?

Mr. RODRIGUEZ. We have approximately 16 investigators, 4 attorneys, 4 accountants, 4 commissioners and an executive director.

Senator Moss. Do you find that staff to be adequate or is that pretty small?

MORE INVESTIGATORS NEEDED

Mr. RODRIGUEZ. Sir, when you have 16 investigators looking into a program of New Jersey that encompasses approximately $400 million, it is really not adequate. The men that we have are extremely qualified men, specially picked. They do a tremendous amount of work in uncovering the abuses in many of our programs. This is not the only investigation that has been conducted over the past 2 years.

Senator Moss. Our staff here tells us of the great cooperation that it received from you in New Jersey and they speak highly of your staff and the work you do. I was under the impression also that the volume of work to be covered was probably more than your personnel is able to cover adequately and that you were probably straining at the limits of what your staff could do.

Mr. RODRIGUEZ. That is very true, sir, because while we were doing the medicaid investigation since 1975 we have reported on one phase of the nursing home and we have reported on the clinical phase, we are reporting on this phase today. We have another report being generated on the capitalization of nursing homes which is another massive abuse. Coming shortly is our report on the hospitals in New Jersey, and we have covered several of the other purveyors.

We keep a continuing eye on the movements of organized crime in New Jersey which is one of our main thrusts, and I think we have

[1] See appendix, p. 599.

received some credit for moving some of the top crime out of the State of New Jersey. We have to maintain a certain amount of our personnel constantly vigilant in other areas. The amount of work they have done, I would like to personally say today in public that is free for the taxpayers of the State of New Jersey and with the assistance of your investigators this will hopefully start a national trend that will save some of these billions that are being ripped off with not 1 cent going to the quality of medical care, it is just rip-off money so I don't like to hear statements of it is defensive medicine that is required. This is quality care money that is now being taken from the poor, it is rip-off money. I think these reports of your investigators clearly indicate that it is an abuse and it should be stopped as quickly as possible.

Senator Moss. Has the degree of cooperation been satisfactory with the State enforcement, legal prosecutors, State attorneys and whoever else does that work?

Mr. RODRIGUEZ. When we submit information to them, many times the results are not forthcoming as quickly as we feel perhaps they might be. I don't believe that there has been a sufficient aggressive management by medical societies of the ethical problems that develop, but by and large New Jersey is or has been taking giant steps in trying to correct the situation, but much has to be done.

Senator Moss. Well, again let me say how very much we appreciate what you have done and what you have brought in to illustrate the type of investigation which was carried on in New Jersey. I think it is one of the bright spots we have uncovered in New Jersey, and Michigan probably will do more in attempting to adequately investigate and police these activities and other States, at least the ones that we are familiar with.

So we want to commend you for that and to offer you our continued cooperation. We hopefully can try to press forward on the Federal level to get better tools to deal with this. Basically law enforcement, this is the local level and it comes to licensing and inspection and criminal procedures so we need to depend on the strong arm of the States with your showing in New Jersey.

Mr. RODRIGUEZ. Thank you, sir.

INDICTMENTS NEEDED

I would like to make one other point that many times our Commission feels through this method of public hearing and disclosing the abuses that it is not necessary for the integrity of the program to obtain an indictment here or there. I think when the proof is there they should be aggressively pursued of the indictment but what is more important is to bring to public light the abuse and the correction so that we don't constantly pay for the mistakes of the past but plug the hole in that pocket.

If we can obtain that objective, then I am willing, as our Commission does many times when it takes testimony and grants witness immunity for obtaining essential information for corrective action, that in the long run the taxpayers gain, and I think that is the main thing that hopefully will come from these hearings, the corrective action immediately, and then let the prosecution follow so that the rules are clear in the future. Then when you find a transgression, you must stamp on it as quickly as possible because it becomes symptomatic.

Senator Moss. Thank you very much. You state the proposition very well and we are pleased to have been able to work with you.

Senator Percy.

Senator PERCY. Mr. Chairman, your testimony today confirms the findings of the subcommittee staff and it is good to have that verification.

Are there any types of medicaid fraud that exist in New York that do not exist in New Jersey?

Mr. RODRIGUEZ. Well, New Jersey did not have the factoring problem that New York had but by and large we find that it is symptomatic. If you find it in New York, you will find it any place you have the medicaid program. Unfortunately I have to make that statement. I don't think we can write off any State that has a large amount of medicaid money flowing to it and say it does not exist in this State. I don't wish to point out New Jersey necessarily as being the culprit but I think we are symptomatic in the problem.

Senator PERCY. Would it be fair to assume that, just like the kickbacks and payoffs in the aircraft industry, what developed to be a part of Lockheed happened to be adopted by various companies, and eventually spread like a cancer through the industry? Is this the kind of thing that is likely—if it starts some place—word is likely to get around that this is the way it is done? Does someone come up to New York and study how it is done so that we really kind of assume that if it exists there in New York and New Jersey, Illinois, California, and Michigan, it probably exists virtually any place in the country where you have large scale expenditures for medicare?

UNCOVERING TECHNIQUES IS KEY

Mr. RODRIGUEZ. I think that is a fair assumption.

Senator PERCY. Finally, has the New Jersey Commission developed any techniques that can effectively curtail medicaid fraud and abuse activities that you could share with the public totally? Have you developed an approach that you think would be helpful and useful to us as we prepare to introduce legislation and offer amendments to it on the floor? Anything you can help us with, either now in your testimony or that you could furnish subsequently to the subcommittee, would be appreciated.

Mr. RODRIQUEZ. First, as part of our statement we do make certain recommendations that we have made this morning to our legislature with respect to this phase of the program but we found, as we did in our clinical blood lab investigation, that there are certain techniques that you can uncover that once you uncover the technique it is only a matter of seeing its application in other phases of the program. The so-called ordering through medicaid, or ordering through a facility the dinner and then charging medicaid a la carte is one of the problems that we find in many areas where they can submit a blood test which we found in our clinical blood lab investigation.

The computer printout would read some 8 to 12 findings and for $3.50 this would be accomplished at one of the laboratories where one of the clinical labs dealing with medicaid would pay the $3.50 and then a la carte the blood test to medicaid and charge 12 times or 8

times. Well, that system we find is also uncovered when I made reference to the X-rays, when they were read each time or billed each time. Look at the right, look at the left, look at the lumbosacral joint. That is three readings when it is actually one plate. They don't charge each time the shutter snaps, they charge each time the eye focuses. So it is a matter of again going to the a la carte method of going to the X-ray plate. I think integrity dictates that when you are dealing with taxpayers money that you give them a little more consideration when you deal with that kind of fund.

I know the reference was made to performance, and we made some reference here when I concluded my testimony, but when I hear Mr. Halamandaris talk about $1.5 billion perhaps being ripped off nationally—in this phase alone New Jersey perhaps had $3 to $4 million ripped off—I think few taxpayers would refuse the Federal Government the thread to sew the hole in the pocket. Unfortunately, these things must be recommended and we recommend a modest example of it here.

Mr. PERCY. Thank you very much, Mr. Rodriguez.

Senator Moss. This has been an exceptionally interesting and revealing morning of testimony and I think all of us understand the problem a little better now.

This will complete our hearings for today. We will meet again at 9:30 in the morning and we hope to be joined by Senator Talmadge and Senator Muskie.

We are now recessed.

[Whereupon, at 1 p.m., the subcommittee recessed, to reconvene at 9:30 a.m., Tuesday, August 31, 1976.]

APPENDIXES

Appendix 1

REPORT OF THE NEW JERSEY STATE COMMISSION OF INVESTIGATION ON THE PRACTICES AND PROCEDURES OF PRACTITIONER GROUPS PARTICIPATING IN THE NEW JERSEY MEDICAID PROGRAM, DATED AUGUST 30, 1976, SUBMITTED BY JOSEPH H. RODRIGUEZ[1]

Introduction and Summary

As part of its evaluative probe of the entire Medicaid program in New Jersey made at the request of Governor Brendan T. Byrne, the New Jersey State Commission of Investigation (S.C.I.) assigned one of three investigative teams to look into the area of health services encompassing providers of other than nursing home and hospital care. Among the major components of this section of the program are dentists and physicians practicing in groups or otherwise associated by virtue of sharing space at a common facility. The practitioner phase of the investigation focused upon the workings of individual medical facilities devoting at least 75% of their practice to Medicaid and bringing in substantial amounts of Medicaid money and the manner in which these facilities are administered by the New Jersey Division of Medical Assistance and Health Services (D.M.A.H.S.).

During the course of this investigation, staff of the Division's small Bureau of Medical Care Surveillance provided valuable assistance to the Commission. We wish to publicly express gratitude to Division Director Gerald Reilly and Surveillance Bureau Chief Boniface Damiano for extending many courtesies and total cooperation. The New Jersey State Commission of Investigation also established a working liaison with the United States Senate Select Committee on Aging which is reviewing the Medicaid program—a program under which Federal and State tax dollars are paid to providers of medical care for necessary services rendered to the indigent—on the National level.

Evidence obtained by the Commission on some twelve sample facilities is not sufficient to dispute statements that only a small minority of practitioner groups receiving substantial Medicaid monies engage in improper or questionable conduct. However, the Commission recognizes that the potential for the abuses outlined in this report is great and accordingly, the Commission is recommending the following steps to promote program integrity, guard against unnecessary utilization and ultimately, conserve State and Federal tax dollars.

The principal thrusts of these recommendations, which are reviewed in some detail subsequently in this report, are:

Promulgation of a scheme to identify and register on an annual basis, medical facilities receiving substantial amounts of Medicaid monies.

Periodic inspection of such facilities for proper procedures and cleanliness.

Outlawing percentage arrangements between facility owner-operators and practitioners.

Establishment of a liaison between the Division of Medical Assistance and Health Services and an insurance clearing house to obtain accurate information on payments made by insurance companies to physicians on behalf of Medicaid recipients.

Addition to the staff of the Bureau of Medical Care Surveillance of undercover agents who would pose as recipients seeking medical cases to ferret out:

[1] See statement, p. 588.

"Ping-ponging": Practice of requiring a patient to see several specialists in the same facility without medical need.

"Family-ganging": Practice under which covered family members are seen by facility personnel without initially requesting care.

"Churning": Practice of unnecessarily requiring patients to come to a facility for billable visits.

"Steering": Practice of directing patients to specific specialists or pharmacies.

Use of para-professionals; requirements to sign claim forms in blank.

Notification to recipients of services billed by physicians.

Require that physicians and radiologists justify the need for radiology procedures and holding both the requesting physician and radiologist separately and equally responsible for assuring that all requested procedures are consistent with the patient's diagnosis.

Outlaw direct telephonic links and common entranceways between medical facilities and pharmacies.

Reduction in Medicaid reimbursement rates to pharmacies sharing space in medical facilities.

Enforcement of State statutes prohibiting lay personnel from participating in the practice of medicine.

Medicaid Group Practice—Characteristics of New Jersey Mills

In connection with its evaluation of New Jersey's Medicaid Program, the Commission determined to examine the professional group-pharmacy aspect component for possible abuse. Scrutiny was centered upon the practices and procedures of relatively large dental and physician groups, their relationships with other providers of medical care and services—especially pharmacies—and the adequacy of existing regulations and integrity monitoring methods utilized by the Division of Medical Assistance and Health Services (D.M.A.H.S.).

The Commission focused upon recognized professional groups, "professional centers" housing various unassociated tenant practitioners and offices of single practitioners in which other physicians would regularly share space in either an employee or independent contractor capacity. More than twelve facilities across the State—each having at least a 75% volume of welfare patients and bringing in substantial Medicaid monies yearly—were examined. Books and records were reviewed, offices were visited by investigators posing as patients, and sworn testimony was taken from practioners, facility employees, Medicaid recipients and program administrators.

The facilities reviewed were located in poverty areas—Camden, Hoboken, Irvington, Jersey City, Newark, Passaic and Paterson—and housed in places such as welfare project high-rise buildings, converted stores, warehouses and tenements. Typically, the facilities were divided into a reception area for patients—some of which were equipped with rows of theater-type seats consistent with mass production technique—and several smaller compartments used for patient examination, X-ray services and laboratory services. Several locations also contained in-house pharmacies.

Each facility had an owner or the equivalent of a business manager to supervise the day-to-day running of the operation, hire and fire physician, nursing and clerical staff, and arrange liaison with out-of-house specialists and suppliers of goods and services. In many cases, the owner of business manager was a layman.

Arrangements are made between owner or administrator and physicians who desire to practice at the facility. In the main, staff practitioners were comprised of foreign physicians and recent graduates anxious to put together enough capital to open their own practice elsewhere. As one doctor told us of plans to stay at a medical center:

> I don't think I'd want to be involved with something so fly-by-night. My main attention is for my private practice, and when it's built up enough, this is where I want to be, in my private practice.
>
> Q. In the Passaic area you mean?
>
> A. No, in Englewood.

In earlier years (1971–1973) many facilities paid staff physicians a straight salary averaging only $15.00 per hour regardless of the number of patients seen or amount of services billed to Medicaid. A pharmacist who owned part of two facilities described early salary arrangements:

> Q. With reference to the salary arrangements at * * * Medical Center and when it was existing at the * * * Medical Center, were doctors permitted to bill, if you know? Were doctors permitted to bill Medicaid, for

instance, for services they performed, or would those monies accrue to the medical center?

A. Well, I'm—I'm sure that doctors filled out their forms and submitted it, but I'm quite sure the monies or the checks coming in from Medicaid or Medicare, whatever, were made out to * * * Medical Center. If that's what you're asking.

Q. Yes. Okay. In other words, what I'm really wondering is, did the doctors get anything more than $15 an hour?

A. No.

Salary arrangements between facility operators and staff practitioners declined because of a fear that such arrangements might subject facilities to the licensing and cost review requirements of the Health Care Facilities Planning Act, *N.J.S.A.* 26:2H–1, *et seq.* A center owner described the strategy:

Q. Do you know how the Doctors and other personnel at the center were hired?

A. When we first took over there was a salary basis. But then there seemed to creep up this certificate of need and we went to two meetings and it seemed as though if you were going to be an organization that hired physicians or opened a medical installation, you had to attain this certificate of need.

Q. From the Health Department?

A. Right. Well, being a nonprofessional. And at this meeting it became evident that they didn't like the idea of nonprofessionals in the medical business, so you had to either go—that idea was canned as far as salary, if you wanted to continue it, and at this point being involved financially I thought we would have to find another way. Then we decided to rent the premises to physicians and that's what we did. We rented the area to physicians.

Arrangements shifted to "rental" or "partnership" agreements based upon a percentage of the fees earned by the practitioner. The Commission identified specific relationships under which the amount kept by the practitioners varied from as little as 30% to as much as 70% less $100. On the average, practitioners involved in such arrangements turned over 40 to 50% of their earnings to facility operators or landlords. Typical negotiations with a lay landlord owner were described by a physician:

Q. Do you recall the substance of that interview; the offer, if any, that he would have made to you?

A. Well, he asked, you know—I told him that at the time I was looking for a job and I was going, you know—I would be interested in working in the clinic and he said he was looking for a general practitioner for his clinic and if I was interested, you know, I could—you could—you know, I could start working at his clinic on the exact day of opening. It was set at the time.

Q. And did you indicate to him that you were interested?

A. Well, I was interested very much to stay in that area because I had a lot of my own patients from * * * that I knew would follow me, and I didn't really want to move out of the area which was acceptable to all of my patients buswise and areawise and at the time I didn't feel very secure to—by myself, to open an office in the Newark area at that area where it was. So I felt it was a very good deal for me. I would still be seeing my patients; I would be in the same location and at the same time I had the security that I wasn't alone * * * practicing in, you know, in an area of Newark that is not really very safe.

Q. Did Mr. * * * suggest some type of financial arrangement or salary to you at your meeting with him?

A. Yes, we discussed that too.

Q. Can you give us the terms of the financial arrangements.

A. Yes. We discussed, and in his terms, I was to bring my knowledge and my stethoscope and he would provide me with space and telephone service, and, you know, all medication, nurses, secretarial work, everything, and so for that he would charge me a definite amount of fee.

Q. What was the definite amount of fee? Was it a percentage?

A. Well, the fee was—yes, it was 50 percent.

Q. How would the 50 percent reach Mr. * * *? Would you have to write a check or would he write a check to you after certain deductions would have been made?

A. I was to write him a check.

Q. Would you bill Medicaid under your own name?
A. Yes, sir, I billed Medicaid in my own name.
Q. Then after you received a check from Medicaid.
A. Yes.
Q. —would you then just take half that?
A. Yes. I would write him a check for half of the amount that was paid to me.
Q. Did Mr. * * * require any type of proof from you as to the amount of money that Medicaid had paid you?
A. All the billing that came to—through * * * and there was a secretary——
Q. I see.
A. —who kept track of it.

The presence of the operator-owner's secretary to keep a watchful eye on billings was not at all uncommon.

Facility administrators contend that the high percentage return to the center is justified by the space utilized by staff practitioners—including all common areas—and expenses including salary of nursing and secretarial personnel as well as other operating costs. The Commission recognizes that certain expenses are indeed borne by the facility, but suggests that economies of scale accruing to large facilities should lessen the necessity of high percentage arrangements. We believe that these percentage arrangements lead to unreasonable profit for facility owner/operators and foster abuses which will be detailed later in this report.

More recently, arrangements between facilities and staff have involved fixed payments which increase with growth of practice. At one facility, a lay owner-operator charged a specialist $500 per month. On its face, the fee did not appear high. The physician went on to testify that he was present at the facility only two days a week.

Q. Can you tell us who the principals in the * * * Medical Center might be?
A. Mr. * * *.
Q. Could you classify him as owner or an operator or——
A. He's owner of the building, I think. I don't know. He owns * * * Medical Center. That's his.
Q. Is there one physician who might be in residence at the * * * Medical Center more than anyone else?
A. I can't answer. I'm there two days.
Q. Is there a physician who might be a director of the center?
A. No.
Q. No. Would you know which physician might be at the center more than two days?
A. I don't think anybody is.
Q. How much rent do you pay to the * * * Medical Center?
A. * * * and I worked out an arrangement that I have to pay the equivalent of $500 a month.

As the physician indicated, he was not the only physician who practiced at the center on a part-time basis. The Commission questioned the owner-operator about his costs and other arrangements at the center. It came to light that he leased the entire building for only $225 per month and had "arrangements" returning much more:

Q. You're paying $225 a month for the floor to * * *?
A. Right, sir.
Q. How much rental do you get? Or any company that you are principal in, what do they get in rent a month?
A. Several thousand dollars. I can't give you an exact number.
Q. So you're taking in several thousand dollars a month as a landlord, correct?
A. Right, sir.

At another facility, a building was leased for $500 per month by a physician. He himself practiced there, and sublet space to dentists for $200 per month and to a physician specialist for $550 per *week.*

At yet another center, physicians paid the lay-owner operator a weekly fee.

Q. How do you determine how much rent a particular doctor in one of your offices should pay?
A. Well, they are—the full time doctors, they paid $300, you know.

Q. Is that a month or a week?

A. This is a week. It depends upon also the medicines and supplies that they use.

Q. So it would be like a flat fee plus the cost of whatever materials they use; is that right?

A. Yes.

Pharmacies also have arrangements with medical facilities. At one medical group, a pharmacy paid in excess of $1050 per month rent for some 225 square feet of space. It is significant to note that the rental increased from $550 to $850 to its present amount within two years and without any concomitant increase in space.

Several of these facilities were visited by investigators from the State Commission of Investigation and the United States Senate Special Committee on Aging. In many cases, investigators reported filthy conditions and questionable and fraudulent practices by employees which will be detailed throughout this report. Our experience with these facilities, as partly set out in this document, demonstrates the need for a new approach by the Division of Medical Assistance and Health Services.

Initially, we recommend that facilities receiving substantial Medicaid monies and having several staff practitioners be identified, registered and periodically inspected for proper procedures and cleanliness. We believe that the Division of Medical Assistance and Health Services presently has power to promulgate an administrative scheme to accomplish this purpose. During the course of the Commission's investigation the Division drafted such a scheme and we add our support to it. We suggest, however, that a more effective solution might be to amend existing State health facility licensing law (*N.J.S.A.*26:2H–1 *et seq.*)—the very law which facility operators now seek to evade—to provide for Health Department jurisdiction irrespective of the nature of the financial arrangements between owner-operators and staff over these facilities which receive substantial amounts of taxpayer dollars. We note that such a statutory amendment would also place in the Health Department power to review and set reasonable rates of reimbursement for these facilities which, hopefully, would be more in keeping with the goals of a public welfare program rather than private profit motive.

Percentage arrangements in a Medicaid setting should be outlawed. As this report will indicate, they are incompatible with the goal of providing quality care to recipients at reasonable cost to taxpayers. Such arrangements foster and incite over-utilization of services, ping-ponging, family ganging and churning. It is unrealistic to expect practitioners to practice fiscal restraint when salary is dependent upon the amount billed.

We further urge that an identification system be developed to indicate on the claim form which specific practitioner rendered service to the recipient and the precise location where the service was rendered. Such information—which is not now readily available—will provide program surveillance personnel with easy access to accurate information on monies flowing through particular locations and facilitate detection of ping ponging, and family ganging.

It will also track Medicaid Doctors who wander from facility to facility. The Commission discovered one physician who visited three facilities in different cities a week. Such a practice raises serious questions about continuity of care and treating physician availability to patients.

The testimony also raises serious questions about possible violations of the Professional Practices Act (*N.J.S.A.*45:9–1 *et seq.*) by facility lay owner-operators who share in the profits of facility associated physicians. The Commission will forward a copy of its investigative record to the State Board of Medical Examiners for consideration of this and other issues.

Affiliated Radiology Services

Once the treating physician determines radiologic services are necessary, a requisition specifying the X-ray procedure desired is drawn. The service may be rendered in one of several ways: The patient can be referred to a specific radiologist or hospital facility; the X-rays can be taken, developed and "read" by a radiologist member of the group using his own equipment and personnel; films can be taken on the group's equipment by a technician paid by the group and interpreted by the radiologist whose office may be located off the group's premises.

Ideally, in this latter situation, the radiologist will closely supervise the work of the X-ray technician and will himself perform (or be present for) more esoteric

procedures. During the course of the investigation, however, the Commission discovered one instance where a radiologist receiving in excess of $118,000 of Medicaid funds between 1972 and 1975 was employed full time at a New York hospital. Despite the fact that Medicaid claim forms signed in his name represented that the radiologic services, including intravenous pyleography, mammography and tomography, "were personally rendered" by him or by a qualified individual in his actual presence, office employees—including the X-ray technician—saw him only once or twice over the years. In the absence of the radiologist, numerous X-rays of questionable medical value were ordered by office physicians and taken by the technician. The radiologist could only review medical necessity on an after the fact basis and, according to the X-ray technician, would question the number of films taken on individual patients:

Q. All right; but what would he say, for instance?
A. Why was an X-ray taken? Or, why was this taken?
Q. He would ask you?
A. Yes.
Q. Would he ask anyone else?
A. No.
Q. Did he sound sort of complaining when he would ask you?
A. I don't know what you mean, complaining.
Q. Well—
A. That I shouldn't do it?
Q. Yes.
A. I don't know. He would ask me why did I take it.
Q. I'm sorry. I missed the last part of that.
A. He would ask me why did I take it.
Q. Okay. And you would say what?
A. Because I was told to take it.

The testimony raises serious questions about the quality of care received by office Medicaid patients in this highly sensitive and potentially dangerous area of health care delivery. The record also raises questions about the conduct of certain physicians which appears to transgress basic standards of medical ethics in practice, issues which are beyond the scope of this report.

At another facility, with the radiologist located in a nearby city, evidence exists that unqualified persons were permitted to take X-rays. Rather than hire a licensed X-ray technician, the lay group administrator allegedly instructed a licensed practical nurse (LPN) to take films. If questioned by authorities concerning X-ray procedures, group personnel were supposedly rehearsed to claim that the LPN only positioned the patient and that a physician actually "pushed the button". Questions concerning these allegations to a physician-partner of the group drew the following responses:

EXAMINATION BY COMMISSIONER LUCAS

Q. During your stay at * * * Health Group was there an employee of the health group by the name of Sonia?
A. Yes.
Q. And do you know how long Sonia was with the group?
A. I'd say about a year.
Q. All right. Do you know what her duties were; that is, were they administrative as opposed to medical?
A. I plead the Fifth and Fourteenth Amendments.
Q. Did Sonia dress in the garb of a nurse?
A. I plead the Fifth and Fourteenth Amendments.
Q. Do you recall if Sonia dressed in the garb of a lay person in the office of a doctor?
A. I plead the Fifth and Fourteenth.

* * * * * * *

Q. All right. Now, in the spring of 1974 was there an X-ray technician—strike that.
In the spring of 1974 was there a young lady at the * * * Health Group by the name of Sonia, who would take X-rays?
[Whereupon, the witness confers with counsel.]
A. I plead the Fifth and Fourteenth Amendments.
Q. Do you know if—strike that.
Do you know whether or not Sonia was a certified X-ray technician?
A. I plead the Fifth and Fourteenth.

Q. Did you ever hear * * * instruct physicians to say that they, the physicians, rather than Sonia took X-rays if anyone should ask?

A. I plead the Fifth and Fourteenth Amendments.

After the group obtained the services of a licensed technician, problems again developed when the facility's lay administrator himself allegedly took X-rays. The physician-partner again raised constitutional privileges when asked if it was ever brought to her attention that the administrator may have taken X-rays. The administrator denied taking X-rays but acknowledged that he could position patients and develop X-rays for a physician who would "push the button".

Radiologists associated with Medicaid Mills, like other practitioners, often work on a percentage fee arrangement. The Commission commonly found group associated radiologists keeping only between 35–40% of Medicaid dollars paid for radiology services with the balance flowing to the facility. Other situations were encountered in which the radiologist would pay the group a lower fixed percentage of his fees plus a monthly rental. (30% of fees plus $100/month is one example of this type arrangement.)

In any percentage relationship, incentive exists to increase dollars received by increasing volume of work performed. The radiologist can maximize his income by billing for as many procedures as possible on each patient. The group can maximize its earnings by supplying as many patients as possible to the radiologist through the practice of "ping-ponging". These temptations often materialize in pressure exerted upon group physicians to order unnecessary X-rays for their patients and radiologists engaging in "creative billing"—billing based upon the number of readings rather than the number of anatomic areas filmed—and false billing for services not performed.

In one mill administered by a layman, a pediatrician preferred to use the services of a radiologist in whom she had "tremendous confidence" rather than the radiologist associated with the facility. The landlord-administrator chided the pediatrician for referring patients to outsiders and suggested that the Mill's radiologist—who paid the landlord a percentage of his fees plus a fixed amount monthly—should be utilized.

Q. Did Mr. * * * ever tell you why he wanted you to use Dr. * * * rather than another radiologist who might be outside the group?

A. He felt that the medical center would make more money if we used our own and he installed the machines and went into the expense to put everything, that we should utilize what we have in the clinic.

At another group where the radiologists received 40% of the Medicaid fees for radiology services, a physician complained the lay administrator would approach him with respect to specific patients and ask, "You're going to order X-rays, aren't you?" On other occasions he was chastised by a physician partner for allowing a patient to have X-ray services performed at a near-by hospital rather than at the group.

* * * * * * *

I remember the incident, Dr. * * * called me aside and said to me, "Why did the patient have the X-rays done at St. Michael's?" I don't remember if it was an upper G.I. series. It possibly was and/or a chest X-ray. But I was taken aback by her and I said, "* * *." I said, "the form that I used for the requisition for the X-ray for the patient was to have it taken at the office of a radiologist, and the hospital has a very similar requisition and the patient can go any place he wants for that X-ray." She says, "Well, we offer the service here. Why didn't you have it done here?" I said, "* * *, the patient had the X-ray done at St. Michael's. I'm only interested that the patient had the X-ray procedure done, not where she had it done." But she was very, very angry with me and I controlled myself * * *

* * * * * * *

When questioned about pressures exerted by the lay group administrator on physicians to take numerous X-rays, a physician partner responded:

* * * * * * *

Did Mr. * * * ever suggest to you that you yourself should order a certain number of X-rays on your patients?

[Whereupon, the witness confers with counsel.]

A. I respectfully plead the Fifth and Fourteenth Amendments and decline to answer the question on the ground that the answer may tend to incriminate me.

The CHAIRMAN. Doctor, in the event we have occasion to rely on those privileges again, the record will indicate the complete context of your statement, but you would simply have to say you plead the Fifth and Fourteenth Amendments. All right? Instead of going through the entire process.

The WITNESS. Fine.

Q. Doctor, are you aware of any advice or suggestions that Mr. * * * may have given to other physicians at the * * * Health Group concerning the number of X-rays they should order for their patients?

A. I plead the Fifth and Fourteenth Amendments.

* * * * * * * *

The radiologist associated with the group maximized his percentage earnings by billing Medicaid for an additional esophogram whenever the group X-ray technician would perform an upper G.I. series and even though the treating physician would not request such a procedure. The X-ray technician testified that he only took films for an upper G.I. series and forwarded a Medicaid claim form to the radiologist which billed only for the procedures he actually performed:

A. I would do a GI series and that would be all. And then one morning I noticed the forms were on the counter and then underneath it, the GI series, and in another person's handwriting "and esophagus," and it had a certain amount of money written on the side.

Q. So "and esophagus" was added in?

A. Right.

Q. You didn't do anything to the esophagus?

A. No.

Q. Right?

A. No.

Q. Who signed the form, do you know?

A. Dr. * * * [the radiologist].

Q. Are you sure?

A. Yes.

Q. Were the words "and esophagus" written in the same color pen as Doctor * * * (radiologist) signature? Did you notice that?

A. Right, yes.

Q. It was. All right. How many times did this happen, often?

A. On practically every G.I. series.

This technician was also instructed by the radiologist to take films other than those requested by the treating physician:

Q. Okay. Did anyone ever tell you or suggest to you that, as the X-ray technician, you should do more X-rays than the X-rays requested by the physician?

A. Right, Doctor * * * [radiologist].

Q. Doctor * * * [radiologist]. What did Dr. * * * say?

A. Doctor * * * requested that if it was a finger, that I would do a full hand on the frame.

Q. Did he tell you why you should do a full hand?

A. No.

Q. He just said do it?

A. Right.

Q. And this is even though the prescription or the written request that you would get from the doctor requesting the X-ray would say the finger?

A. Right.

Q. What would you do, the finger or the full hands?

A. I would do the full hand.

Q. Any other particulars, such as a foot, ankle?

The WITNESS. Yeah. He said if it was an ankle I was to do a foot and ankle.

Q. Right. In other words, if the request said please X-ray right hip—

A. I was to do both hips.

Q. In other words, if the request said please X-ray right hip, you would do both hips?

A. Both hips.

Q. Do you know why doctor would make that request—Doctor * * * [radiologist]?

A. Just for a comparison. But most comparison studies are done between children under sixteen.

Q. And you say children under sixteen. Were most of these hips X-rays taken of children?

A. Not really.

When questioned concerning the practice of the affiliated radiologist to engage in "creative billing", the physician partner invoked the Fifth Amendment.

Steps can be taken to safeguard the program from overutilization of X-ray services and "creative billing". Primary physicians requesting radiologic procedures should be required to document *clearly* the medical necessity of such procedures in the patient's chart. The requesting physician should then specify the precise X-ray procedure desired on a multi-copy combination Medicaid X-ray requisition claim form. A line should be drawn under the last test required and immediately thereunder the requesting physician should list the diagnosis and "rule-outs" for the benefit of the consulting radiologist and Medicaid surveillance personnel. The requesting physician should then personally sign the form and forward it to the radiology consultant for use as a description of services to be rendered and as his own program billing invoice. Both the requesting physician and the radiologist should be separately and equally responsible for assuring that all requested procedures are consistent with the patient's diagnosis. If a radiologist believes that services requested should be modified, extended, or rejected, he should be required to consult with the requesting physician. Claims not submitted in complete accord with the above procedure, should be rejected by the processing agent.

Steps should be taken to make it clear to providers that radiology billing should be based on the number of anatomic areas filmed rather than on the number of readings. While for example, a pelvic film allows interpretation of multiple anatomic segments, a radiologist should not bill for readings of "right hip," "left hip", "pelvic", lumbosacral spine", etc. Only the minimum number of views necessary to delineate anatomic pathology should be taken.

The Commission also suggests that the Division of Medical Assistance and Health Services give serious consideration to the amount and method of reimbursement to program radiological providers. The fact that many providers are willing to accept 35–40% of the present Medicaid fee itself suggests that the fee may be high. 60–65% of that fee, or the portion taken by the group, may contain excess profit in addition to monies sufficient to cover costs related to radiological procedures. The Division may well decide to adopt a method similar to that now utilized by New York City whereby one fee is paid to the radiologist for X-ray interpretation and another to the entity which owns and operates the equipment.

Not Getting Our Money's Worth

The Commission's investigation disclosed a number of practices used by physicians to maximize unfairly the amount of Medicaid reimbursement they receve. Many of these practices contravene the requirement (*N.J.A.C.* 10:54–1.1) that reimbursable services be rendered by the physician or in his actual presence:

"Physician's services" means those services provided within the scope of practice of the profession as defined by the Laws of New Jersey, or if in practice in another state by the laws of that state, by or under the direct personal supervision of an individual licensed by the State of New Jersey to practice medicine or osteopathy. It includes services furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere. Direct personal supervision means that the services must be rendered in the physician's presence.

One method of maximizing Medicaid income is to disguise non-reimbursable treatment through the use of codes applicable to reimbursable procedures. Medicaid pays for physical therapy under certain conditions. Payments are not made for "physical medicine procedures administered by a physician, or physical therapy which is purely palliative such as the application of heat *per se* in any form, massage, routine calisthenics or group exercises, assistance in any actiivty or use of a simple mechanical device not requiring the special skill of a qualified physical therapist." *N.J.A.C.* 10:54–1.7.

At one facility, patients were scheduled to come in for diathermy, hydroculator and electric muscle stimulator (E.M.S.) treatments at a time when the physician was not in the office. A facility clerical employee who operated the equipment testified as follows:

Q. I see. Now, would you run this EMS and hot pack machine when Dr. * * * was not in the office?

A. Sure. That's when we used it. We used it mostly in the morning because when he came in he had patients to see, and, you know, if we had a

patient in there taking treatment it would tie the room up and we needed the room. So we advised most of the patients to come in the morning for their treatment.

Q. I see. What about the EKG. Now, was this another situation where an EKG would be taken in the morning when Dr. * * * would be absent?

A. Yes.

Q. Was that standard procedure?

A. Yes, because it took time and it was also done in the same room and that took time to do also.

Q. Is all this equipment that we are talking about located in the one room?

A. Yes.

Q. And is this room also used for the examination of patients?

A. Yes.

Q. I see. So that any patients who would require treatments from these various electronic devices would be handled in the morning?

A. Yes, because if they came when he was seeing patients they would tie up that room for like ten or fifteen minutes and we only have four examination rooms to work with.

The clerical employee often "treated" as many as 30 patients per day out of the physician's presence.

Medicaid claim forms were submitted for these services in the name of the physician. The services rendered were described as "prolonged office visit" and processed for payment by the fiscal intermediary. The facility's registered nurse, who handled much of the Medicaid billing, testified as follows:

Q. When would you write prolonged office visit?

A. Whenever we give a physical therapy treatment.

Q. But, again, the physical therapy treatment might be diathermy?

A. Diathermy, EMS, EMS and hot packs, hot packs.

Q. So in your own mind were all these words and descriptions synonymous, they all meant the same?

A. No, because the diathermy machine is a different machine than the electro—electro-muscle stimulator machine.

The WITNESS. Did you get that lisp in there?

Q. No. But the prolonged office visit category, okay, would be used sometimes at least when physical therapy services would be rendered?

A. Would be used all the time when physical therapy service is rendered.

Q. All the time?

A. Yes.

The women who operated the physical therapy equipment and also gave injections, had no medical training. One of them testified concerning her background as follows:

Q. Are you a registered nurse?

A. No.

Q. Are you an L.P.N. or practical nurse?

A. No.

Q. Do you have any kind of training in the medical field?

A. I'm a medical secretary by training.

Q. And where were you trained?

A. Lyon's Educational Center, 900 Broad Street, Newark, New Jersey.

Q. And how long did you attend Lyon's? How long did you study there?

A. It was a year.

Q. Did you receive some sort of certificate—

A. Yes.

Q. —or diploma?

A. Yes, a thousand hours.

Q. And generally what kind of training did you receive there? What did they teach you?

A. Well, medical terminology. I had shorthand already in school, so I had shorthand, medical office procedures. I had typing. I imagine that's about it. English.

Q. Did you learn to operate any type of office equipment at Lyon's, any medical equipment?

A. No.

Q. Like a diathermy machine?

A. No.

Q. Did you learn how to give injections at Lyon's?

A. No.

Q. Did you learn how to take blood from a patient at Lyon's?
A. No.

She went on to detail the methods she used to give electric muscle stimulation treatments:

Q. What's a EMS and hot packs?
A. Electrical muscle stimulation. That was part of that machine. It was just like—I never knew heads or tails what it did. I was just told that's the way I had to do it. You just put the lotion on and you just iron; give him certain amount of watts. You ask him if he feels it. If he feel it, then you just leave him there and iron him for ten minutes. Just rub him back and forth.
Q. And did Dr. * * * leave you instructions as to what degree of voltage you should use with each patient?
A. Well, he showed me a couple of times and he said you would normally leave it on—like it was just a knob and it has numbers from one through eight, and like I used to put it midway, somewhere between four, five and six, you know, unless the patient said it was too much. Then I would turn it down. That's all.

One must seriously question the quality and value of these services.

Another abuse involved billing Medicaid for injections administered by a nurse or clerical assistant rather than the physician under the guise of an office visit. A registered nurse testified as follows:

Q. You mentioned earlier you gave injections, right?
A. Yes.
Q. Suppose the patient came in for an injection and you actually gave the injection. Would you fill out a Medicaid form——
A. Yes.
Q. [Continuing]. If the patient were a Medicaid patient? All right. And would you sign it in Doctor * * * name?
A. Yes. When a patient comes in for an injection and walks in the door, it's an injection that Doctor * * * has said, "Mrs. Jones, you come here each week for an Imferon injection each week and she comes for an injection.

The nurse claimed that in addition to giving the injection, she would check the patient's weight and blood pressure and ask questions about general well-being. Again, the services billed were not rendered by the physician although claims were submitted in his name.

Medicaid was also billed for office visits when patients telephoned the facility for prescription renewals. Often the decision to renew the medication would not even be made by a physician but by a nurse or clerical assistant. The nurse explained her procedure when a call from a patient was referred to her by the receptionist:

Q. Suppose she gave it to you, what would you do?
A. I check the patient's chart.
Q. Then what would you do?
A. See when her last visit was. If it was somebody who I was familiar with and her medications were normally renewed, they would be renewed. If it was somebody I was not familiar with or if she hadn't been there for a long time, I'd have her come in or I would hand it over to Dr. * * *.

In addition to the nurse, clerical personnel in the office renewed prescriptions. Instructions from the physician called for a Medicaid claim to be submitted in these situations. The medical secretary testified as follows:

A. Yeah. A lot of times I would go ahead and refill it and I would tell the patient, you know, you would have to come in and see Doctor some time this week.
Q. Okay.
A. Nine out of ten they would never show.
Q. What would happen as far as someone filling out a Medicaid form based upon my telephone call?
A. You see, I never did it. But it has——
Q. Would (the nurse)?
A. Yes.
Q. Well, what were her procedures? Would you make a list?
A. Doctor would tell—if Doctor was there and I told him a patient called and wanted meds renewed and I renewed it already, he had said get a form

and fill it out. Any one of us could do that. Just fill out the top part, the name and Medicaid number. We would hand it over to him or (the nurse) and they would take it from there.

* * * * * * *

Q. But the Medicaid form that's filled out is based upon the telephone call?

A. Right.

Q. Right. Not the patient coming in to see the Doctor?

A. Right.

Q. Right, Okay. Do you know what procedure code—you know what a procedure code is——

A. Yeah.

Q. [Continuing]. in Medicaid?

A. Um-hum.

Q. Do you know what procedure code is placed in or on that Medicaid form?

A. Triple o-one.

Q. Triple o-one means what to you?

A. Just a regular office visit.

A related problem involved instructions giving by facility employees to patients who would call in for prescription renewals. The receptionist described her procedures which were geared to getting the patient into the office for a billable visit:

Q. Have you ever answered the phone and gotten people on the other end who want to renew their prescriptions?

A. Yes.

Q. Well, what did you do? What is your procedure when that happens?

A. Well, I usually tell them to come down and talk to Dr. * * * about it.

Q. You ask them to come in in person?

A. Yeah.

Q. What would you say to them? Suppose I were the patient. What would you say to me?

A. Well, say, you know, you better come down to the office and bring your bottles, you know, the empty bottles and talk to him. If he can renew it, then he'll give it to you. If not, you know, whatever he says.

This is one example of techniques which we label as "churning" or unnecessarily requiring patients to come into a facility for a billable visit. A medical secretary at one facility described another technique:

Q. Was there any practice or procedure that you were aware of on the part of the doctor or anyone else in the office acting under his instructions to get patients to come back on any type of a regular basis?

A. I don't understand what you mean.

Q. Well, for instance, did Dr. * * * ever instruct you or the receptionist or any other persons working in the office to instruct the patients to return next week or the week after——

A. Yes, me.

Q. [Continuing]. to—all right. How would that work? What would his instructions be like?

A. Well, he would see a patient and say the patient had a cold, So he would say tell her I would want to see her Wednesday or Thursday. If they came in on Monday, tell her to come back Wednesday or Thursday to see me.

Q. And would the doctor actually examine these patients when they came back the second time?

A. He would come in and say, you know, "How do you feel?" you know, "How's the medicine working?" And they would say, "Okay." He would say, "Finish up your medicine and come back and see me again." That's what he would say.

Q. So he would want them to come back a third time?

A. Yeah. A lot of them came back three times a week.

Q. Three times a week?

A. (The witness nods her head.)

Q. What would happen the third time?

A. The same thing. He would come in and say, "How do you feel?" You know, "Cold all gone?" and they would say "Yeah." "Okay. Take it easy." And that was it.

Q. Okay. But there wouldn't be any further physical examination?
A. No.
Q. On his part?
A. No.

Another abuse involved billing medicaid *and* an insurance company for services rendered to recipients in connection with auto accidents or workmen's compensation claims. Medicaid claim forms presently ask the following questions:

8. Was patient's illness or injury connected with his employment? Yes/No
If yes, give name and address of employer here.

10. Did injury result from automobile accident? Yes/No

The fiscal intermediaries depend on accurate and truthful responses to these questions in determining whether treatment for certain conditions is reimbursable under the program. At one facility, these sections purposefully would be left blank. The fiscal intermediary processed the claims in this condition rather than rejecting them, and Medicaid was billed and paid for services which would also be billed and paid by an insurance company. The medical assistant/secretary testified as follows:

Q. Do you know of any instances where patients who were involved in accidents received payments from the insurance company or an insurance company and some of these payments from the insurance company went to Dr. * * *?
A. Yes.
Q. But Medicaid was also billed for services that Dr. * * * rendered to these patients?
A. Yes.
Q. What can you tell us about that type of a situation? How would that work?
A. Well, that patient—we had an invoice card on the patients. So whenever they came in, we would put down the date and at the end of the twenty-five or thirty treatments, you know, the secretary would type the bill up and send it into the lawyer. Meanwhile, if they were on Medicaid, we still had to fill out a form and submit the form to Medicaid. That's all.
Q. Do you recall any specific names of patients where this happened?
A. Yes.

Because of this rule, Medicaid monies could not only be paid to the physician, but also to pharmacies, laboratories and other providers of care.

The Division should take a hard stand with respect to this double billing. Any physician submitting claims to Medicaid who also claims reimbursement for identical services from another third party payer should be immediately and permanently suspended from the program.

We further suggest that appropriate State and Federal agencies consider such conduct in connection with possible actions against professional licenses and criminal sanctions.

Rather than relying upon the accuracy of information provided on the claim sheets or the good faith of hospitals or physicians in notifying Medicaid of any inquiries indicating the existence of an insurance claim, we suggest that the Division consider establishing a liaison with a local insurance clearing house. During the course of the investigation the Commission subpoenaed one such clearing house for information relevant to Medicaid recipients treated by suspect physicians for "trauma." The clearing house was quickly able to provide details of treatment and insurance company payments for which Medicaid was also billed.

Other common abuses include ping-ponging—the practice whereby a Medicaid recipient will be seen by many or all practitioners in a clinic, and family ganging—the practice under which covered family members of the patient are seen by facility personnel without initially requesting medical care. "Family ganging" often occurs when small children accompany a "Medicaid mom" to a facility.

A medical secretary described the procedure at one office:

Q. All right. Did Dr. * * * himself or did Dr. * * * instruct personnel in his office to try to get patients to bring their children in to him?
A. Well, no. He would ask the patient when they were there—you know, if the mother had the child with her, he would, you know, ask her if, you know, the child had all his baby shots. That's what he hit them with most, the baby shot bit. And she would say no or something and he would say get a form, fill out a chart and then we would start with the baby.

Q. And the mother would return with the baby to get the shots?
A. Um-hum.
Q. And who would give the shots?
A. Me.
Q. You would. Would the Doctor see the baby?
A. No, not unless the baby was sick.

At one facility, ping-ponging to the Dentist-tenant was common.

Q. And do you know who would, if anyone, make suggestions to the patients that the dentist be seen?
A. Usually Dr. * * *.
Q. Did he ever make that suggestion in front of you?
A. Yes.
Q. What would he say?
A. Your teeth look bad. I want you to see the dentist.
Q. And would he then escort them to the dentist's office?
A. Yes, most of the times he would.

Another employee corroborated ping-ponging to the dentists:

Q. Were there any other medical personnel associated with Dr. * * *? How about dentists?
A. Dr. * * * and Dr. * * *.
Q. All right. And would they come to Dr. * * * office?
A. The office was right behind us. All we had to do is walk through a hall.
Q. And were these two dentists in every day?
A. Yes, well, they would take turns.
Q. I see. One of them would be present every day?
A. Yeah.
Q. And how did Dr. * * * refer people to the dentist? Strike that question. Did Dr. * * * refer his patients to the dentists?
A. Yes.
Q. How would that happen?
Q. He would look at their mouths, you know, and like he would just ask them, "When was the last time you saw a dentist?" And he would send them right over to them.
Q. Would this be the same day that Dr. * * * saw the patient?
A. Yeah.
Q. He would send them to the dentist?
A. Yeah.
Q. Would the dentist then do something?
A. Take it from there.

At another facility a physician was pressured by the lay owner to refer patients to other in-house facilities, even for procedures which did not require services of a specialist:

Q. All right. Can you give us an idea of the nature of his advice; what did he suggest or advise you to do?
A. To have, for example, breast screening done on more female patients over age thirty.
Q. This would have entailed the services of the radiologist?
A. Yes.
Q. On the premises?
A. Yes.
Q. Possibly it was Dr. * * *?
A. Yes.
Q. All right, any other advice concerning what might be done with the patients or for the patients?
A. Well, that, for example, I shouldn't be—while there was available a GYN man on the premises that I should utilize his services.
Q. And was this the suggestion to you to utilize the service of the GYN man in connection with some specialized service that only a GYN man could render?
A. No. The pap smears I presume could be done by a general practitioner as well.

This facility was visited by investigators from the New Jersey State Commission of Investigation and the United States Senate Select Committee on Aging who posed as Medicaid recipients. Each of the three "patients" was greeted by a receptionist who extolled the merits of the facility and the various specialists

who practiced there. Before each of the investigators was examined or even seen by a physician, the receptionist made appointments for return visits with the dermatologist, radiologist, podiatrist, gynecologist, optometrist and dentist.

At another medical group a physician described pressures to ping-pong exerted by the lay administrator.

Q. It started——

A. When the Group got downstairs which was approximately May of '74 and the new office suites were ready and the dentist had then come in the area and there was an optometrist there part time and then the optometry office was on the side of the clinic. When we got downstairs, I was told to make referrals to the dentist, to the optometrist, to the obstetrician, to the gynecologist and also with the orthopedic doctor who was coming in eventually. And my answer at that time, I recall, to Mr. * * * was that if I think it's medically necessary for this patient to be seen by the dentist, I will tell him to go to a dentist, but I will not tell him to go to your dentist. I will not tell him to go to this eye doctor or that eye doctor. I will ask him when was the last time your vision was checked and examine eyes, which is a normal part of my routine exam.

* * * * * * *

Q. Okay. Now, you have indicated to us that Mr. * * * approached you with suggestions that you make referrals to certain of the other physicians in the group?

A. That's right.

Q. Are you aware of Mr. * * * or anyone else approaching other physicians and making a similar request for referrals?

A. Yes. I know that he was quite frequently harassing. I'll use the word harassing, Dr. * * * to make referrals to the gynecologist and eye, ear, nose and throat specialist or an orthopedic doctor.

* * * * * * *

Q. Do you have any idea why he requested the referrals to be made?

A. I assume that he was looking to ping pong his patients. That's an assumption—a presumption on my part, and that he was going to get a percent of the billing from the particular consultant, which would increase his income, certainly not mine.

The physician claimed that these pressures were one reason which caused him to disassociate himself from the group. The administrator involved allegedly referred group patients as "warm bodies" and urged physician staffers to "keep the warm bodies flowing" ("ping-pong"). A physician partner was questioned about the activity of the lay administrator:

Q. Doctor, have you ever heard Mr. * * * use the term "warm bodies" in connection with the patients at * * * Health Group?

A. I plead the Fifth and Fourteenth Amendments.

Q. Doctor, have you ever heard Mr. * * * suggest to physicians at the * * * Health Group that they should circulate the warm bodies amongst themselves?

A. I plead the Fifth and Fourteenth Amendments.

The lay administrator's actions apparently did not end at advising physicians how to practice medicine. One female Medicaid recipient told of being examined at the facility by a "physician who did not wear a white coat."

Q. What did this man, this person do? Did he examine you?

A. He examined me with that thing around his neck. With it up here. The thing that you put on your ears and hangs on your neck.

Q. Did he listen to your heart?

A. He put it in a lot of places and in back and in front.

Q. Do you remember what he told you or did he tell you anything?

A. No, he didn't say anything to me.

Q. Did you tell him you felt sick?

A. Yes, I did.

Q. And then he examined you with a stethoscope?

A. Um-hum.

Q. Now, let's go back to when this person examined you, okay? Did he ask you to open your mouth and say ah?

A. He put something in my mouth and looked into my throat and he just examined my throat and then he gave me the pills.

Q. But he listened to your body with an instrument, didn't he, besides examining your throat?

A. Yeah.

The INTERPRETER. She doesn't know——

A. I don't know the name of the instrument he used, but he put it in his ears and examined my back and front and all over.

Q. When he was examining you with this instrument, did he tell you to breathe in and out deeply?

A. Yes, he told me to breathe deeply.

Q. When he was examining you, did he ask you to put on a gown?

A. Yes—he asked me to put another gown on—no.

The INTERPRETER. She just——

A. He just had me lift my blouse—open my blouse. I had pants on at the time.

The individual—who also prescribed medication for the recipient—was positively identified by the recipient as the group's lay administrator.

The Commission also discovered it a prevalent practice for Medicaid recipients to be required to sign claim forms in blank and prior to having any service rendered. This practice allows physicians to bill the program for other than services actually rendered. United States Senate Select Committee on Aging personnel who assisted the New Jersey State Commission of Investigation were required to sign forms in blank virtually at every facility visited. A comparison of claims submitted by the facilities for services allegedly rendered with detailed investigative notes itemizing services actually rendered showed gross discrepancies in many cases. Physicians billed for injections that were not given, for blood which was not drawn and for urinalysis and tine tests which were not performed.

The Commission is also concerned with the amount of time spent with Medicaid patients by physicians. In several facilities visited, undercover investigators from the United States Senate Special Committee on Aging reported that physicians would spend only minutes with them and give the most cursory examination for which Medicaid was billed $30.00. Such minimal procedures again do not appear consistent with quality medical care.

Many of the abuses outlined above—extensive use of paramedical and even lay personnel or duties which are reimbursable only to physicians, double billing, ping-ponging and family ganging—can be and are being detected by the Division of Medical Assistance and Health Services through the use of sophisticated computer screens and time studies. We commend the Division and specifically the Bureau of Medical Care Surveillance for the effectiveness of current methodology. Existing computer program comparison procedures, however, do not uncover abusive practices in each and every case, but only when certain factors are present. To further protect the intergity of the program, we recommend that the Division obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. The Commission found that the use of such agents provided a quick, reliable and efficient method of uncovering practices inconsistent with the aims of the Medicaid program. Evidence gathered by such investigators, who we envision would be assigned to the Bureau of Medical Care Surveillance, could and should be aggressively used by the Division in suspension hearings or passed along for the review of appropriate law enforcement agencies.

We additionally recommend that facilities performing substantial amounts of Medicaid work be required to disclose to the Division the names and positions of employees. This information which, of course, should be updated periodically, will prove helpful in detecting use of para-professionals in place of physicians. We would also suggest that the Division consider legitimatizing the use of *qualified* medical para-professionals in certain instances. Services rendered by such individuals, however, should be paid at a rate lower than that now designated for physicians.

We again recommend that the Division consider the possibility of contracting with an insurance clearing house. Our own experence indicates this to be an effective step in obtaining reliable information on the presence of sources of medical payments other than the Medicaid program.

Lastly, we urge that steps be taken to insure that recipients be made aware of services billed to Medicaid on their behalf and be given an opportunity to challenge the accuracy of physician requests for reimbursement. At very least, a procedure should be instituted and strictly followed requiring recipients to

sign only completed, itemized claim forms. We further recommend that recipients be advised of services billed on their behalf, either by a Division listing of billings periodically through the year, or simply by adding a copy claim form to be given to the recipient by the physician at the time of service as a "receipt". We anticipate that costs incurred as a result of the adoption of either of these proposals would be offset by savings realized from more truthful billings. Either procedure would build a sorely needed "check and balance" into the existing system.

Unholy Alliances Between Mills and Pharmacies

During the course of the investigation, the Commission discovered a number of questionable relationships between pharmacies and mills. At one location an owner of the pharmacy and a lay "entrepreneur' 'also "owned a substantial interest in a medical center located less than a block away. The pharmacist paid the salaries of physicians at the Center and subsequently played a role in determining the "rent" physicians would pay for use of the facility. According to the pharmacist, Center patients initially numbered more than 50 a day and rose to the point where they comprised about a third of his business. We believe this estimate to be conservative.

Q. Do these prescriptions from the * * * Medical Center constitute any significant part of your business?

A. Enough to make me notice. I didn't want to lose it due to the fact when I took over my store we were only doing about fifty a day, and when the physicians were there at the medical center I had seen, you know, quite a few.

Q. Give us a ball park figure.

A. I would say about a third of my business.

Q. About a third?

A. My prescription business is from the medical center.

Q. Was that in May of 1973 or are we talking about today?

A. No. It's the same as it was.

Q. All the way through?

A. Right.

According to the pharmacist, Center patients patronized his store because of convenience. He claimed that the next closest pharmacy was four blocks away. In order to determine whether factors other than convenience were involved, personnel from the State Commission of Investigation and the United States Senate Select Committee on Aging recenly visited the subject medical center. Following an examination, a physician at the Center contacted the pharmacy by an automatic-dial phone and ordered several prescriptions for a Committee undercover investigator. The Center receptionist then directed the investigator to the pharmacy to pick up her medication.

In another area, a pharmacy and a medical center located directly across the street were sold as a "package" to a pharmacist and a lay person. Initially, physicians at this Center were paid a salary and subsequently, arrangements changed to a percentage "rental". The County Medical Society recently objected to the pharmacist and his lay partner acting as owners of the Center. Accordingly, arrangements were made to the end that the Center was "sold" to a physician. The physician now pays rent to a realty company whose principals are the former owners, a fee for the former owners to open and close the facility daily, and a fee to the "former" owner's brother who acts as facility bookkeeper. Investigators from the State Commission of Investigation and the United States Senate Select Committee on Aging who visited this facility were directed to the "former" owner's nearby pharmacy for prescriptions.

A comparison of the location of the medical center and that of the pharmacy rendering service to significant numbers of the center's patients may itself suggest impropriety. Surveillance personnel should closely scrutinize situations where pharmacies distant from centers provide service to large numbers of center patients. The Commission was surprised to find one situation where the majority of one medical facility's patients were having their prescriptions filled by a pharmacy located some five to eight miles away, notwithstanding the fact that at least two drugstores were located within blocks of the office. Prescriptions from the one facility alone accounted for 55% of the drugstore's total business and 80% of its Medicaid volume.

Investigation disclosed that the pharmacy was once a tenant of the physician. When the physician relocated to another town, direct telephone lines were estab-

lished to the subject pharmacy. The physician, as well as his registered nurse and lay office help, would phone in prescriptions to the pharmacy and the pharmacist would then type a script with the relevant information for his files. Evidence indicates that the pharmacist would be supplied with blank prescriptions pre-signed in the physician's name by his registered nurse. These blanks were apparently used in violation of Federal Law to record transactions involving controlled substances.

The medical facility involved maintained a cardboard box into which was placed drug samples left by pharmaceutical salesmen and medications returned to the physician by patients. According to several present and past employees, the pharmacy's delivery man would regularly pick these up. The facility's registered nurse described the items placed in the box as follows:

Q. All right. Now, did Mr. * * * ever take things away from Doctor * * * office?

A. Yes.

Q. What type of items would he take away?

A. Samples.

Q. What type of samples? You mean pharmaceutical samples that salesmen might drop off?

A. Yes.

Q. Any other type of material?

A. Sometimes he would pick up my laundry for me.

Q. Well, relating to medicine, would patients ever bring in syrups or pills into Dr. * * * office?

A. Yes.

Q. Well, would these ever go to Mr. * * *, these syrups or pills the patients would bring in?

A. Yes.

Another employee agreed that the box contained mainly sample pills and syrups.

Q. * * *, do you know what an injectable is, something that you inject into a patient rather than give the patient orally?

A. An injectable?

Q. Yes, an injectable is a drug that you might inject into a patient.

A. Yes.

Q. As opposed to something you might take like a pill or some syrup.

A. Yes.

Q. All right. What type of items would go into the box? What type of samples, pills or syrups or injectables?

A. Mainly pills and syrups.

The pharmacy's deliveryman recalled picking up only outdated vaccine and specifically denied ever taking pills and syrups. He recalled picking up samples only between one and three times a year. While the drugstore's employees maintained that he personally placed the medication in a trash receptacle, a real possibility exists that these items were redispensed. In addition to this possibility, the Commission has received material from the State Division of Consumer Affairs indicating that the pharmacy had been billing the Medicaid program for expensive brand name drugs while actually dispensing cheaper "look-alike" generic drugs.

Another abuse involved the short-circuiting of normal checks and balances between the pharmacy and recipients. The pharmacy's deliveryman would take the prescriptions to the facilitiy's patients. The Medicaid claim forms acknowledging receipt of and requesting payment for the medication were not signed by the recipients. They were pre-signed in the patient's name by another pharmacy employee. With such a procedure, there is no need for the recipient to ever see the claim form and no way for the recipient to compare drugs billed on his behalf with drugs actually received.

All of the facilities and pharmacies mentioned above were involved with others in an ingenious scheme designed to maximize personal profits. A lay entrepeneur who owned substantial interests in several medical centers banded togther with a relatively small group of physicians, pharmacists and clinical laboratory operators to form a company which would arrange for laboratory tests to be performed and repackage and resell relatively inexpensive generic drugs under its own brand name. Stockholders included the physicians who would write prescriptions for their corporation's products and lay medical facility owners. With each prescription and sale, stockholder equity in the corporation increased. Questions of

product quality aside, such a situation raises grave questions of conflict of interest and temptation to overutilize scant Medicaid program funds.

The Commission's investigation also surfaced what appears to be a new trend in the medical center-pharmacy alliance. More and more centers are opening with on-site pharmacies whose hours of operation exactly coincide with those of the facility. These pharmacies often "rent" small amounts of floor space at high rates and share waiting room and entrance space with physicians. Because these pharmacies cater almost exclusively to center patients, they are able to concentrate upon maintaining an inventory of only those items which center physicians prescribe. Thus, they may qualify for volume discounts or institutional rates on drugs purchased and at the same time save monies by not stocking drugs facility physicians do not commonly prescribed.

Problems of steering are exacerbated in physician groups having an on-premises pharmacy. At one facility the in-house pharmacy "rented" some 225 sq. ft. of space for in excess of $1050 per month. Entrance to the pharmacy was via the facility's door and waiting room. A plexiglas partition separated the two areas and prevented the patient from physically entering the pharmacy. Employees of the facility testified that it was the practice of the lay administrator to approach patients following an examination and say in English or in Spanish, "You can obtain the prescription at the pharmacy and you can wait in the waiting room," or "Honey, could you please take your prescription to the pharmacy and then have a seat outside." Another facility employee told of instructions to direct patients to the pharmacy which were given by the lay administrator.

Q. Would Mr. * * * instruct any of the girls or any of the doctors to send the patients in to the pharmacy?

A. Especially he told me himself.

Q. Mr. * * * told you to send patients to the pharmacy?

A. Right.

Q. What did he tell you?

A. When the pharmacy was open, he go straight to the lab and he told me that they should tell the patient to go to the pharmacy to pick up the prescription. .

Q. And along with his instructions, did you tell the patients to go to the pharmacy?

A. It was in front of the patient and most of the patients understands a little bit in English.

Q. So you didn't have to tell them, they heard?

A. Right.

The same employee, who was neither a State licensed registered nurse (RN) or practical nurse (LPN)—described another ploy used upon patients to insure that prescriptions would be filled at the in-house pharmacy:

Q. Did you ever hear any of the other doctors who worked at the * * * Health Group telling patients to go into the pharmacy with their prescriptions?

A. No, only if the patient had to have penicillin injection I am. So then I have to tell the patient to go to the pharmacy and get it and bring it back to the lab. Then I give it to the patient.

Mr. DICKSON. Off the record.

(Whereupon, there is a discussion off the record.)

A. (Continuing) The patient handed the needle, right.

Q. The patient handles the needle, yes.

A. And back again to the lab.

Q. Where you are?

A. I am right in my office. I call my office, anyway. I give the needles to the babies or the patients. Is the patient from Dr. * * * [the internist], sometime I give the needle for them, right, or the babies.

Q. But you have to tell the patient first you have to go to the pharmacy?

A. Yes.

Q. To get the penicillin?

A. Yes, they have to go there and sign, and the girl in the pharmacy give it to the patient. The patient come inside again and I give it to the patient.

When the patient presented the prescription for the injectable at the pharmacy window, another employee would request all other prescriptions and promise that these could be ready for pick-up after the injection was given.

The faciilty also maintained a double standard as to whether a charge would be made for injectable drugs. Private patients would not be charged for injecta-

bles while the taxpayers picked up the bill for injectables given to Medicaid recipients. An employee described the practice as follows:

Q. Now, Mrs. * * *, suppose a Medicaid patient comes in and he needs an injection of penicillin. What would happen?

A. Then the doctor give the prescription and the patient go to the pharmacy. We tell the patient, "Get in the pharmacy, get the needle," you know, because for the patient it's very easy to tell that way, and come back to the lab and I give it, the needle, to the patient.

Q. And at the pharmacy would the patient sign a Medicaid form for the penicillin?

A. Yes, they have to sign.

Q. So Medicaid would be billed for the penicillin injection, right?

A. Right.

Q. Now, suppose a private patient came, somebody who didn't have Medicaid or Medicare but was going to pay cash, and suppose the private patient needed an injection of penicillin. What would happen?

A. Well, we have a salesman supply some samples, right, and we got some sample, you know, for like we have 600 dozen units of penicillin and we keep it for special patient you know, private patient, and we supply, you know. Like a doctor do a little favor, save a little money.

Q. No charge?

A. No charge.

Q. So the Medicaid patients would have to pay for the penicillin and the other injectables, right?

A. If the doctor order, yes, yes.

Q. Yes.

A. Like Detanusdozide, D-e-t-a-n-u-s-d-o-z-i-d-e.

Q. My point is, if it's a Medicaid patient, Medicaid gets billed for the injectable; but if it's a private patient, then the patient doesn't get billed for the injectable, it comes with the visit, right?

A. Right, right, yes.

A physician-partner of the facility was questioned concerning allegations of abuse involving pharmacy and center staff. The testimony was as follows:

EXAMINATION BY MR. DICKSON

Q. Doctor, we spoke about the pharmacy being located on the premises at one point in our discussions today. Are you aware of any circumstances where anyone in the * * * Health Group would direct patients of the * * * Health Group to the pharmacy in order to have prescriptions filled?

A. I plead the Fifth and Fourteenth Amendments.

Q. Have you ever had occasion to hear Mr. * * * [lay administrator] speak to * * * Health Group's—I'm sorry—* * * Health Group patients in Spanish and direct them to the * * * Medical Pharmacy?

A. I plead the Fifth and Fourteenth.

Q. Would you sometimes write prescriptions for injectables?

A. Yes, I would.

Q. What would you do with prescriptions for injectables?

A. The same thing that I gave—that I did with the prescriptions for oral medication; gave it to my nurse.

Q. Would your nurse indicate to the patient that an injectable should be obtained from the * * * Medical Pharmacy and brought back to you so that an injection could be administered?

A. I plead the Fifth and Fourteenth Amendments.

Q. Doctor, did Mr. * * * or anyone else at the * * * Medical Group or Medical Pharmacy suggest to you that Medicaid patients should be regularly given vitamins?

I'm getting a mixed response.

ATTORNEY: You're not getting any response yet.

A. I plead the Fifth and Fourteenth Amendments.

Q. Did Mr. * * * or anyone else at the * * * Medical Group or Medical Pharmacy give you suggestions or advise as to prescribing vaporizers for patients of the * * * Health Group?

A. I plead the Fifth and Fourteenth Amendments.

The Commission has received material from the State Division of Consumer Affairs indicating that the subject pharmacy short-weighted or short-counted

medications going to Medicaid recipients. Information from the Division of Medical Assistance and Health Services suggests over-prescribing of vitamins, preparations and vaporizers.

In another pharmacy, which had a direct telephone link to a doctor's office, evidence of the following additional abusive practices came to light: Medicaid recipients were required to sign forms in blank and prior to receiving medication; billing Medicaid for drugs not dispensed; billing Medicaid for drugs covered by the program and dispensing a drug not so covered; tracing recipients' signatures from old claim forms onto blank forms and billing for drugs allegedly supplied to recipients who were deceased.

A major step in reducing program costs was taken during the pendency of the Commission's probe by the Division of Medical Assistance and Health Services. Under present regulations, generic rather than brand drugs should be prescribed and dispensed whenever possible. Additional steps can be taken to further reduce abuse and unnecessary expenditure of limited program monies. The Division currently has the computer capability to develop a prescribed profile on Medicaid program physicians. This program would analyze prescribing patterns of physicians and display questionable or abusive practices. Unfortunately, the profile is not effectively used because program providers choose not to supply necessary information on claim forms. We recommend that the Division assume a tough stance on this issue and reject for payment any claims not containing relevant information.

To facilitate the gathering of information relevant to program integrity, we suggest that a standard Medicaid multi-copy prescription/claim form be developed. The name of the prescribing physician could be pre-stamped on the form. The physician should list the medication desired and draw a line immediately under the last item prescribed and personally sign the form. Space can also be provided for the physician to list a substantiating diagnosis. A copy can be kept for the physician's record and the balance forwarded to the pharmacy via the patient for use as a description of drugs to be dispensed and the pharmacist's billing invoice.

Existing program regulations prohibiting the referral of patients to a particular pharmacy by physicians should be broadened to encompass all facility employees and stringently enforced. It should be made clear to all that the physician may not require nor may he recommend that a prescription be filled by a particular pharmacy; nor may his receptionist or any employee do so. Patients who ask must be reminded of their free choice of pharmacy. Any liaison—including direct telephonic connection and common entranceway—between physician and pharmacist should create a presumption of impropriety. Landlord-tenant and other relationships between physicians and pharmacists should be subjected to special scrutiny as to pharmaceutical utilization.

Landlord tenant relationships present perhaps the greatest temptation to overutilize pharmacy services. Even without direct steering by facility staff, patients are usually required to pass the pharmacy entrance to pick up coats or children before arriving at the public street. The in-house pharmacy truly has a "captive" audience. For this reason, the common entranceway should be prohibited. Moreover, when a physician or a landlord owns a pharmacy or has a pharmacy for a tenant, he is induced to take whatever steps are necessary to see that the pharmacy succeeds. In-house pharmacies also present opportunity for profit based upon the precise nature of inventory kept and the ability to obtain volume discounts on drugs. We recommend that the Division take these savings into consideration along with the fact that in-house pharmacies primarily—if not exclusively—service patients of the facility and reimburse these pharmacies at a lower institutional pharmacy Medicaid rate. We further suggest that the professional boards in their licensing schemes take into account the great potential for overreaching present when pharmacies enter into financial relationships with physicians located on the same premises.

Recommendations

The Commission has already recommended substantial changes in program legislation and administrative practices and procedures in previous reports on nursing homes, independent clinical laboratories and hospitals participating in the New Jersey Medicaid Program. Many of these previous recommendations—such as those calling for criminal sanctions against kick backs, establishment of a scheme of financial penalties for incidents of fraudulent conduct, subpoena

power and accountants for the Division of Medical Assistance and Health Services, and increased monitoring of fiscal agent actions—have effect in several program component areas. We take this opportunity to supplement the record with recommendations pertinent to the administration of the physician groups aspect of the program.

1. Shared Health Care Facilities receiving substantial amounts of Medicaid funds should be identified and annually approved for program participation by the Division of Medical Assistance and Health Services. Practitioners rendering service and the facility at which service is rendered should clearly be identified. We have reviewed proposals drafted by the Division of Medical Assistance and Health Services to achieve these goals and concur with their substance (see appendix for copy). We pause, however, to add our own suggestions.

D. PROHIBITED PRACTICES—ADMINISTRATIVE REQUIREMENTS

1. Percentage letting prohibited—The rental fee for letting of space to providers in a shared health care facility or the remuneration of providers for services in such facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered in the premises in which the shared health care facility is located. A copy of each lease or details of any agreement between the facility and any provider and any renewal thereof shall be filed with the Division.

5. The Commission understands that the separate entrance requirement imposed by this section is applicable to in-house pharmacies.

6. Claims—All provider claims submitted for services rendered at a shared health care facility shall (a) contain the registration code of the facility at which the service was performed and (b) be personally signed by the practitioner who rendered service (c) contain the code number of the physician who rendered the service, (d) be personally signed by the patient who received the goods or service.

8. Order for ancillary clinical services—all orders issued by providers for ancillary clinical services, including, but not limited to, x-rays, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the registration code of the facility at which the order was written and the code number of the provider requesting the service or goods.

A line shall be drawn under the last good or service requested and the diagnosis justifying the request and requesting providers personal signature shall be placed below that line.

10. Direct telephonic links between providers is prohibied.

11. Providers shall not order ancillary clinical services from providers in which they hold a financial interest.

12. Providers shall not submit claims to medicaid who also claim reimbursement for identical services from another third party payor. All information requested concerning possible third party liability shall be listed on claim forms.

2. We strongly recommend that the Division obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. Evidence of improprieties gathered by these agents could and should be aggressively used by the division in suspension hearings or passd along for the review of appropriate law enforcement agencies.

3. Medicaid recipients should be made aware of services billed to the program on their behalf and be given an opportunity to challenge the accuracy of physicians requests for reimbursement.

Lastly, and perhaps most importantly, we recommend that there be constant and close coordination between Division Surveillance personnel and those responsible for the review and promulgation of administrative regulations applicable to program providers. Many of the abuses identified by the S.C.I. were previously found by surveillance personnel, and passed along for further action. Unfortunately, in many instances warnings of potential wide-spread abuse noticed by the Bureau of Surveillance and passed along to others seem to have fallen through the cracks of bureaucracy. The Commission notes that conditions have improved and many aggressive, explicit regulations have been promulgated during the course of our own investigation by new Division leadership. We fully expect that such efforts will continue.

Copies of the investigative record compiled by the Commission in this probe will be forwarded to the State Attorney General, the United States Attorney for the State of New Jersey, the State Board of Medical Examiners, the State Board of Pharmacy, the Division of Medical Examiners, the State Board of Pharmacy, the Division of Medical Assistance and Health Services and the State Legislature for further review and consideration.

Appendix to Report

Requirements Applicable to Shared Health Care Facilities

A. definitions (when used in this item)

1. Department shall mean the Department of Institutions and Agencies.
2. Division shall mean the Division of Medical Assistance and Health Services.
3. Program shall mean the New Jersey Health Services Program.
4. Shared Health Care Facility shall mean two or more providers delivering health care, either independently or in association with each other, within a single structure and (a) two or more of whom share any of the following: common waiting areas; examining rooms; treatment rooms; equipment; supporting staff; any shared space; or common records, and (b) one or more of whom receives payment on a fee-for-service basis.
5. Provider shall mean any person, firm, corporation or other entity providing services under the Program.
6. Purveyor shall mean any person, firm, corporation or other entity who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users any medical supplies, equipment and/or services for which reimbursement under the Program is received, including, but not limited to, clinical laboratory services or supplies; x-ray laboratory services or supplies; inhalation therapy services or equipment; ambulance services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eye glasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment.
7. Patient shall mean anyone eligible to receive benefits from the Program.

B. application of item

1. This Item shall apply to shared health care facilities as defined herein and to the providers located in a specific health care facility.
2. This Item shall apply to purveyors, whether or not located in a building which houses a shared health care facility.
3. Nothing in this Item shall apply to an association of health care practitioners delivering health services on other than a fee-for-service basis.

C. registration of shared health care facilities

1. No shared health care facility shall be operated under the Program unless the owner or, if the structure in which the shared health care facility is located has been leased, the person who leases space in the shared health care facility, has registered such facility with the Division. Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to—

(*a*) The name and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the structure and of the shared health care facility;

(*b*) The name and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in any equipment located in and used in connection with a shared health care facility and a brief description of such lien or security interest;

(*c*) The name, residence address and professional license number of every practitioner working in the shared health care facility. This information shall be maintained on a current basis. Division shall be notified of any

change in the status of practitioners within the shared health care facility; and

(*d*) The name, residence address and professional qualifications of the individual designated to assume responsibility for the central coordination and management of the shared health care facility's activities.

2. The registrants shall re-register on the June 1 next following the initial registration and annually thereafter on June 1.

3. The Division shall be notified by the shared health care facility of any change in—

(*a*) The persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the share health care facility; or

(*b*) The persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in any equipment located in and used in connection with a shared health care facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

4. The Division shall be notified within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The division shall also be notified within fifteen days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

5. The Division shall be notified within fifteen days of any termination of the services of any practitioner in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

D. PROHIBITED PRACTICES; ADMINISTRATIVE REQUIREMENTS

1. Percentage letting prohibited: The rental fee for letting of space to providers in a shared health care facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located. A copy of each lease and any renewal thereof shall be filed with the Division.

2. Referral fees prohibited: No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for—

(*a*) Recommending or procuring goods, services or equipment of such purveyor or provider for any other person, or

(*b*) Directing patronage or clientele to such purveyor or provider, or

(*c*) Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

3. Patient referrals:

(*a*) No provider in a shared health care facility or person employed in such facility shall refer a patient to another provided located in such facility unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

(*b*) Every provider practicing in a shared health care facility who treats a patient referred to him by another provider practicing in the same facility shall communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record; and

(*c*) The invoice submitted to the Program by the provider to whom such patient has been referred shall (1) contain the full name and provider number of the referring provider and (2) identify the medical problem which necessitated the referral.

4. Pharmacy notice: Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the Program

may be obtained at any pharmacy of the patient's choice enrolled in the Program in the city.

5. No entrance on the premises by purveyors: No purveyor who maintains a business in the building in which a shared health care facility is located shall maintain a door or window opening into the offices or waiting room of the shared health care facility, except where the profession of the provider permits the provider to function simultaneously as a purveyor.

6. Claims: All provider claims submitted for services rendered at a shared health care facility shall (a) contain the registration code of the facility at which the service was performed and (b) be signed by the practitioner who rendered service.

7. Billing: In a shared health care facility, procedure code 9000 (Initial Office Visit) or 9580 (EPSDT), or 9001 (Comprehensive Office Visit) may be billed only once. All referrals within the shared health care facility will be billed as 0001 (Routine Office Visit), 0005 (Brief Office Visit), or 9007 (Prolonged Office Visit). Use of 9029 and 9030 Consultation codes are prohibited. If an ophthalmologist is a member of the shared health care facility and a comprehensive eye examination, including refraction, is performed, then procedure code 5400 may be used.

8. Orders for ancillary clinical services: All orders issued by providers for ancillary clinical services, including, but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the registration code of the facility at which the order was written.

9. Fee splitting prohibited: It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred, except where the paying of a fee is compensation for services rendered to the patient.

E. QUALITY OF CARE REQUIREMENTS

1. To ensure quality, continuity and proper coordination of medical care each shared health care facility shall—

(*a*) Designate an individual, who, on a full-time basis, shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this Item.

(*b*) Devise an appropriate means of insuring that (1) patients will be scheduled to return for appropriate follow-up care and (2) will be treated by a practitioner familiar with the patient's medical history.

(*c*) Post conspicuously the names and scheduled office hours of all practitioners practicing in the facility.

(*d*) Maintain proper records. Such records shall contain at least the folllowing information:

(1) The full name, address and Medicaid number of the patient.

(2) The dates of all visits to all providers in the shared health care facility.

(3) The chief complaint for each visit to each provider in the shared health care facility.

(4) Pertinent history and all physical examinations rendered by each provider in the shared health care facility.

(5) Diagnostic impressions for each visit to any provider in the shared health care facility.

(6) All medications prescribed at each visit to any provider in the shared health care facility who is qualified to issue prescriptions.

(7) The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility.

(8) All x-ray, laboratory work and electrocardiograms ordered at each visit by any qualified provider in the shared health care facility.

(9) The results of all x-ray, laboratory work and electrocardiogram ordered as in "8" above.

(10) All referrals by providers in the shared health care facility to other medical practitioners and the reason for such referrals, and date of referral.

(11) A statement as to whether or not the patient is expected to return for further treatment.

(*e*) Inspection of records—The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any pro-

vider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

(*f*) Names of providers to be filed with Division—Every shared health care facility shall file with the Division the name of each provider or purveyor currently rendering services in such facility. If any provider vacates a facility or a new provider is added therein, such change shall be reported to the Division by registered mail within fifteen days of such change.

EXHIBIT B

It is recommended that a committee of staff and contractor personnel be formed to analyze and prepare a report recommending changes in existing computer capability related to provider identification and service tracking. Specifically, this committee suggests reducing the provider number from a 9 digit code to a 5 digit code, thereby allowing utilization of the remaining 4 digits to identify the provider group and the individual practitioner who rendered the service. It is believed that other applications of the 5–4 digit system could be developed. Although this recommendation is extremely general, it should serve as the starting point for the committee to commence its work.

Appendix 2

CORRESPONDENCE BETWEEN SENATOR FRANK E. MOSS AND DEANS OF SCHOOLS OF MEDICINE

DEAR DEAN: You may have read about the recent investigation and disclosures concerning fraud and abuse in the Medicaid program revealed by my Subcommittee on Long-Term Care. These news stories also conveyed much of my worries about the quality of medical care being rendered to the poor, aged, blind and disabled.

I am writing to enlist your support for increased involvement of schools of medicine with public health clinics, hospital outpatient clinics and shared health facilities which are the primary sources of medical care to residents of America's inner cities. Many medical schools already have a significant number of initiatives in this area, but I believe there is a need to intensify our efforts.

I would appreciate any suggestions you might have on the question of greater involvement of medical schools in providing treatment for indigents, the aged, blind and disabled. Moreover, I would be grateful for any suggestions about improving the fiscal integrity of government health programs.

In closing, I want to underscore the fact that my Subcommittee has repeatedly stated that only a tiny minority (4 percent) of physicians cheat government programs; nevertheless, the dollars involved are substantial. The Medicaid program increasingly has been turned over to foreign medical practitioners who often lack requisite skills to compete with American trained physicians.

Again, I would be grateful for any suggestions you might have for dealing with these problems.

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

ITEM 1. LETTER FROM DR. JOHN I. SANDSON, DEAN, BOSTON UNIVERSITY MEDICAL CENTER, BOSTON, MASS.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: Thank you for your letter of September 7. It is important to get more medical school involvement in ambulatory care settings. Some medical schools are interested in doing this. One major difficulty in moving forward has been the inability to pay for the necessary teaching costs in ambulatory settings. This is a major problem that has to be overcome if substantial progress is going to be made.

I would be most pleased to meet with you to discuss this further at your convenience.

Sincerely,

JOHN I. SANDSON, M.D.

ITEM 2. LETTER FROM DR. D. KAY CLAWSON, DEAN, COLLEGE OF MEDICINE, UNVERSITY OF KENTUCKY, LEXINGTON, KY.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: Thank you for your letter of September 7, asking for suggestions that might improve the opportunities for treatment of the indigents, aged, blind and disabled. I, too, share your concerns yet take this opportunity to call to your attention the serious financial plight facing many of our medical schools. I am sure you are barraged with data from the AAMC so I would like to only state the position faced by the University of Kentucky.

We are the only city, county, state institution serving Eastern Kentucky with 1.5 million people. Our 463 bed University Hospital provides tertiary care for people of all levels. It is the only place that can do renal dialysis and transplants, open heart surgery, specialized burn care and advanced radiation therapy for the people of this region. Because there is no other resource, we end up providing an inordinate volume of unreimbursed care (22.2 percent of total services in 1975–76). We do this trying to deal with inflation and respond to advances in medical technology and support this effort with state funds for hospital operations which have not increased since 1968. We are the primary center for the care of Medicaid patients. Medicaid funds support 30 percent of our patients.

From the standpoint of our clinical faculty, we must generate 79 percent of our faculty income from outside sources including grants and fee for service practice. Given the large indigent and non-pay population which we service in an undistinguishing manner from full-pay patients, we do not have an adequate budget to hire the clinical teaching faculty necessary to care for the patients and maintain our teaching and research program at the level expected for an academic institution of this quality.

The State has been unable to pay fee for service under the Medicaid program higher than 62 percent of the 75th percentile of usual and customary fees as charged in 1973. This means that the fees collected are frequently so low that physicians in and around the state will not take care of Medicaid patients, therefore, these patients can only come to our institution. Many of our patients are classified as medically indigent and receive financial allowances even though they do not qualify for the Medicaid program. The physicians are giving services to medically indigents and Medicaid allowances of about $3.0 million. We hold regional clinics in Pediatrics, Neurology and Community Medicine in an effort to provide better care for our citizens.

Our fee for service income must be used to subsidize the teaching program. We have active teaching areas in a variety of courses and a major component in community medicine teaching the problems of the indigents, of the nursing home patient, and the disabled. In addition, we are now requesting some governmental support to develop an Aging Institute here that will combine our resources of the Sanders-Brown Center for Biological Research in Aging with outreach programs using the resources of several of the Colleges and Departments of the University plus the community college system.

In summary, we believe that we are doing an outstanding job in attempting to answer the problems you stated in your letter but are so completely strapped financially that we are having a struggle to meet the needs of all of the constituencies. The falling off of our capitation money from $855,000 in 1975 to $398,000 this year only compounds the problem. It is unfortunate that at a time when we are desirous of doing so much, inflation at the rate of 10 or 12 percent is moving faster than our state support and other resources.

I do not have any magical solutions but know from my experiences as a faculty person at the University of Washington, that there was a tremendous difference in the level of care being rendered to the underserved populations when the State of Washington changed from a concept of an indigent or charity hospital and gave all indigent or medically indigent patients an opportunity to select the physician and the hospital of their choice through a Medicaid program that paid usual and customary fees. Most physicians and other faculty members at the University of Kentucky and I am sure other medical schools are extremely concerned about this problem and would like to join with you in efforts to alleviate the situation. However, we are already so financially strapped trying to meet our teaching commitments while taking care of large numbers of indigent patients that it is very difficult to expand any activity.

Most sincerely,

D. KAY CLAWSON, M.D.

ITEM 3. LETTER FROM DR. JOHN P. UTZ, DEAN, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE, WASHINGTON, D.C.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: I am pleased to acknowledge your memorandum of September 7 and its request for suggestions on how medical schools might be more greatly involved "in providing treatment for the indigent, the aged, blind, and disabled.

Georgetown University has been for 25 years, is now, and expects to be committed in the future, to the care of just exactly the patient you cite, particularly at the District of Columbia General Hosptial. In salaries of attending physicians, house staff, and consultants we calculate the annual contribution to be approximately $1 million a year.

We also serve the Area A Psychiatric Clinic for inner-city citizens.

To the best of my knowledge, none of our faculty receive any Medicaid support for such extensive service to our central inner-city citizens.

I hope this is a help to you.

Sincerely,

JOHN P. UTZ, M.D.

ITEM 4. LETTER FROM DR. JOHN A. DIXON, VICE PRESIDENT FOR HEALTH SCIENCES, UNIVERSITY OF UTAH, SALT LAKE CITY, UTAH; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: Thank you very much for your letter of September 10 regarding increased involvement of schools of medicine with public health clinics, hospital outpatient clinics and shared health facilities which are the primary sources of medical care to residents of America's inner cities. I can assure you that the University of Utah College of Medicine is deeply involved in all of these areas and has formed significant relationships with ten of the state's community hospitals to provide resident support for manning of just such facilities.

A statistic you might be interested in is as follows: In 1974, the percentage of the population of Utah over 65 years of age was about 7.5 percent. The percentage of patients over 65 served by our University Medical Center over the past year was 17 percent and the percentage of patient days for people over 65 was 22 percent. These figures indicate that a substantial portion of the Medical Center activities are directed toward meeting the needs of the geriatric community.

The colleges in the University of Utah Health Sciences Center (Nursing, Pharmacy, Medicine and Health) are currently involved in long-range planning affecting the indigent, aging, blind and disabled population. In particular, the College of Nursing is involved in some very innovative programs in nursing homes to improve badly needed care there.

We appreciate all you have done for medical education in the west and will continue to work with you to eliminate these areas of health care deficiency.

Sincerely,

JOHN A. DIXON, M.D.

ITEM 5. LETTER FROM DR. RAYMOND D. PRUITT, DEAN, MAYO MEDICAL SCHOOL, ROCHESTER, MINN.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 22, 1976

DEAR SENATOR MOSS: We have followed with interest news reports about your recent investigations of the Medicaid program. We share your concerns about both the cost and quality of medical care, as all except a "tiny minority," to use your own words, of physicians and health care institutions do.

Mayo Medical School, which enrolled its first class in 1972, is owned and operated by Mayo Foundation, and its patient component is drawn from Mayo Clinic. This experience is supplemented by affiliations with 54 family physicians in the nearby area. In Mayo's first graduating class, 59 percent of the students elected primary care residency training.

Because the geographic settings of medical schools vary, it seems to us that each medical school must make an effort to be responsive to the particular needs of its own area. In the case of Mayo Medical School, this area is predominantly rural. We know you are aware, as are your colleagues in the Congress, that efficient and responsive delivery of health care in a rural area is also a challenge and Mayo is responding to that challenge.

The larger institution of which the medical school is a part, Mayo Clinic-Mayo Foundation, continually directs a major share of its administrative expertise to improving efficiency in health care delivery and holding down costs. Moreover, we believe that in the group practice of medicine in this institution there exists intrinsic forms of peer review which are conducive to excellence of care and which remove the incentive for unprofessional behavior, including fraudulent

charges. These desirable features are enhanced by the fact that members of our staff are salaried on an annual basis that is not profit-sharing.

We should be pleased to have you or any member of your committee visit us, with or without notice. We recognize the limitations of our experience and our expertise, but we would be pleased to share them to the extent possible.

Sincerely yours,

RAYMOND D. PRUITT, M.D.

ITEM 6. LETTER FROM DR. ALLEN W. MATHIES, JR., DEAN, UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE, LOS ANGELES, CALIF.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 24, 1976

DEAR SENATOR MOSS: I am pleased to respond to your letter of September 7th, in which you express your concern about the quality of medical care being rendered to the poor, aged, blind, and disabled. The investigations have received very extensive national coverage. Because the issue is complex, I am responding at some length.

At USC School of Medicine our prime teaching facilities are public hospitals in which we direct the professional care in partnership with the County of Los Angeles. Our medical school classes have been more than doubled over the last decade and this academic year began with 550 medical students enrolled; more than 100 are ethnic minority students. We are also responsible for the postgraduate education of approximately 1,000 interns, residents, and fellows, many of whom come to us from completely different training settings.

USC School of Medicine does not own a university-owned teaching hospital and because of our public hospital setting we have emphasized upgrading of quality medical care and sensitization of medical students to the whole human being from their entrance into medical school through our Introduction to Clinical Medicine course. We have worked with lay consumers in the community to develop responses to their concerns and have establish patient care units in the hospital which have become national models. This type of quality medical care requires adequate funding, however, many of the reimbursement standards of publicly funded programs do not provide. Let me provide some examples of our patient mix, to which medical students and house staff are exposed, and the subsequent dollar funding problems.

At the Los Angeles County-USC Medical Center, there are approximately 8,000 inpatient admissions per month of which 10% are Medicare patients. Of the 10%, over 88% are more than 65 years of age; 12% are under 65 years of age. This means that about 800 patients are elderly and our students are involved in the care of this population in their required clinical clerkships on the hospital wards. Of the remaining 90% of the inpatient population, 37% are Medi-Cal (Mediciaid) patients and 42% are "self pay". To us, self pay means that some of them have some resources but if the hospital cannot recover the costs of their care, the County of Los Angeles bears the health care costs. Eight percent of the patients are covered through Crippled Children Services funding and Short-Doyle funds, and the remaining 3 percent fall in the deferred category (which include prisoners).

Now, unlike a privately owned hospital or a community hospital, public hospitals must accept every patient who presents at the hospital for care. Private or community hospitals may turn patients away if they cannot pay for their care or if their medical problem is not of interest for teaching purposes, i.e., alcoholism or drug overdose, aging, chronic illness. If, after receiving medical care, the patient cannot pay his health care costs and is not eligible for Medicare or Medi-Cal, the County of Los Angeles must pick up the costs. Lack of adequate reimbursement from the funded programs has placed a very severe strain on the ability of the County of Los Angeles to provide funds for high quality medical care and the taxpayers of the county have been very vocal this year about the high costs of medical care over and above the reimbursement schedules. Along with the county officials, we are concerned about the large number of illegal aliens in this area who fall into the "self pay" category.

In suggesting remedial measures concerning the failure to provide quality medical care, funding is, of course, one critical issue. We feel that stressing an ethical approach to health care professions in instruction of medical students is another issue which must be stressed in ever more relevant terms. "Ethics" means something to young physicians in the context of viewing the person as a

human being of worth—I feel your investigations have sharpened the importance of this issue. But it takes time for the physician to build a caring relationship with his patients and if he is overworked, overtired, and neglecting his own family until long into the night, he tends to become cynical and uncaring. And, again, time costs money.

The issue of maldistribution of physician manpower is another facet of the problem. I recommend the Report of the National Conference on Health Manpower Distribution as a document which raises the issues we must solve in this area and the problems faced by physicians who seek to practice in the disadvantaged urban and rural areas.

Licensing standards also impinge on this problem. Some states have very loose laws for licensure which favor the unscrupulous, either U.S. trained or foreign medical graduates. California laws are so strict, for example, that obtaining a license to practice without demonstration of competence is virtually impossible. It has not eliminated the incompetent entirely, but it has reduced the problem compared to some of the eastern states.

Our late Dean, Franz K. Bauer, M.D., used to say that the practice of medicine today is being asked to solve problems of society entirely unrelated to medicine's ability to solve. For instance, good nutrition is not possible for the person who does not have the money to buy food. The problems that your committee faces are formidable and I support your concern and determination to seek to develop a health care system that the nation can afford and that works. This medical school will always be willing to assist in the solution of that challenge.

Sincerely,

ALLEN W. MATHIES, Jr., M.D.

ITEM 7. LETTER FROM DR. WILLIAM R. DRUCKER, DEAN, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE, CHARLOTTESVILLE, VA.; TO SENATOR FRANK E. MOSS, DATED OCTOBER 15, 1976

DEAR SENATOR MOSS: As you know, we in medicine share your concern regarding fraud and abuse in the Medicaid program and have suggested that those physicians participating in such activities should be prosecuted to the full extent of the law. Whether our society is more or less afflicted than any in the past is not clear, but, we do seem to have considerable problems with integrity at all levels. Our profession, like yours, is not immune to these problems.

I am pleased to note that our medical school is one of those which has always provided extensive service to the poor, aged, blind and disabled of our region. We are the major referral center for the entire western portion of this state and serve as a community hospital for a large portion of the rural population in our vicinity. Our average patient travels some 90 miles to our facility.

The most difficult question you ask is that referring to the fiscal integrity of government health programs. In the past physicians dealt directly with a patient and were paid by the patient; they were constrained to make certain that the patient understood the reason for the fee. The patient had every opportunity to complain about the fee or to make arrangements for deferred payment or, sometimes payment by barter. When third parties intervene between the patient and the physician, several things change: patients think less about the cost of services they demand, physicians consider less the effect of the charge, and the insurance company simply passes the increased cost on to the insured. Patients frequently demand extra days in the hospital or unnecessary hospitalization, because they have paid premiums to this or that insurance program for many years and want something in return. Insurance is no longer a hedge against catastrophe, but an investment to be collected at some particular point in life.

In order to correct these misuses of government and other forms of health programs a major public education effort is needed. This effort must include facts about the real cost of such programs and the patients must be made responsible for part of their own bill in order that they not make excessive demands.

Finally, I would like to make a suggestion that you interview some practicing physicians on a one-to-one basis to gather from them first-hand their programs in dealing with government programs. As Dean of the Medical School I come into contact with such programs, only indirectly, but practicing physicians have complained that the regulations and lack of balance of such programs make it almost impossible to deal with them. I have heard of physicians who see patients eligible for medicaid and never send a bill for the simple reason that it is too complex and costly to submit the bill; they would rather see the patient with-

out charge. I do not believe that you can appreciate the real feeling of physicians by dealing with agency heads, representatives of various professional groups or by asking a practicing physician to appear before your committee where he would be ill at ease. There are many excellent physicians in the Washington area in the private practice of medicine who could give you a great deal of information about these programs if you have time to sit down with them in your office.

I hope these thoughts will be of some use to you.

Kindest regards,

Sincerely,

WILLIAM R. DRUCKER, M.D.

ITEM 8. LETTER FROM DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, D.C.; TO SENATOR FRANK E. MOSS, DATED OCTOBER 20, 1976.

DEAR SENATOR MOSS: I have read with a great deal of interest your letter of September 9 enlisting the support of the Association of American Medical Colleges "for increased involvement of schools of medicine with public health clinics, hospital out-patient clinics and shared health facilities which are the primary sources of medical care to residents of America's inner cities."

Over the last several years, the staff of the Association has had many discussions with various members of its constituency on the set of issues raised by your suggestion. There are essentially two important questions to be resolved. One concerns the proper role of the medical schools in community service while the other relates to the financial integrity of these institutions. Let me review briefly the range of views held by the nation's medical schools on these problem areas.

The question of the extent to which educational institutions in general and medical schools in particular should be involved in community service, e.g., the provision of health care to the indigent citizens of our inner cities, has been a subject of lively debate within this constituency for many years. The debate is premised on the fact that the primary purpose of a school of medicine is to educate physicians; no other institutional form for that purpose exists within our society. Additionally, it is recognized that the clinical training of the medical students has been characterized for the last three quarters of a century in this country by a style and tradition which couples education and service. This contrasts with other traditions in which both pre-clinical and clinical training are largely if not exclusively didactic, carried out by lecture rather than clerkship and completely decoupled from patient care. Non-educators, seeing the service component of the "joint product", frequently view medical schools as primarily medical service institutions and call upon them to expand commitments in the service area. Many of the nation's medical schools have responded to such importunings and greatly expanded the amount of community service which they render. In calendar year 1974, the Association of American Medical Colleges surveyed the then 396 medical school affiliated hospitals belonging to its Council of Teaching Hospitals; 303 reported that among the 5,977 non-federal short term hospitals they alone accounted for 21% of the total of 194.8 million out-patient visits, 16% of the total 67.1 million emergency room visits and 22.9% of the total 1.5 million home care visits. Clearly, the medical schools of the country are already deeply involved in the delivery of health care as an inseparable part of the discharge of their primary objective, the education of medical students. The extent to which this can be increased cannot be stated with precision, but I am sure that most of the medical schools would be quite willing to undertake further responsibilities for the medical care of the indigent populations of our inner cities as long as it does not interfere with their basic educational mission.

The crucial question is the extent to which service can be expanded without interfering with the process of education. No medical school is unwilling to provide community services to the degree that that particular school believes is feasible; on the other hand, there is great variability among schools in the perception of the level of community service that begins to compromise the educational process.

The other major consideration relevant to your suggestion is financial. The type of service most important to the group of Medicaid and Medicare patients central to your interests is that which is rendered on an ambulatory basis in the out-patient clinics of the teaching hospitals affiliated with the nation's medical schools. The financing of ambulatory care facilities is one of the most troublesome

problems facing the medical schools at the moment; most of them are sustaining very substantial financial losses in the operation of these facilities. A number of factors have been identified as contributing to the deficit operations. Many insurance plans provide no reimbursement for ambulatory care. While Medicare and Medicaid do, both of these federal programs reimburse on fee schedules considerably below the average and customary. Since the overwhelming number of patients who seek care in the nation's medical centers are indigent, they are, moreover, unable to pay the "deductible" and "co-insurance" components required by various plans even when they are covered by some type of insurance. Thus, income is severely reduced.

At the same time, the conduct of teaching exercises for both undergraduate and graduate medical students in connection with the ambulatory services substantially reduces the efficiency of the medical care process, for the obvious reason that it takes additional time per patient if students are going to participate in their workup. The inefficiencies thus induced substantially raise the cost of handling the patient in a situation in which reimbursement is inadequate for even efficient operations. Finally, Medicare denies reimbursement under Part A for the costs of educating interns and residents in ambulatory facilities and recovery of these costs under other programs is equivalently unsatisfactory.

Thus, the schools will have to ponder deeply the question of whether or not they can afford this type of community service before taking on further responsibilities for the care of ambulatory patients. In spite of these financial problems, some institutions have in the past few years made significant progress in reorganizing their ambulatory services so as to provide effective and reasonably efficient one class ambulatory comprehensive care to the surrounding communities. Most have required outside funding, over and above the reimbursable health care dollar, in order to make this conversion. Many others are prepared to accomplish the necessary organizational and structural rebuilding of the ambulatory services if they can be assured of some stable reimbursement procedures.

Cognizant of these developments, the Association has during the past year sponsored a program of workshops addressing the issue of ambulatory care restructuring. Material relating to this program is enclosed for your review. The interest among our constituent institutions is high. We have reason to believe that we could easily attract thirty other large urban-based university affiliated ambulatory centers to similar workshops if we could secure the necessary funding to carry the program into 1977.

We believe the several concerns which these workshops address are in complete accord with those raised during the recent committee hearings on the quality of medical care for the urban poor. We are convinced that a large number of the nation's medical schools and affiliated teaching hospitals stand ready to assume responsibility for improved care for inner city residents, addressing many of the problems enumerated in your committee reports. The major problem is that of identifying a means of long-term, stable financial reimbursement for services provided, and a means for stable support of the associated educational programs.

I and members of the Association of American Medical Colleges staff would be pleased to meet with you and other members of the Committee, and with Committee staff to discuss these problems of mutual interest.

Sincerely,

JOHN A. D. COOPER, M.D.

Appendix 3

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURES FROM DR. EMIL LENTCHNER, EXECUTIVE DIRECTOR, ELEVENTH DISTRICT DENTAL SOCIETY, JAMAICA, N.Y.; TO SENATOR FRANK E. MOSS, DATED AUGUST 31, 1976

DEAR SENATOR MOSS: On returning from vacation, I find your letter requesting information additional to that which I submitted in my earlier response of June 28, 1976.

With reference to questions two, three and four of your inquiry of June 7, 1976:

Question #2—The Dental Society is not empowered to discipline a dental medicaid provider. The Dental Society does have an agreement with the New York City Health Department to review on request the quality of dental care performed by a dentist and to render its judgment to the Health Department as to whether the dental care examined is adequate or inadequate. (Enclosed: agreement reaffirmed July 16, 1976; initiated September 1970). In all cases where submission is made to the Dental Society for such "peer review" the Dental Society submits a complete report of its findings to "Medicaid" and to the dentist in question. Final decisions as to actions which may invoke discipline of suspension or disqualification are solely the prerogative of "Medicaid". The Dental Society has a well structured peer review committee which will provide review only upon request. *Since 1970*, when the enclosed agreement was first arrived at, there have been *only two cases* referred to the peer review committee of the Eleventh District Dental Society for investigation, despite our continuing offer of cooperation in the resolution of alleged inadequate or incompetent performance by dental medicaid providers.

Question #3—As previously stated the Society is not empowered to invoke discipline in medicaid cases. The Society does not have subpoena power, nor is it an agency of government. Hearings relative to medicaid abuse are legally the responsibility of the Departments of Health and of Social Service and of the Office of Professional Conduct which is an agency responsible to the State Attorney General and the New York State Board of Regents.

Question #4—The enclosed peer review agreement is currently in force, but is not utilized to any significant degree by the Department of Health.

I hope this answers your request for additional information. I continue to urge that amendments to federal medicaid legislation will be directed to provide the medically indigent with adequate health care, administered in such a fashion as would encourage participation by the majority of dentists in New York City and State as well as the country. My former letter details the urgent need for reform of the medicaid program.

Sincerely,

EMIL LENTCHNER, D.D.S.

[Enclosures.]

THE CITY OF NEW YORK DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES.
New York, N.Y., July 16, 1976.

DR. EMIL LENTCHNER,
Executive Director, Eleventh District Dental Society,
Jamaica, N.Y.

DEAR DR. LENTCHNER: The New York City Health Department acknowledges that the following constitutes the terms of the peer review agreement that it has negotiated with the three District Dental Societies of New York City:

1. A peer review committee would be established by each District Dental Society.

2. The district peer review committee would exercise its function in connection with society members, or non-members within its geographic area.

3. The names of the members of each committee and any changes in composition would be communicated to "Medicaid".

4. The peer review committee would concern itself solely with the quality of dental care, and pronounce its judgment as to whether dental care examined is adequate or inadequate.

5. The peer review committee would be convoked by the Dental Society at the request of "Medicaid" whose examinations had disclosed serious or consistent deficiencies, and informal discussions with aberrant dentists had not produced the prescribed improvement in quality of care.

6. The peer review committees shall establish their own internal mechanisms and provide the facilities and equipment for such examinations.

7. After examining patients and records and interviewing the practitioner, the peer review committee will submit a complete report of its findings to "Medicaid" and to the dentist in question.

8. The peer review committee must render its report on a case within 60 days of its receipt from "Medicaid".

9. Although the identity of the dentist in question will be made known to the society, the society will have the option of maintaining his anonymity to the peer review committee up to the time he appears for its interview. A non-member should not be identified as such to the committee.

10. Upon receipt of the report "Medicaid" will take the report of the Peer Review Committee into consideration in making a final decision as to appropriate subsequent administrative actions which may include demands for restitution, suspension or disqualification.

11. The report of the peer review committee findings will always be offered in evidence to hearing officers in formal proceedings.

12. The peer review function represents the commitment of organized dentistry to fostering the dental health of the community and reflects dentistry's responsibility. It offers its service to these ends without compensation.

Sincerely yours,

MARTIN A. PARIS, M.D., M.P.H.,
Executive Medical Director, Medicaid.
ESTHER KAPLAN COLCHAMIRO, D.M.D., M.P.H.,
Director, Dental Medicaid.

THE CITY OF NEW YORK DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES,
New York, N.Y., September 9, 1970.

Dr. ROBERT FISHER,
Chairman, Inter District Committee,
Brooklyn, N.Y.

DEAR DR. FISHER: The New York City Health Department acknowledges that the following constitutes the terms of the peer review agreement that it has negotiated with the three District Dental Societies of New York City:

1. A peer review committee would be established by each District Dental Society.

2. The district peer review committee would exercise its function in connection with society members, or non members within its geographic area.

3. The names of the members of each committee and any changes in composition would be communicated to "Medicaid".

4. The peer review committee would concern itself solely with the quality of dental care, and pronounce its judgment as to whether dental care examined is adequate or inadequate.

5. The peer review committee would be convoked by the Dental Society at the request of "Medicaid" whose examinations had disclosed serious or consistent deficiencies, and informal hearings with aberrant dentists had not produced the prescribed improvement in quality of care.

6. "Medicaid" will be responsible for delivering the patients and their treatment records, evaluation forms and x-rays to the respective societies for examination and evaluation.

7. The peer review committees shall establish their own internal mechanisms and provide the facilities and equipment for such examinations.

8. After examining patients and records and interviewing the practitioner, the peer review committee will submit a complete report of its findings to "Medicaid" and to the dentist in question.

9. The peer review committee must render its report on a case within 60 days of its receipt from "Medicaid".

10. "Medicaid" will make patients and treatment records available to peer review committees in actions initiated by practitioners when the quality of their work has been questioned by Medicaid.

11. Although the identity of the dentist in question will be made known to the society, the society will have the option of maintaining his anonymity to the peer review committee up to the time he appears for its interview. A non member should not be identified as such to the committee.

12. Upon receipt of the report "Medicaid" will, at its discretion, temporarily suspend the practitioner from all participation in the program and set the date for formal hearings by the Department of Health.

13. The report of the peer review committee findings will always be offered in evidence to hearing officers in formal proceedings.

14. The peer review function represents the commitment of organized dentistry to fostering the dental health of the community and reflects dentistry's responsibility. It offers its service to these ends without compensation.

Sincerely yours,

MORTON A. FISHER, D.D.S., M.P.H.,
Deputy Executive Director, Medicaid.

ITEM 2. LETTER AND ENCLOSURES FROM DR. MARTIN MARKOWITZ, PAST PRESIDENT, MEDICAL SOCIETY OF KINGS COUNTY AND THE ACADEMY OF MEDICINE OF BROOKLYN (N.Y.), INC.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 9, 1976

DEAR SENATOR MOSS: I am enclosing copies of correspondence dating back to September 15, 1975 which are self-explanatory.

You can see that the Medical Society of the County of Kings alerted officials about Medicaid Mills and requested an investigation of Medicaid practices in 1975.

Sincerely,

MARTIN MARKOWITZ, M.D.

[Enclosures.]

STATE OF NEW YORK DEPARTMENT OF HEALTH.
NEW YORK CITY OFFICE,
New York, N.Y., January 16, 1976.

MARTIN MARKOWITZ, M.D.,
President, Medical Society of the County of Kings,
Brooklyn, N.Y.

DEAR DR. MARKOWITZ: Our New York City Office of Professional Medical Conduct received your letter several months ago that was forwarded to Mr. Robert Asher of the Division of Professional Conduct, New York State Department of Education, and which concerns Dr. Reiter's article entitled, "Medicaid and Me: Condition Normal."

I have recently had a lengthy discussion with Dr. Reiter concerning that article and I referred to your letter dated September 15, 1975. Dr. Reiter told me that his article was a composite of many facilities which can be referred to as "medicaid mills" or "shared health facilities." Dr. Reiter feels that what is happening in these facilities is "parallel to what is going on in nursing homes." He also stated to me that his "beef is with the system, not with any particular physician." He refers to the owners and operators of medicaid mills and shared health facilities as business entrepreneurs.

I am sure Dr. Reiter would be most pleased to speak with you if you wish to discuss this article with him at any great length. His telephone number is 861-5498. We hope we have been of some help to you in your inquiry about the facts behind this article. Thank you very much for referring this matter to our

Office. Please do not hesitate to call on us if there is anything within our jurisdiction that we can investigate for you.

Sincerely,

MAXINE M. ODENWALD,
Office of Professional Medical Conduct.

THE CITY OF NEW YORK DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES,
New York, N.Y., September 30, 1975.

Dr. MARTIN MARKOWITZ,
President, Medical Society of the County of Kings,
Brooklyn, N.Y.

DEAR DR. MARKOWITZ: I am responding to your letter of September 18, 1975 regarding the article entitled "Medicaid and Me, Condition Normal" by Dr. B. P. Reiter. We have spoken with Dr. Reiter and he tells us his article was a composite of many Shared Health Facilities plus a multitude of tales from his colleagues. He was loathe to name any one place. However, for your information we have an ongoing investigation and indepth audits of many like facilities and we are making concerted efforts to remedy the situation.

As you know Item 230 which would give us some administrative teeth is in the courts. We trust that if this law becomes applicable, we can count on your cooperation in erasing, as you say "blatant unethical conduct by some physicians", thereby upgrading the standards of good medical practice.

Sincerely yours,

JOHN T. GENTRY, M.D., M.P.H.,
Executive Medical Director, Medicaid.

MEDICAL SOCIETY OF THE COUNTY OF KINGS AND
THE ACADEMY OF MEDICINE OF BROOKLYN, INC.,
Brooklyn, N.Y., September 15, 1975.

Mr. ROBERT S. ASHER,
Director, Division of Professional Conduct, New York State Department of Education, New York, N.Y.

DEAR MR. ASHER: I would like to call to your attention an article written by B. R. Reiter, M.D., entitled "Medicaid and Me: Condition Normal" that appeared in the July 21, 1975 issue of New York magazine. I am enclosing a xeroxed copy of the article. If true, this article blatantly reveals unethical conduct by some physicians in the County of Kings.

The Medical Society feels obligated to follow this matter through and investigate the activities of the physicians involved. We enlist your aid in obtaining the names of these physicians so that we may pursue the matter.

Sincerely,

MARTIN MARKOWITZ, M.D.
President.

SEPTEMBER 18, 1975.

Dr. JOHN T. GENTRY,
Executive Medical Director, Medicaid, Department of Health, New York, N.Y.

DEAR DOCTOR GENTRY.: I refer you to a copy of my September 15th letter addressed to Dr. Robert S. Asher, Director of the Professional Conduct Division of the New York State Department of Education, regarding an article entitled "Medicaid and Me: Condition Normal" that appeared in the July 21, 1975 issue of New York magazine. In case it went astray, I am enclosing another copy of the article.

Unquestionably, this article reveals blatant unethical conduct by some physicians and very questionable standards of good medical practice.

I should like to know whether your office has investigated this medical establishment and its members. If so, what has been the disposition of this case?

If by some oversight, an investigation has not been conducted, we believe it is

necessary. The Kings County Medical Society has a stake in assuring that good medicine is practiced in our Borough.

I would appreciate hearing from you.

Sincerely,

MARTIN MARKOWITZ, M.D.
President.

ITEM 3. LETTER AND ENCLOSURE FROM SIDNEY G. SPARROW, ATTORNEY, KEW GARDENS, N.Y.; TO SENATOR FRANK E. MOSS, DATED OCTOBER 13, 1976

DEAR SENATOR MOSS: On August 31st my clients, Doctors Joseph Ingber and Sheldon Styles, appeared before your Committee and testified. Thereafter, you forwarded to me a transcript of the hearing minutes and I have returned same under separate cover.

After considerable discussion, my clients have prepared the enclosed set of proposals to your Committee and I forward them herewith in the hope that they may be of some value to you—recognizing as I do that there is good likelihood that most—if not all—of the content has already been assessed and evaluated by you.

Thanking you once more for the opportunity to be of some assistance, I am

Respectfully,

SIDNEY G. SPARROW.

[Enclosures.]

PROPOSALS TO THE SENATE COMMITTEE INVESTIGATING MEDICAID FRAUD

SUBMITTED BY SIDNEY G. SPARROW, ESQ., ON BEHALF OF DOCTORS INGBER AND STYLES

I. WEAKNESSES IN MEDICAID PROGRAM

1. In concept, the program is doctor oriented, rather than patient oriented. It rewards doctors for making more visits rather than fewer visits. Our experience is that this creates many so-called "grey areas" of doctor judgment that can never successfully be challenged.

(a) Was this test necessary?

(b) Was that follow-up exam necessary?

(c) Was that specialist really in for the patient's benefit, or was it for the doctor's increased billing and the Center's increased income?

(d) Are those blood tests being run for income or patient need?

(e) Are unnecessary drugs, shoes (orthopedic), supports, etc. being prescribed?

2. The common abuses this concept of health care fosters are:

(a) Pingponging; every doctor in the clinic sees the patient.

(b) Family ganging; every child is billed for multiple services.

(c) Up-grading; follow-up visits and billed as a first visit.

(d) File picking; names are picked from files at random, leading to totally false invoices.

(e) Overbilling; false visits or extra unnecessary visits.

(f) Round-robin; one doctor after another bills the same patient for services not given.

3. Medicaid Program leads to various incentives to cheat. Amongst them are the following:

(a) Percentage arrangements between doctors, laboratories and factors. Clinic owners as well are allowed to factor through doctors.

(b) Selective justice in the investigatory system (infrequent and spot checking).

II. SPECIFIC RECOMMENDATIONS AS TO PROBLEMS AND THEIR SOLUTIONS

1. *Problem.*—Patients are unsure of where to complaint.

Solution.—The use of a complaint number in a bright color (red) on the Medicaid Card.

2. *Problem.*—There is patient apathy toward doctors cheating.

Solution.—"BountyHunting"—the patient gets a ten percent reward or something similar of all monies recovered from cheating doctors. Similar to methods used by the IRS to informers.

3. *Problem.*—Doctors are rewarded for writing extra visits.

Solution.—(Major) capitation a la H.I.P. Centers where doctors are paid a salary based on the number of people in the area using the facility. A useful concept here would be—"a front line medicine pay" e.g. very good salaries to induce good men to come aboard.

4. *Problem.*—The system of family ganging and ping ponging.

Solution.—Computer profiling with "abuse triggers" to follow up investigation.

5. *Problem.*—Passing around of Medicaid cards in order to get free drugs and care.

Solution.—Picture of the patient on the Medicaid Card.

6. *Problem.*—The doctor billing for services not rendered.

Solution.—Patient signs each invoice.

7. *Problem.*—Some areas have too many clinics and/or there may be a legitimate clinic and other clinics must overbill to survive.

Solution.—Capitation—limit and license multi-discipline centers which treat more than twenty-five percent Medicaid patients, e.g., one center per 10,000 persons.

8. *Problem.*—Front desk administration and the clerical staff ping pong effect.

Solution.—Each center must have a city employee at the front desk as a "watch dog". The "watch dog" may be a paramedic, R.N., or a specially trained new unit of City Health Department team (Health Ombudsman).

III. CONCLUSION WITH REGARD TO SPECIFIC PROBLEMS AND THEIR SOLUTIONS

It is my feeling that if doctors could be compensated generously for working in Medicaid Centers, with the cheating incentive removed, then the situation would return to sanity and could result in savings in the hundreds of millions of dollars. This could also result in unnecessary follow-up visits, unnecessary medication, and society would benefit in general.

IV. SUGGESTED IMPLEMENTATION THROUGH THE LEGISLATURE, ETC.

1. Percentage deals outlawed—flat rent only.
2. Factors should be licensed and rates charged.
3. Separate by law: (a) Factoring from the Center ownership; (b) labs from the Center ownership; (c) limitation on ownership of Centers to only one.
4. Set specific licensing standards for Medicaid Centers with regard to health. supply and staff.

○

IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 2—BOSTON, MASS.

AUGUST 30, 1976

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Improving Legal Representation for Older Americans:
Part 1. Los Angeles, Calif., June 14, 1974.
Part 2. Boston, Mass., August 30, 1976.
Part 3. Washington, D.C., September 28, 1976.
Part 4. Washington, D.C., September 29, 1976.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

MONDAY, AUGUST 30, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Boston, Mass.

The committee met, pursuant to notice, at 10 a.m., at Gardner Auditorium, Boston, Mass., Hon. Edward M. Kennedy presiding.

Present: Senator Edward M. Kennedy.

Also present: David A. Affeldt, chief counsel; Deborah K. Kilmer, professional staff member; Mark Schneider, legislative assistant to Senator Kennedy; Margaret S. Fayé, minority professional staff member; and Kathryn T. Dann, assistant chief clerk.

OPENING STATEMENT BY SENATOR EDWARD M. KENNEDY, PRESIDING

Senator KENNEDY. We will come to order. This is a meeting of the Special Committee on Aging of the U.S. Senate on the issue of legal services programs for the elderly people of this Nation and on the programs that are in effect which impact elderly people here in the Greater Boston area and also in the State of Massachusetts. It is of great importance to the Committee on Aging that elderly people know their legal rights, have their legal rights protected, and take full advantage of this Nation's legal system.

There is probably no group of citizens of our Nation who have a relationship with their State government, their local government, or their national Government like our elderly people. They are the ones who have paid into a social security system for an extended period of time and they are entitled to the system's benefits. Therefore, they have a stake in insuring that they are able to get the benefits they have paid for, and which they are entitled to. In too many instances, they have not received those benefits. Sometimes the supplemental insurance programs may have been calculated to exclude them from the benefits to which they are entitled.

How many problems do our elderly people have in computing their own income to find out whether they are eligible for free housing or for supplemental housing benefits? Shouldn't elderly people be protected from utilities being turned off in their housing unit, from their rents being raised arbitrarily without sufficient notification, or from being unable to enter or exit a building because it does not have special ramps for the handicapped?

There are innumerable circumstances where our legal system must protect the elderly. The Older Americans Act, which is now law, requires that appropriations be made to develop legal assistance for the elderly. That provision was put into the Older Americans Act as a result of a hearing that we held here 5 years ago. Perhaps some of the witnesses who testified then, will be testifying today. We also have a Legal Service Corporation which has a budget of approximately $125 million. It was explicit in the drafting of the charter for the Legal Service Corporation that it protect the rights of our elderly people. In 3 weeks, the Senate will be faced with what is called a rescission. President Ford and the Office of Management and Budget are going to say we have got $45 million we don't need to expend because there isn't a demand for it. Now, I don't believe that to be so, and when I stand on the floor of the U.S. Senate, I want to be able to bring to my colleagues in the U.S. Senate testimony from today's hearing which will point to instance after instance where individuals' legal rights have not been protected and where they have been protected. Where they think that either the Legal Service Corporation or the other organizations committed to protecting the legal rights of our elderly people can function more effectively and more efficiently, with more paralegal personnel, and perhaps additional lawyers.

I want to welcome those who will testify here today. In many instances they are old friends. They have been extremely articulate and persuasive spokespersons for the elderly people, not only of the Greater Boston area, but for the elderly people of our State and of our Nation. We are looking forward to their comments and suggestions.

I will make a part of the record the statements we have by Congressman—and Majority Leader—Thomas P. O'Neill, Jr., Congressman Joseph D. Early, Congressman James A. Burke, Congressman Joe Moakley, and Congressman Paul E. Tsongas.

[The statements follow:]

STATEMENT OF CONGRESSMAN (AND MAJORITY LEADER) THOMAS P. O'NEILL, JR.

As Congressman and now as the House Majority Leader, I have always had a deep and compassionate concern for the well being of the elderly of this commonwealth and the Nation. I have continually worked to improve the lives of our senior citizens, enabling them to live in both comfort and dignity.

In fact, the reason why I cannot personally be present at this hearing and have asked my legislative assistant to submit this statement on my behalf is because I must be in Washington to offer an amendment, the O'Neill Amendment, to the Supplemental Security Income (SSI) Amendments of 1976. The O'Neill Amendment, which is the first order of business on the House floor today, will affect the lives of many of the senior citizens who are attending this hearing.

As you all know, supplemental security assistance provides a basic cash income to people over 65 who are in financial need. The O'Neill Amendment will have the effect of guaranteeing that future cost of living increases are passed through to the recipients. A recent change in the share of Federal/State contribution meant that approximately 130,000 SSI recipients never received the SSI increases to which they were entitled this year. My amendment will correct this discrepancy so that such an injustice can never happen again.

I offered a similar amendment to the first budget resolution which put a guarantee in the social security laws that enables benefits to keep pace with inflation. Thus, whenever the cost of living increases 4 percent or more in 1 year, your social security check will increase automatically the following July if you

have not already received the increase through congressional action. This means that your purchasing power will be protected against increases in the cost of living in the future.

I want to heartily commend Senator Kennedy for holding the hearing here today to determine ways in which the Government can improve legal representation for older Americans. I firmly believe that the Federal Government has a significant and dramatic role in the task of creating a life of dignity for older Americans.

It was more than 10 years ago that the Congress created the Older Americans Act, landmark legislation which developed community services to put more meaning into the lives of the senior citizens. Included in this act was a bill of rights for older Americans which sought efficient community services whenever needed.

Through the Older Americans Act we have developed programs to meet the nutritional, health, social, and economic demands of older Americans. Now, we must build upon these bills of rights and add an 11th bill of rights—improving the availability and accessibility of legal services to senior citizens.

The Older Americans Act amendments that we passed this Congress contained, as one of its four priorities, the availability of legal services. There is a need for legal services for the elderly and a need for review of existing programs.

Already grants for research and demonstration projects are in operation. For instance, in 1975, Massachusetts received a grant of $18,385 for a State nursing home ombudsman, to process legal complaints for nursing home inmates, and in the same year, the State received $377,000 for administration of the older Americans program planning. Massachusetts also received $2.3 million for area planning in social services and community services.

States are required to adopt a plan of providing legal representation to qualify for Federal funds. No specific guidelines for eligibility are yet in existence. But these initial undertakings are only a commencement. We must improve legal representation for older Americans.

The purpose of this hearing is to determine how we can best improve the availability of legal services for the 22 million elderly in this nation. Nearly 30 percent of the senior citizens in the country are living on or below the poverty line. Yet, they receive less than 7 percent of the legal services provided by the Legal Services Corporation. I think we need to press for a change of direction in the allocation of funding of legal services.

I wholeheartedly support the objectives of this hearing, and may I assure all of you here that I will urge Chairman Randall and the members of the House Committee on Aging to explore ways in which we can improve upon the legal representation of the elderly through the State agencies which implement the Older Americans Act.

The Congress of the United States has a commitment to aid the elderly in this country. We must build upon the bill of rights set forth in the Older Americans Act and continue to develop benevolent and innovative programs as well as improve existing programs for our senior citizens. This is our goal, and all of you participating in this hearing can work with us to make this objective a reality.

STATEMENT OF CONGRESSMAN JOSEPH D. EARLY

I appreciate this opportunity to address the Senate Committee on Aging, and I want to especially thank Chairman Frank Church and my distinguished colleague from Massachusetts, Senator Edward Kennedy, for their commendable dedication to the work of the Committee on Aging.

Older Americans are clearly one of the most discriminated against minorities in American society. We do not reward our elder citizens for their years of contribution, but penalize them, regardless of their contribution, for growing older. We force them out of the work force despite their abilities, energies and experience. We relegate them to "retirement" and place them in a position where their usefulness and their vast wealth of knowledge are left to waste. Worse, the majority of these senior citizens are totally dependent on income far below a subsistence level. They are stripped of the human dignity they have strived for by a system that no longer recognizes them as assets.

We have created a psychological and economic monster by our misguided attitudes and policies toward the aging. Not only do these attitudes and policies destroy a potential in our elder citizens to be productive contributors—to control

their own lives and destinies and to continue to enhance our American democracy with their years of experience and their unique perspectives on the future—but, they rob the rest of us of the benefits of tapping those experiences and perspectives to improve our own lives, our working society and our social future. Truly, what we have done to older Americans is a terrible loss to us all.

The Older Americans Act states 10 objectives to assist older people to secure the full and free enjoyment of our Democratic society: an adequate income; the best possible physical and mental health; suitable housing; full restorative services; employment without age discrimination; retirement in health, honor, and dignity; participation in civic, cultural, and recreational activities; community services; immediate benefits from research; and freedom and independence. Reaching these objectives will be no easy road. Our country—its political figures, its economic leaders, and its general population—in establishing priorities, both social and economic, all too often listen to the loudest voice without thought to the direction that voice may take them. Our society has become more and more fast paced and simultaneously less and less stable. Crime has increased tenfold in the past 20 years. The divorce rate in this country is now about two-to-one and climbing. Our cities are bankrupt and our rural communities are being starved by the neglect of Federal and State governments to insure equal services. More and more of our earned incomes are going to Federal, State, and local taxes and fewer and fewer services are evident to show for that investment. This is the society that we are asking to reassess its disposition toward Older Americans. And, the battles ahead strike the core of our domestic instability. We want medical services available at reasonable costs. We want equal opportunities in the work force. We want this Nation to face the reality that aging is a process, but a growing process that should be recognized as such and dealt with at every level with respect and dignity.

That the law discriminates against the elderly is probably the most symptomatic of our attitudes as a society. It implies that we, as a Nation, fear aging and fear the aged for what they represent—our own destinies. As we have seen, to a large degree, with racial discrimination in this country, the law is the place to start. Changing the laws to guarantee equal treatment of the elderly will begin the process by which attitudes will be changed. The essential in improving legal representation for older Americans is the willingness of older Americans themselves to demand representation. There are many of us who stand ready to help, assist, and direct the attention of these demands—but there is not one of us who can restore senior citizens to their rightful place of participation in this Nation alone.

The Committee on Aging has been largely responsible for calling national attention to many of the needs of older Americans. Again, I want to thank Chairman Church and Senator Kennedy for allowing me to submit this statement for the record. The committee has my full support and I stand ready to assist, in any way I can, to promote equal and equitable treatment of the elderly under the law.

STATEMENT OF CONGRESSMAN JAMES A. BURKE

Today there are over 20 million Americans who are age 65 or older. Over the past several years the Federal Government has increased its commitment to improving the quality of life for our elderly citizens, in addition to numerous liberalizations in the Social Security and SSI programs. A major thrust of federal action has been the Older Americans Act which under the 1975 amendments provides the impetus for addressing many of the social service needs of the elderly. However, one need which continues to go unheeded for great numbers of the elderly is effective access to legal advice, counseling and representation.

For those with the means, if a legal problem arises in their daily lives, they have the financial resources to seek out the services of an attorney. But that choice is not readily available to a large segment of the elderly. One in every four elderly families lives on less than $5,000 annually. More than 50 percent of old people living alone live on less than $3,000 a year. People over 65 make up about 16 percent of the poverty population. Most of these people rely on social security or SSI.

Many of the elderly, of course, receive free legal services from federal programs administered by the Legal Services Corporation and the Administration on Aging, but the resources of those programs are not sufficient to reach the potential clientele to be served. Although the elderly comprise 16 percent of the

nation's 24 million poor, it is estimated by the Legal Services Corporation that they comprise only 6 percent of the client caseload of an average Legal Services Corporation grantee.

Even for those elderly citizens with middle class incomes, the prospects for obtaining needed legal services are not good. Typically, these are the people who are too "rich" to be considered eligible for free legal services from one of the Legal Service Corporation offices even though they are too "poor" to afford an attorney.

The elderly face a myriad of legal problems for which they are in persistent need for legal advice, counseling and representation. The elderly encounter not only general legal problems but many other special problems involving age, discrimination in employment, probate, pensions, long-term hospitalization, and nursing homes. In addition, the complexity of federal laws and regulations in such programs as Social Security, SSI, Medicare, Medicaid, Railroad Retirement, and Veterans Pensions, often requires the assistance of lawyers or paraprofessionals trained in the area.

It is important that more of our elderly citizens fully understand their legal rights in matters which affect their daily lives and have fuller access to legal representation. I am encouraged by the recent increase in appropriations for the Legal Services Corporation and am hopeful that the expansion of their program effort will include increased coverage for the elderly poor. The increased efforts of the Administration on Aging in the development of legal services capability for serving the elderly is also encouraging. I am particularly interested in their efforts to expand the use of trained paralegals and lay advocates as a means of creating opportunities for trained older persons to take an active role in the provision of legal assistance to other older persons.

Although increased efforts must be continued at the federal level, it is also necessary to encourage fuller participation by the private bar. The legal profession is becoming increasingly aware of its responsibility for helping to improve the availability of legal services to those unable to afford their services and I am hopeful that they will address their efforts to the needs of the elderly.

The hearings today will hopefully enable the committee to focus on the current problems and lay the groundwork for determining the directions that must be taken to insure that the legal needs of older Americans are met.

Throughout my entire career in the U.S. Congress, the needs of the elderly have been of special interest to me. Now, as chairman of the Social Security Subcommittee of the House Committee on Ways and Means, I am continuing my active role to secure for our senior citizens the means for them to live their lives with the dignity and security they so rightfully deserve.

Thank you, Mr. Chairman.

STATEMENT OF CONGRESSMAN JOE MOAKLEY

Today we are finally realizing the magnitude of the legal needs of millions of older Americans—needs which have been sadly neglected in the past. At this time in our Nation's history, there are more people past the age of 65 than ever before 650,000 in Massachusetts alone. Notwithstanding, these citizens' basic legal needs have not been fully addressed, making a fundamental precept of our Nation, "equal justice under law."

Many of the elderly lead productive lives. Many others are burdened with health, transportation, nutrition, and housing problems. Many are poor. Many live on limited incomes which often forces them to rely upon complex public and private institutions for their daily subsistence. Yet, they are not capable of dealing with the many legal aspects of this maze of governmental agencies and bureaucracies upon which they are so heavily dependent.

For example, their shelter may be provided or secured under federal and state public and subsidized housing laws, relocation laws, environmental protection laws, and zoning laws.

Their health is often dependent upon medicare, medicaid, laws regulating nursing homes, and laws relating to the advertisement of prescription drugs.

Their nutrition is often secured by the food stamp program.

The source of their income may be social security, supplemental security income, or private pensions.

The dignity of personal freedom and control of property is subject to the vagaries of the law of guardianship, conservatorship and involuntary commitment. Furthermore, the elderly also have numerous consumer and landlord-

tenant difficulties, legal difficulties which are shared by all age groups. In fact, hardly any facet of the lives of our elderly may not be helped by legal representation.

While the elderly are, on the one hand, confronted with a vast complex of crucial legal issues, bureaucracies, and forms with which to deal, on the other hand, they have no real place to turn for effective economic and personal assistance. Many of the elderly are not adept at coping with the governmental system and are unable to deal with issues of a legal nature. Yet, it was noted by Paul Nathanson, executive director of the National Senior Citizens Law Center, "There is often no one available to explain the technical language of Federal regulations, or the requirements for witnessing a will, or the qualifications to be met in a pension plan, or the tax implications of retirement programs." Many of these "legal" problems require lawyers' help, but others require only that competent paralegal or nonlegal advice be available. But even nonlegal help is oftentimes inaccessible to our elderly, some of whom are physically unable to leave their homes or convalescent centers or are without transportation; with out information about where to find help when help is needed; without the understanding of the fact that they need help; and most importantly, without the income capability to pay attorney's retainer fees. The situation of the nondestitute elderly, with respect to legal representation, is perhaps even more acute than that of the elderly poor, because they have too much income or resources to qualify for free legal services and yet, cannot afford to hire a private attorney.

Clearly, the need of our senior citizen's for legal service is pressing. However, for all but a small fraction of the elderly, the legal system is beyond reach. It is our responsibility to expand the provision of legal services to the elderly by all appropriate means. No society can properly claim that it is governed by a system of law when millions of its citizens are denied access to the legal system because they are past the age of 65.

STATEMENT OF CONGRESSMAN PAUL E. TSONGAS

Senator Kennedy, and members of the Senate Committee on Aging, thank you for inviting me to submit testimony concerning "Improving Legal Representation for Older Americans."

My office has maintained a close working relationship with agencies, such as Merrimack Valley Legal Services, as well as senior citizens organizations throughout the Fifth Congressional District to encourage the development of effective programs for seniors.

I support efforts now being made at the local level to provide free legal services for the elderly who must live on a fixed income. I will continue to support. and actively work toward, the expansion through increased Federal and State funding of existing agencies who also service other segments of the population.

I do not favor the creation of additional layers of bureaucracy to deal with existing problems which can be solved by established agencies.

Senator KENNEDY. We have a full witness list here this morning. We will move right to the witnesses. If there are others in the audience who want to speak, we will put a legal pad at the "no smoking" area. You can sign up. We will make sure that their comments are made a part of the record by dividing the time available between the witnesses we have scheduled and members of the audience. We will start off with Cecilia Fennessey. Mrs. Fennessey is a resident of Franklin Field elderly housing project, 70 years old, and a longtime resident of Boston.

STATEMENT OF CECILIA FENNESSEY, DORCHESTER, MASS.

Mrs. FENNESSEY. I am Cecilia Fennessey, and I am from the Franklin Field housing project, and the increase in the rent in some of the cases were resolved. I get $212 and I am a diabetic, and I do take two kinds of insulin, and all my supplies that I need, alcohol, and so on.

The $10 increase wouldn't mean that much to me, but some increases in rent were from $28 to $48 to $68, and we are getting a small social security check, and also some from SSI.

No Services

The conditions in the project that we live in are ridiculous. We get no service, no nothing. We call week in and week out to get lights fixed and end up in the darkness. Last winter I was without heat and had to go out and buy an electric heater. It had got so bad that I wanted to have an electric heater so that I could get up and get dressed in the morning. I had no heat so I had to go to my sister-in-law, Mary Fennessey, in South Boston and stay with her. There wasn't even a month's notice when we got the increase. I got a $10 increase, which wasn't too bad. I have all my medication and medicines to buy. Some tenants there, who weren't as well off as I, were getting much bigger increases in their rents. They all had to turn to the legal advocates and whatnot to see if they could get their amounts adjusted so that they could pay the rent. But as luck has it, it fell through anyway.

Without a month's notice beforehand, that kind of an increase is kind of terrible where we have very little service, very little anything in the project that we live in, and I think the same prevails throughout Boston.

Senator Kennedy. Mrs. Fennessey, how much notice did you have that the rent was going up?

Mrs. Fennessey. One month. We pay our rent for just the next month, and we were told that, and we had already signed up leases for the year, the fiscal year, and the first of the year we get another notice of an increase in rents.

Senator Kennedy. When did you sign up? At the start of the year?

Mrs. Fennessey. At the start of the year, and then it started to climb up the month before last. It was supposed to be for the second month.

Senator Kennedy. You started off at the beginning of the year with a $40 allocation?

Mrs. Fennessey. A $40 allocation.

Senator Kennedy. Your budget for the year was at $40, and then halfway through the year you found out that it was increased, is that correct?

Mrs. Fennessey. Yes; a $10 increase a month for rent.

Senator Kennedy. How much notice did you have, 1 month?

Mrs. Fennessey. One month's notice.

Senator Kennedy. Now, when was the last time that the rents were raised, do you remember that?

Mrs. Fennessey. No; I don't. I am only in there 3 years now.

Senator Kennedy. Three years. What are the changes? You mentioned that there have been changes at Franklin Field. I understand that your heater cost you $16.

Mrs. Fennessey. Yes; I bought it at Jordan Marsh because there was no other way to heat. Some of the people can bleed their radiators for their apartment, but in the apartment that I am in you can't bleed

the radiator because the radiators are built into the wall and there are grids over them, so therefore I couldn't live there for 2 or 3 months. I had to go outside and live with my sister-in-law.

No Heat for 2 Months

Senator KENNEDY. Well, the heat was off. When was the heat off, Mrs. Fennessey?

Mrs. FENNESSEY. This past winter the heat was off.

Senator KENNEDY. For how long a period of time?

Mrs. FENNESSEY. I didn't have any heat for 2 months.

Senator KENNEDY. For 2 months?

Mrs. FENNESSEY. For 2 months.

Senator KENNEDY. Well, what happened when you——

Mrs. FENNESSEY. Well, I kept calling, calling. They came up finally to do something, but it didn't seem to make any difference.

Senator KENNEDY. It still wasn't fixed then?

Mrs. FENNESSEY. No; then there was only two rooms where there was heat, the parlor and the bedroom; the bathroom and the kitchen had no heat whatsoever. You need heat in the bathroom. You need heat in the kitchen too.

Senator KENNEDY. That is right. What are the kind of changes you would like to see out there, Mrs. Fennessey?

Mrs. FENNESSEY. Well, I would like to see something done so we can get some kind of services. We don't get any services. The dead animals outside on the lawn, and whatnot, nobody will pick up; the rats, and the cats, and everything else. There is one out there right now in the back for 6 weeks. I called the office and they said they would do something, but they never did do it. The lights in the hall. We can't, people can't climb up the inside hall to the ceiling without a ladder, and there is no light there. It doesn't do any good. You just keep complaining and complaining and nothing is done about it. I know people who live there for months, and in fact, 6 months out of the year, and they don't even take care of the leaks. They have to keep pans under the sink to catch the drips. That is right in the next house, for that matter. Right next to me.

Legal Aid to Recover Funeral Downpayment

Senator KENNEDY. Were you able to get legal assistance during the time that you have been at Franklin Field?

Mrs. FENNESSEY. Oh, yes.

Senator KENNEDY. Can you tell us a little bit about that?

Mrs. FENNESSEY. Well, it seems that I kind of got fed up on things out there and I didn't know what to do. The people were coming up and saying "have you got plans made, or this or that." Well, I purchased a grave and then I went to an undertaker up there across from Mission Church. I wanted to go in and make plans for burial, which doesn't scare me, we all have to go sometime. I paid $200 down on my funeral and at that time they told me it would come to around $1,700, although he said that by the time it happens, it would have jumped so much more. I paid $200 down on my funeral, which I never heard anything about, and the next thing I know, somebody, a cousin

of mine up on Tremont Street, called me to ask me if I knew that the place was being sold and isn't in business any more. I said, "What?" She said, "Yes." Well, in looking into it, I found out that they folded up and I never got no word, no nothing, so my $200—I don't know where it is either. He got it. And I got a receipt for it, so I went to the legal authority down at Grove Hall, and they helped me, and they are still investigating. Whether they get to any point or not, I don't know.

Senator KENNEDY. But they tried to be of some help to you?

Mrs. FENNESSEY. Oh, yes. Oh, yes.

Senator KENNEDY. How about at the time that they raised your rent, did you get any kind of legal help?

Mrs. FENNESSEY. Yes, I did.

Senator KENNEDY. Will you tell us a little bit about that?

Mrs. FENNESSEY. Well, they came down to our project——

Senator KENNEDY. Who is "they?"

THE LEGAL ADVOCATES

Mrs. FENNESSEY. The legal advocates. They are located down on Massachusetts Avenue somewhere; they have moved from Grove Hall, and they, in fact all of our neighbors, we have them come down to our hall where we give them the situation; they come down and the people give them their amounts of incomes for the month and what the amount of the increase that they could give. Some of them were very objective in the light of this because the increases were exorbitant.

Senator KENNEDY. They brought your case to the attention, I guess, of the city administration, city hall?

Mrs. FENNESSEY. Oh, yes; and a lot of neighbors, too, in the same site. In fact, I think they are still working on them.

Senator KENNEDY. Do you have a feeling that they are, or you have a voice speaking for your interest now?

Mrs. FENNESSEY. Definitely. Definitely.

Senator KENNEDY. Do you feel good about it, even though you don't know what the outcome is going to be?

Mrs. FENNESSEY. Yes, I do. And the neighbors, too. What would we do if we didn't have someplace to go for advice? It would only be impossible for us.

Senator KENNEDY. Thank you, very much. I hope you stay with us during the hearing, and I want to thank you very much.

Mr. Richard McCusker is the chief paralegal coordinator, Council of Elders Legal Service program. He will discuss the special role that paraprofessional legal aides can play in meeting the legal needs of the elderly.

STATEMENT OF RICHARD McCUSKER, CHIEF PARALEGAL COORDINATOR, COUNCIL OF ELDERS LEGAL SERVICE PROGRAM, BOSTON, MASS.

Mr. MCCUSKER. Thank you, sir. We are a group of eight paralegals, four attorneys, two secretarys, one of the attorneys being the managing attorney. We are involved in trying to assist the elderly in such

areas as social security, supplemental security income, rent control and housing, consumer and utility disputes, conservatorships, guardianships, tenant-landlord problems, housing code violations, wills, trusts, and many other legal areas.

The way we get to the elder client is by virtue of outreach. We do a tremendous amount of outreach by group meetings, on a one-on-one basis, and we have assistance from the Council of Elders, because of their ESP programs on a referral basis. If they have clients that require legal services, they are free to call on us. Our services, which are provided if they meet the eligibility requirements, are free.

How Paralegals Work

We also have an operational requirement that any case that is brought in is reviewed by an attorney. The reason for this is that however mundane it may be, we don't want anything to fall between the chairs, so each case is reviewed by an attorney. Paralegals are then given instructions as to what to do, what is the roadmap, what can we do to carry this right through to its conclusion. This saves much time. Many cases can be brought to completion by paralegals in social security, small claims, and many other areas that they have the expertise to do this. Paralegals are elders; all of them are over 60; they work 4 hours a day because of the stipulation you cannot make over $2,760 a year, or you get clobbered by social security and have to return $1 for every $2 you earn over the $2,760, and in 4 hours a day they just about get started. We bring in four paralegals in the morning and four in the afternoon so that the office is being completely covered.

They are interfaced with the attorneys on a basis that has been thoroughly tested and checked; two paralegals report to one attorney. Each case is reviewed and they follow through from there. This program has been going on since 1969. It started out as a model program. The reason was to bring legal services to elders on a no-fee basis. It was then known as LRSE; however, when we reached this point of viability, we began going full bore to really try to cover the area. Right now we have insufficient paralegals because of the grant requirements. We don't have sufficient lawyers to cover all the Greater Boston area, and we are looking for additional funding so that we can spread this point of viability into full growth.

Examples of Legal Assistance

One of the types of cases that we have untangled, in just a rough outline, is where one person in particular was robbed and attacked. We brought suit against the Commonwealth under the statute providing that she could recover her expenses under the Violent Crimes Act. Her medical bills from recognized physicians were not available inasmuch as she had Christian Science practitioners, which were not compensable. Upon the recommendation of the judge in the district court, after talking to the attorney general's office, they were found acceptable. She received an award of $142, which at that time, with the $100 deductible, would give her $42. The judge was greatly chagrined, and he erased the $100 deductible clause, and she netted the entire $142.

We had another client who was living with her son in the household. She was receiving SSI for both of them; however, she was asked to return it because they were overeligible. Now, this hardship was found out by one of our paralegals and it was determined that the social security shutoff and the requested return of the money was incorrect. It was reinstated, and further than that they were refiled and put back on SSI again.

We had another case with a person in St. Elizabeths Hospital in Brighton, 80 years old. She was found in a comatose condition on the floor in her bedroom. She was brought into the hospital by the police. She had no living relatives. She owned a home and a car. At such time as the board of the hospital decided that she no longer needed medication, she was immediately put on the list for transfer to a nursing home. We were pulled into the case because of the client not having any dependents. Further than that, we executed a power of attorney for her, so that we could begin to get in and take care of her bills, and also, with the exception of getting her located in a decent nursing home, we made arrangements for the purchase of clothing. We also went to her home and actually did a very clandestine thing, we had to break in in order to get the person her glasses, and also found $500 in her pocketbook.

The question now is that she had the home and no relatives, nobody living there. We had to do something about disposing of the home. We are looking very seriously at a conservatorship to handle the entire matter. This is an area where legal services and protective services are so closely related, it is very difficult to break them loose.

I could go on and on with more and more cases here. We have files full of them that have been resolved very beneficially to the elders and we have succeeded in bringing them to a very satisfactory culmination. Thank you.

Senator KENNEDY. You're sponsored by the Older Americans Act, am I correct on that?

Mr. MCCUSKER. Yes. Well, I work directly for the Council of Elders, under the Older Americans Act. funding under title XX as well, but legal services does not use title XX money.

Senator KENNEDY. What legal training did you receive to help you respond to these problems?

Mr. MCCUSKER. Purely by osmosis, by getting out and doing things.

Senator KENNEDY. Do you think that elderly people have a greater insight into the needs of the elderly than a young attorney that's just out of law school? If so, why do you believe that to be so?

Mr. MCCUSKER. I would say, yes, primarily because of the rapport of the elder paralegals with an elderly client. Elderly clients are very apprehensive about dealing with anybody younger than they are. They have problems, and they will talk to their friends and neighbors, but they will never bring them to the forefront because of this fear.

Senator KENNEDY. Do most of you agree with that?

[Response affirmative and negative from the audience.]

Senator KENNEDY. Go ahead.

Mr. MCCUSKER. That is about all I have to say.

Senator KENNEDY. You gave an interesting example of paralegals working with the attorneys to solve a problem.

Mr. MCCUSKER. Thank you, sir.

Senator KENNEDY. If there are some legal questions or issues which are complex and difficult, you have access to the attorneys, as I understand it.

Mr. MCCUSKER. At all times.

Senator KENNEDY. So this is really an extension of the——

Mr. MCCUSKER. Right. Actually, what we do is the legwork, in many instances, for the attorneys to save time any try to expedite these things to completion of the case.

Senator KENNEDY. Finally, what are the areas in which you find the most demands for assistance?

Mr. MCCUSKER. Well, we have a tremendous number of social security and SSI cases. We are always bombarded because of a lack of housing on a subsidized basis. We are constantly before the board on some of the housing organizations; increases in rents, the conditions of the homes that they live in. We write a good many wills. In fact, we also have an eligibility requirement of 60 years old; however, we did run into a client who was 57 years old who wanted a will. At that point in time we had to think about it, but we related to the fact that the woman was terminal with cancer. So what do we do? We write a will regardless of the age factor. But we run the whole gamut of problems with the elders, other than criminal cases. We do not handle criminal cases.

WHY DO ELDERLY HAVE LITTLE LEGAL COUNSEL?

Senator KENNEDY. What do you think the principal reason is that elderly people do not have much legal guidance or advice?

Mr. MCCUSKER. The problem is that the elderly don't know about it. Roughly 25 percent of the elder population have a complete lack of guidance. In an effort to reach them you have to do it on an outreach basis, and there is insufficient time and funding to do it; however, we are doing it by virtue of going to elderly clubs, nutrition programs, just about anyplace that anybody wants to hear of the Elders programs and legal services for the Elders.

Senator KENNEDY. How many paralegals are there in your particular group?

Mr. MCCUSKER. A total of eight.

Senator KENNEDY. How did you hear about the paralegal program itself?

Mr. MCCUSKER. Well, I was reading about it in the paper one day and decided to look into it, and I thought it would be interesting. Having been in industry all my life, I felt that anything that should be done, should be done.

Senator KENNEDY. OK. Thank you very, very much, Mr. McCusker. We will now hear from a panel of senior citizens, all of them familiar faces. They are all concerned with improving the quality of life for the elderly of Massachusetts. Mrs. Melnea Cass, president of the Council of Elders. She is certainly no stranger to myself or to this committee. Her testimony 5 years ago before this committee was helpful not only on focusing the attention on the need for direct legal services, but on the need for providing special aid in monitoring nursing homes. We have now opened free legal services for the elderly, although not enough, and a federally funded nursing home ombudsman program. Frank Manning is another friend. He is an adviser on

matters affecting the State's senior citizens, president of the Legislative Council for Older Americans, and an outspoken advocate for the State's elderly. Whatever the issue, whether legal services, nutrition, employment opportunities, or housing, Frank Manning has been a constant source of information and wise counsel. James Peace is another leader of a statewide organization dedicated to the betterment of living conditions for the State's elderly. As State director of the National Retired Teachers Association, and as the executive director of the Cape Cod and the Islands Area Agency for the Cape under the Older Americans Act, his efforts have been a vital source of information for both State and national policymaking in the field of aging. We have three good witnesses here. Melnea, would you like to start off this morning? I don't know if those lights are too bright for you.

Mrs. CASS. No; thank you very much, Senator.

Senator KENNEDY. Good to see you.

Mrs. CASS. Welcome home.

Senator KENNEDY. I enjoyed that very complimentary and fine article of yours the other Sunday in one of our Boston publications.

Mrs. CASS. Thank you.

Senator KENNEDY. It's a great, great tribute to you and well deserved. All of us feel that way. Please proceed.

STATEMENT OF MELNEA CASS, PRESIDENT, COUNCIL OF ELDERS, BOSTON, MASS.

Mrs. CASS. Thank you very much. I might start off by saying that the Council of Elders, of which I am president, the board of directors, sponsor in Boston this program for senior citizens, and it has three branch offices; one in Roxbury, one in what we call Grove Hall, the fringe of Dorchester, and one in Brighton. It serves many, many elderly, all kinds of people, all ethnic groups. It doesn't matter who they are. They serve everybody.

It has met the need of many. I notice when Mr. McCusker spoke, he told of some of the many instances that come up. Well, that could be multiplied many, many times, but the main thing is that it meets a need, and it really hasn't got enough money, Senator, to meet the needs. It needs a whole lot more money poured in, because the elderly people are now at the point where they have very little income, and when it comes to getting a lawyer, that is the last thing they do with their money. Most of them, the real poor ones, and mostly the poor white and the poor black, never had lawyers anyway. They never thought they needed a lawyer. When they went to court, the court gave them a lawyer when they got in trouble, and they used whatever lawyer that came. It was not part of their everyday living to have a lawyer or doctor, or anybody else.

So, they are reluctant when they grow older, many of them, who haven't had the advantages of knowing what it is to hire a lawyer. They just don't do it, and they have so many inequitable things happening to them.

Many of them that I talk with among my people, especially about making a will, or telling their family how much money they have, that is a great secret. They won't let anybody know what they have—

you're not supposed to know—and when they die nobody knows what they have. When you look around you will find money under mattresses, and behind pictures, under the rugs, and all kinds of places. So the lawyer who steps into these kind of cases have been great.

Outreach Workers Needed

The outreach to get to these people is really a big, big problem. The person who opens the door for the young lawyer is important. He's needed in these cases, but the elderly are sometimes suspicious of them, and many of them fear them, and they think they are young and are putting something over on them and meddling in their business. But when you have a senior paralegal who comes along and talks to them, or when an outreach social worker who is in our program gets on the good side of them, they will tell them everything as a result, and that is the only way that you are going to reach them. Really, more money is needed in the program so there can be more outreach workers to find the people who are hidden away who don't know their rights. That is the way it is.

So as far as the program goes, I would say it's one of the greatest programs there is. I have a friend right now who has made her will with the undertaker. She went over there and she got the casket, told the undertaker how much the policy is for, the amount of insurance so they know how much to charge her, you know. And then she has to pay every single month on it, because, years ago you could get buried for $500. Now, it is going to cost about $2,000. She has to pay out of her income every month to the undertaker on her bill for burial. Nobody knows what she is paying to the undertaker. So, that is where you need good lawyers, to go along to help her, and to guide her. She is only one person; there are many, many, who do this very same thing.

There are many other things that we do—old people—because we don't want to tell anybody. If we have a good friend and we like them, we will sometimes sit down and tell them.

More Volunteer Lawyers Needed

I think that more money, as I said before, is needed in the program to expand upon these services, to give the program more people who are really trained to do this job. There should be more volunteer lawyers. I think that some of the lawyers who retire from some of the big law firms should give some of their time as a volunteer to come around and help the poor people, because a lot of them made money on them and they could give some of the money back. [Applause.]

There is a field for much more development in this. It is brand new, and the National Council of Senior Citizens, in Washington, D.C., of which I am a board member, are really the people who are behind this, pushing this, and seeing that it works all over the country. You should be proud that we have all these organizations to speak for us. We go down to Washington to visit with Senator Kennedy and all the rest of our representatives to see that they do the right thing down there. [Applause.]

We appear down there in Washington just like we are appearing here today at this hearing in Massachusetts. All do not speak for us

but we have somebody in Washington lobbying for us all the time who really takes care of us. We should thank them all. We are thankful in our old age, and back them up. Those of us who don't know anything about the law have them to speak for us because we really need it.

I also want to pay a tribute to the workers who work with us, the young people who work with us. They are well equipped. As I always say, you all went to school, and you got the education, so you ought to know what to do. So, we put ourselves, many times, in their hands, and they do a good job. So, I want to pay a tribute to all of them because without them we couldn't make it.

We have a lot of big ideas, you know, when we get old, but our steps are slow, and our heads get a little slow, too, so maybe they can think while we are trying to get it together. We tell you what to do. You can get it together from what we say, so we thank you for your help.

Senator, we thank you, too, down in Washington, for what you do for us. We watch you, you know. We know what you are doing. He is always in our corner. [Applause.]

Senator KENNEDY. Thank you.

Mrs. CASS. We don't have to worry about him. He is there when we need him, and when there is a vote coming up for the elderly, you can pick up your paper and read that he was there and what he was there to do. That is what we want. So, we want to keep him there—please don't forget that. [Applause.]

Senator KENNEDY. I didn't see those remarks in your prepared testimony. They are nice to have—a little cool northerly breeze on a hot morning in August. Thank you, very much.

Frank, why don't we hear from you now.

STATEMENT OF FRANK J. MANNING, PRESIDENT, LEGISLATIVE COUNCIL FOR OLDER AMERICANS, BOSTON, MASS.

Mr. MANNING. First, I usually agree with Melnea Cass. One thing that she said that I have to take exception to is that age slows up our mental faculties. I have felt a slight acceleration in that area since I retired. In fact, I laughingly call it my retirement—I have never been so damn busy in all my life. But what we are discussing here this morning is one of the issues connected with retirement, an ever-growing problem in this country. Elders are not problem people; society is giving us a hell of a lot of problems, not the least of which is the lack of adequate income maintenance plans in this country. When an ordinary elderly person, on fixed income, thinks about a lawyer, he immediately thinks of a big fee and he also has a certain amount of mistrust, which, of course, is not always justified. The fact that most of those connected with Watergate were lawyers doesn't mean that they are all that way. A couple of them that I know are all right.

"THE LAW . . . IS AN AWESOME THING"

As a matter of fact, the law, to many elderly people, is a very awesome thing, a distant thing, and let me cite you a case in particular. One afternoon, about 3 o'clock, I received a telephone call from a

woman who identified herself as being about 75 years of age and she had a real problem on her hands. She said, "Mr. Manning they are selling my house, because I couldn't pay my taxes."

So I said, "Well, when are they selling your house?"

She said, "Tomorrow morning at 8 o'clock."

I said, "Dear, I wish you had gotten in contact with me sooner, but we will do what we can." So, I immediately got hold of one of our VISTA volunteers and, by the way, you can thank Senator Kennedy for having those VISTA programs, because when they threatened our programs, he used extraordinary means to save them. I don't know all the details. [Applause.]

We have a retired lawyer among other professionals, and I talked it over with him, and I said, "Do you have a friend?" I am not going to give the locale or the name of this. It's a little shady, you know. I said, "Do you have a friend in the right place?" And we worked out a deal that he would be there at 8 o'clock in the morning when the sale started. And he would have the opportunity to bid on the house. So, he arrived on time with a certified check for $1,000. Those two people are still sleeping in their own home, thank God, and they don't have to worry about the back taxes because, technically, they are new owners.

Now, where could you get service like that for nothing? [Applause.]

I am sending a memorandum on it to F. Lee Bailey to wise him up. As a matter of fact, the cost of legal service today—and I don't really want to downgrade all lawyers, surely they have overhead and heavy expense—and any program of legal services that needs lawyers should pay them an adequate fee so that they can serve us properly; but, however, at present we have about 22 million senior citizens over 65; and in 1980, there will be 24 million; and in 1990, there will be 27 million. In 2000, it will be 30 million; and in 2010, it will be 40 million; and yet I have not heard outside of the Senate Committee on Aging, and Senator Kennedy is a member, I have not heard, by any of our leading public officials, an in-depth discussion of how the Nation is going to meet that problem.

Full Access to the Law a Major Need

One of the great needs in any society is full access to the law regardless of your income, station, regardless of who you are; it is part of our creed that every man, woman, and child is entitled to full access to the law, and a poor person cannot get that, and I think that in this respect the legal services program is performing a service.

Now, as a representative of a statewide organization, I get calls from other areas, small communities, that do not have legal services, and one of the things that we would like to do is to get retired lawyers, volunteers, young people, to work with them in these communities, so that not only Boston and the urban communities will have these services, but also the smaller communities.

Now, the economics of the situation is such, where do we spend our money? Aside from an occasional Drambuie or martini, where do we spend it? Mostly on clothing, food, shelter, and medical costs. That is where most of our money goes. There is very little left for things like legal services or anything else that is outside the ordinary necessities of life, and the principal reason for this my friends is that in determining

our social security and other pension systems there is no margin for living. We are caught in a tight economic vise.

Just consider this one fact alone: A study in the early 1970's of the income of families in this country shows a glaring discrepancy which should bring the crimson of shame to the cheek of any conscientious American. The median income of couples under 65 is $12,500. The median income for couples over 65 is $4,800. We got a long way to go folks to tighten up that gap there, and it means that legal services, among other things, are consistently denied to you.

I know a lot of people that come into my office, as you have suggested, Mrs. Cass, to have wills made out, or even in some cases, and I don't like to say this, where members of the family are trying to do them out of their homes. We have a few cases like that, too. It is horrifying to think about, but it is true, and then you have tenant-landlord relationships and you have administrative decisions.

A good advocate for the elderly does not confine himself to any one area. There is a wide range in the administrative area, or wide range in the legislative area, and a wide range in the judicial area. So, you have to be a good advocate and you have to know where to go to get the help that this particular person needs, and so as far as the courts are concerned, all too often they are so busy that they don't have much time for poor defendants who have no friends or don't have much money.

Of course, if you operate on a large scale, there is always a good chance that you get a pardon, but if you do any minor offenses, you are in real trouble. So very often there is not adequate representation, and while the problem of the elders is not so much the criminal field, there are major problems in their everyday lives.

Paralegal Advocacy Is Needed

I want to close with this because I think my time is up, but I want to fill in with this little illustration where legal, paralegal advocacy, is needed.

A woman came into our office and said for some reason the Social Security Administration had denied her money for her children who were classified as survivors. She was a widow. There was some technical difficulty there. I can't go into it now. As you know, Senator Kennedy was instrumental recently in getting an ombudsman office for social security.

Now, the purpose of this ombudsman office is to handle cases that are so tangled that they require in-depth study. This is where that special social security office headed by Mr. McNamara comes into the picture.

So, this particular woman, not only did she win her case, but she got $2,250 for one of the children which she should have been receiving for the last couple of years, and in the case of another child, $125 a month. I don't have to tell you the difference this made in the quality of her life. Had she not had an advocate, she might have gone on in cramped existence for the rest of her life and never received the full measure of justice.

Sometimes I wish that I could be like the judge who said "This court is often in error, but never in doubt." But unfortunately, I have

doubts, and I have frustrations, but I want to tell you this, that we have to support these elderly programs, and at the earliest opportunity we have to get together with the Senate Committee on Aging saying, in addition to these programs, what about the 80 percent of senior citizens whose only need is a decent home, a decent income, and good health programs. Let's get down to brass tacks, and in the meantime, get legal services going. Thank you.

Senator KENNEDY. Jim Peace.

STATEMENT OF DR. JAMES S. PEACE, STATE DIRECTOR, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS, HYANNIS, MASS.

Dr. PEACE. Mr. Chairman, you have assigned to me one of the most difficult jobs that I ever had. To follow Mrs. Cass and Frank Manning is most difficult.

Senator KENNEDY. I agree.

Dr. PEACE. I don't see how it is humanly possible to add very much, but just let me try to be rather brief because I have cut down my testimony, after acting on instructions from not only your staff people, but because as we get older our tongue does not lose its elasticity. Maybe our muscles do, but we keep on talking. I will use a guide here so that I will stay within the bounds.

My name is Jim Peace, and I am the Massachusetts State director for the National Retired Teachers Association. I am also executive director of the Elder Services of Cape Cod and the Islands, Inc. Nationally, I believe the National Retired Teachers Association and the American Association of Retired Persons have approximately 9.8 million members, and in Massachusetts, we have 366,300. That is quite a significant number.

I am meeting here today with you in order to orient the committee to my testimony which has been prepared and has been distributed—the concerns that we see on a day-to-day basis in dealing with older people. Before going into what is needed in legal services—and I think that, in general, you know the ramifications of it—I would like to take a moment to describe, what, in fact are the legal problems of the elderly and their difficulties in obtaining legal services to assist them. I will also touch briefly on efforts by the Congress and our associations.

It must be remembered that the elderly, as a class, may be more vulnerable and more susceptible to abuses in these areas and may be physically unable to take meaningful action on behalf of themselves to rectify such wrongs.

UNIQUE LEGAL PROBLEMS OF ELDERLY

The elderly also experience legal problems that are unique to them; for example, age discrimination in employment, protection with respect to nursing home care, involuntary commitment, enforcement of pension rights, and eligibility for special tax relief programs. The most prevalent and serious problem, however, is one that may not even be perceived as a legal one; namely, the inability of many older persons to obtain sufficient resources on which to live decently. The elderly have legal rights to food, medical care, and money payments; things

under a complex network of local, State, and Federal programs, including social security, SSI, medicare, medicaid, and food stamps.

The elderly may forfeit their legal rights because they do not recognize that they have legal problems. They may be too proud to seek what they consider "free" help or are anxious somewhat about the uncertainties of obtaining an attorney. More importantly, the elderly, at times, forfeit their rights because they are unable to obtain legal assistance.

A retired person with a legal problem arising from a public benefit program may not be able to obtain counsel from the local bar association which regards public benefit law as too complex and unremunerative to be of interest. The alternative, free legal assistance through a legal service office, is also, for all intents and practical purposes, unavailable. Legal service offices, with their limited professional staff, have apparently been unable to develop sufficient expertise to handle problems in the public benefits area expeditiously, and, therefore, have been willing to draw out a large segment of their client population—the elderly—whom they know that they will not be able to serve effectively.

Elderly Represent 6 Percent of Legal Clients

Recent statistics indicate that the elderly represent 17 percent of those eligible for free legal services, but were only 6 percent of those actually served.

The situation of the nondestitute elderly and the availability of legal assistance to them is something that deserves very serious attention. Because legal service programs funded locally or by the Legal Services Corporation have rigid income guidelines, a retired person may not qualify for assistance. Unfortunately, this same person may not be able to afford a private attorney who may charge from $25 to $60 an hour.

The associations have obtained proof of this unfortunate fact in the letters they receive from their members. Although the associations do not purport to, nor do they, offer legal service to their members, the legislation department and caseworker staffs of NRTA/AARP national headquarters report that they receive an average of 485 letters a month from members seeking legal services because they cannot obtain it elsewhere. I want to add something. We can document this information, Senator.

We believe that these facts lead to the following conclusions: The elderly seriously need services to assist them with their special legal problems. It is important to develop legal service delivery systems if you are going to help them. The Congress, our associations, and others, have recognized this need and attempted to meet it. We believe, however, that these actions will encourage development of further legal services we are planning in certain areas.

In 1975, the Administration on Aging, and their representatives, here this morning, because of increased appropriations under the Labor-HEW Appropriations Act, was able to fund 11 model projects designed to foster improvement of legal services for the elderly. The 11 projects offered a variety of approaches toward this improvement.

Lawyer-Social Work Team

Now, I do want to say a word or two about the work that has been done by the associations. We believe that the retired persons constitute an important human resource that should be utilized in the delivery of legal services. Two universities were awarded research grants through the NRTA and AARP Andrus Foundation—St. Louis University and Duke University. I applaud Mrs. Cass' suggestion a moment ago. Under the grant awarded to St. Louis University of Applied Gerontology, the project will be to test whether a lawyer-social worker team, operating in tandem, can provide services to meet more fully the legal, social problems of the elderly in a more comprehensive manner.

The American Bar Association, at its convention this month, considered a plan to create legal aid panels to serve the elderly, to be manned by retired attorneys.

Future action: We suggest appropriate legislation would require any federally funded legal services program to create a special component that is designed to assist the elderly. Our associations "legal counsel" project has successfully demonstrated that retired persons can be trained and be utilized as paraprofessionals.

We also stated that the retired person who has a legal problem under a public benefit program may not be eligible for assistance and yet cannot secure a private attorney. We strongly suggest that consideration be given to establishing alternative conditions, other than income, in order to determine eligibility for assistance under federally funded programs.

Denial of Rights

The most prevalent and serious legal problem affecting the elderly is the denial of their rights under local and Federal programs. The associations legal counsel project has demonstrated that entitlement to public benefits is of primary concern to retired persons, regardless of income.

I say these things, Senator Kennedy, because I feel now that the Older Americans Act now requires all States to spend a percentage of their title III moneys in one or more of the four items listed under law. A State, if it determines, may not allocate any title III moneys for legal services. Fortunately Massachusetts does. In the light of the present need for such services, perhaps the law should be amended to insure that a percentage of title III funds will be spent on legal services.

We have pointed out that the elderly may not know that they have encountered a legal problem, and even if they do, they may not know assistance is available. Continuous effort is required to keep the legal counsel project before the elderly who need the services. Hence, it is essential that the public must be made aware of legal services as services are more fully developed and they must be more fully utilized. We believe specific legislation may be needed to insure that sufficient funds are available to inform and educate the public about legal services.

In conclusion, we believe that important steps have been taken to alleviate the problem of inadequate legal services to the elderly. More action is called for. I hope that our remarks and suggestions will be

helpful to you in considering and determining what future action is necessary. Thank you.

Senator KENNEDY. Thank you, very much. Frank Manning had to excuse himself. He was to be on a television program on channel 7, a new program devoted to the elderly, and it was getting close to air time. He had to excuse himself, which he did with considerable regret. We can be satisfied that he is out giving the gospel in other places as well. We appreciate the fact that he was able to be here and give, along with the rest of our panelists, absolutely superb testimony.

I don't see how anyone could argue or differ, or fail to agree, with just about every aspect of these comments. These three panelists have probably devoted as much time and energy and talent, and probably more importantly, their real heart and soul to the needs of our elderly people as anyone.

RESPONSE OF THE PRIVATE BAR

Before we ask Mrs. Cass a few questions, I would like to ask Jim Peace just one, and that is, what has been the response of the bar in your area to providing different kinds of services? Melnea Cass made a very good point earlier about involving the local, State, and national bar associations in these problems. I think this is an excellent suggestion. It is very interesting to me, as someone who is a strong supporter of the legal services program, that by far the most innovative legal program was developed within the OEO program and not within the bar association.

Once the legal service programs were initiated, we were able to begin to extend it to the elderly. It still doesn't do nearly enough.

I am going to write to the American Bar Association.* We will invite them to submit testimony on what they see their responsibilities as being and what action they are going to take within their associations to meet the challenge of providing legal assistance to the elderly. But now I would like to hear from Jim Peace. What is going on in your area?

Dr. PEACE. We get very little on the Cape, Senator, and I would like to make reference to what I feel to be a very significant report of the recent American Bar Association convention. In the legal profession, change is slow, which you probably will endorse.

Ralph Nader, the consumer advocate, said at the bar association convention that prospects for increased sensitivity by the bar to these needs were zero—just zero. Chesterfield Smith, a former association president, who favors many of our proposals, said that in a few years he hoped more lawyers would be disbarred if they did not make their individual contributions to public interest law. He knows that "in a few" means 14 years to 16 years. Of course, I do want to point out, too, that when a law is changed, many of the legislators, I believe, Senator, are also attorneys. So whether or not that will move as quickly as 14 to 16 years, I am not so certain.

But it has been very slow on the Cape. We have used the public defender on the Cape who has agreed to come in on occasion to assist us. We do have a very serious problem of a good number of ripoffs,

*Senator Kennedy wrote the American Bar Association on Sept. 8, 1976, requesting a representative from the association to testify at the September 29, 1976, hearing on "Improving Legal Representation for Older Americans" in Washington, D.C. See part 4 for the testimony of the American Bar Association.

and these people are being ripped off and they do not know where to turn.

I would like to add, Senator Kennedy, if I may, that Ray Eldridge, the president of the Massachusetts Retired Teachers Association, endorses the concept of the recommendations that I have made, and I support the statement of Mrs. Cass. I think that the senior aides out there in the audience demonstrate very effectively what can be done when senior power goes to work to help seniors. Why don't you stand up—all you senior aides—so we can see who you are? [Applause.]

Senator KENNEDY. We welcome them here. There are 63 senior aides, representing 55 communities, which are served by the senior aid program. All of these aides are working in social service fields. All of them are assisting other senior citizens in their given communities. The aides assembled today represent a force of 158 throughout the Commonwealth, providing services to all senior citizens, and they are sponsored by the community service employment program. Might I just mention at this point that I am delighted to have been the sponsor of that particular program. We have seen in our own State of Massachusetts what the talents and skills of our senior citizens can do. We have great needs in the cities, towns, and rural areas of this State for the kind of attention these senior aides can provide. I want to indicate my continuing commitment to that program.

Melnea, is there any final word of wisdom you want to give us?

Mrs. CASS. No; I just want to tell you, keep up your good work. And don't get tired, because you can get tired too quickly.

Senator KENNEDY. Don't you get tired. You're the one that I am worried about. [Applause.]

Mrs. CASS. I tell you I am never going to give up, but I want to say that they open the door too, Senator, and much of this legal thing, because they talk to the people one to one. It means a lot to people. God bless all of them. And are you through with us?

Senator KENNEDY. I am never through with you. But we are glad to have you.

If we could have the other Members of the Congress and the Senate listen to this panel, we wouldn't have problems funding these programs. We will try and give them the message down there.

The prepared statement of Dr. Peace will be inserted into the record at this time.

[The statement of Dr. Peace follows:]

PREPARED STATEMENT OF DR. JAMES S. PEACE

Mr. Chairman: My name is Dr. James S. Peace. I am here today to testify on behalf of the National Retired Teachers Association and the American Association of Retired Persons. These associations represent approximately 9.8 million retired persons nationally and 366,300 persons in Massachusetts. I appreciate this opportunity to testify before you on an issue that is very important to our people—the delivery of legal services to the elderly.

I am presently NRTA State director for Massachusetts. As state director, I am meeting with our members throughout the State and learning firsthand their problems and concerns. I am also executive director of Elder Services of Cape Cod and the Islands, Inc., which provides supportive services to enable the elderly to remain in their homes as long as it is medically possible. These include homemaker services, chore services, and congregate meal programs in which elderly volunteers are utilized.

Before discussing what action may be needed to improve and expand legal service delivery systems for the elderly, I would like to take a few minutes to describe what, in fact, are the legal problems of the elderly and their difficulties in obtaining legal services to assist them. I will also touch upon efforts by the Congress, our associations, and others to alleviate these problems.

The elderly experience legal problems that are encountered by all citizens, for example consumer and landlord-tenant difficulties. Even though the problems may be substantially identical among all age groups, it must be remembered that the elderly, as a class, may be more vulnerable and susceptible to abuses in these areas and may be physically unable to take meaningful action on their behalf to rectify such wrongs.

The elderly also experience legal problems that are unique to them; for example, age discrimination in employment; protection with respect to nursing home care and involuntary commitment; enforcement of pension rights; and eligibility for special tax relief programs. The most prevalent and serious problem, however, is one which may not even be perceived as a legal one, namely, the inability of many older persons to obtain sufficient resources on which to live decently. The elderly have legal rights to food, medical care, and money payments under a complex network of local and Federal programs including social security, SSI, medicare, medicaid, and food stamps. A list[1] has been attached to this statement outlining the legal problems of the elderly which require legal assistance.

The elderly may forfeit their legal rights because they do not recognize they have legal problems. They may be too proud to seek what they consider to be "free" help or are somewhat anxious about the uncertainties of obtaining an attorney. More importantly, the elderly, at times, forfeit their rights because they are unable to obtain legal assistance. There are a number of reasons for the unavailability of legal assistance.

A retired person having a legal problem with a public benefit program may not be able to obtain counsel from the local bar association which regards public benefit law as being too complex and lacking in monetary awards. The alternative, free legal assistance through a legal services office, is also, for all practical purposes, unavailable. Legal services offices, with their limited professional staff, have apparently been unable to develop sufficient expertise to handle problems in the public benefits area expeditiously, and therefore have been unwilling to draw out a large segment of their client population—the elderly—whom they know they will not be able to serve effectively. Recent statistics indicate that the elderly represent 17 percent of those eligible for free legal services but were only 6 percent of those actually served.

The situation of the nondestitute elderly and the availability of legal assistance to them deserves serious attention. Because legal service programs, funded locally or by the Legal Services Corporation (formerly by the Office of Economic Opportunity), have rigid income guidelines, a retired person may not qualify for assistance. Unfortunately, this same person may not be able to afford a private attorney who may charge from $25 to $60 an hour. Furthermore, even if resources are available to pay a private attorney, such attorneys may be unavailable since, as mentioned above, the private bar association concentrates minimal assistance to public benefit programs.

The associations have obtained proof of this unfortunate fact in the letters they receive from their members. Although the associations do not offer legal services to their members, the legislation department and caseworker staffs of the NRTA/AARP national headquarters report that they receive an average of 285 letters a month from members seeking legal services from the associations because they cannot obtain it elsewhere. Our associations' "legal counsel for the elderly" project, which I will discuss later, reports that in 1 month (June 1976) it received approximately 200 letters from individuals across the country requesting assistance with their public benefit problems.

We believe that these facts lead to the following conclusion. The elderly seriously need legal services to assist them with their special problems. It is important to develop legal service delivery systems specifically designed to help the elderly. The Congress, our associations and others have recognized this need and have attempted to meet it.

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[1] See p. 164.

The Congress has promoted the expansion of legal services to the elderly. Under the Older Americans Act Amendments of 1975, a new emphasis was placed in the law upon legal services to the elderly. Certain provisions under the 1975 amendments, which related, in whole or in part, to legal assistance, have produced the following significant results. The social services, which the elderly should be receiving under a comprehensive and coordinated service system, developed by the State and local agencies on aging, now include legal and other counseling services. All States are now required to spend a certain percentage of their title III funds on one or a combination of the following items: transportation; home services, including homemaker services and home health services; legal and other counseling services and assistance programs, including tax counseling and assistance; and residential repair and renovation programs. Finally, the commissioner is now authorized to make grants for the training of lawyers and paraprofessionals in the rendering of legal assistance in a broad variety of cases. We believe these actions will encourage the development of legal services in the planning and service areas.

In 1975, the Administration on Aging, because of increased appropriations under the Labor-HEW Appropriations Act, was able to fund 11 model projects designed to foster improvement of legal services for the elderly. The 11 projects offered a variety of approaches towards this improvement. Particular emphasis was placed upon initiating a process that would result in the inclusion of a legal services component as part of the coordinated services provided in each planning and service area. Our associations were among the 11 grantees and developed a model project in the District of Columbia, entitled "legal counsel for the elderly," to which I referred earlier. This project successfully demonstrated the effective use of elderly paraprofessionals. Working under the supervision of an attorney and with special training in public benefit programs, these elderly volunteers were able to do all client interviews, handle informal and formal contacts with agencies, and, in many cases, draft correspondence and do basic research. I understand that a witness from "legal counsel" will be testifying before you in Washington at a later date, so I will not discuss the activities of this office in any greater detail.

Recently, the Congress increased HEW appropriations to a sufficient level so that the Administration on Aging was able to proceed with its second phase to improve legal services. Essentially, the plans call for the establishment of the State agency on aging as the focal point for the promotion and development of legal service activities in that State. AoA intends to award model project funds to the State agencies on aging on a formula basis. To assist the State agencies, AoA has awarded grants to five model projects for the purpose of providing technical assistance. Based upon the success of the "legal counsel for the elderly" project, the associations are among the five grantees. We expect to assist States in establishing legal service activities that involve volunteer workers and developing organizational links between State and area agencies, legal service organizations, and voluntary organizations. To what extent that AoA's second phase of activities will expand and improve legal services is yet to be determined.

Our associations have long sought to improve and expand the delivery of legal services to the elderly. In addition to our projects funded by AoA, we have developed our own legal counseling programs and promoted other educational groups in their studies of this problem.

Most notable among the associations' efforts to assist retired persons with their legal problems is our free tax-counseling program known as Tax-Aide. Under the Tax-Aide program, NRTA/AARP members, a majority without prior experience in the tax field, have been specially trained to provide tax counseling. In 1974, 2,329 volunteer tax counselors provided free tax-counseling to 213,696 elderly taxpayers.

The NRTA/AARP Andrus Foundation awarded research grants to Duke University and St. Louis University. Under the grant awarded to the Duke University Center for the Study of Aging and Human Development, law students are given the opportunity to represent the elderly clients through outreach work in the senior citizen centers and legal aid society. Under the grant awarded to the St. Louis University Institute of Applied Gerontology, the project will test whether a lawyer-social worker team can provide the services to meet the legal and social problems of the elderly in a more comprehensive manner. We believe that these projects will provide valuable insight into the most effective and efficient method to deliver legal services to the elderly.

State and local agencies, legal aid or services programs, and others have acted on their own initiative, and developed legal services for the elderly well in advance of AoA's recent actions. While we do not have a compilation of legal programs for the elderly throughout the country, it is estimated that approximately 100 such programs are in operation. These programs present a broad spectrum in terms of the elderly clientele served (e.g., income limits, residency requirements), the type of assistance provided (e.g., full range of services, only nonfee generating cases) and the funding obtained to insure continued service (e.g., title XX funds, OAA funds). According to the Massachusetts Department of Elder Affairs legal services for the elderly in this State are presently provided through the activities of the nursing home ombudsman program. The department also plans to publish and distribute to the area agencies on aging a booklet on the legal problems of the elderly.

I had briefly mentioned that the role of the private bar association in assisting the elderly with their special legal problems has been limited due to the unique nature of these problems. This does not mean that the private bar association has not recognized its obligation to improve services to the elderly. Assistance can be improved, particularly where the legal problem is encountered by all citizens, and the private attorney would have considerable experience in dealing with it. The American Bar Association, at its 1975 annual meeting passed a resolution which supported a program to establish, with the cooperation of local and State bar associations, panels of retired attorneys. These panels would provide legal assistance on a pro bono basis to the elderly who are financially unable to obtain an attorney. Moreover, the family law section of the ABA is currently considering a proposal that in 1977 the association will sponsor a national institute on the legal problems of the elderly. We believe these to be very constructive programs and encourage the ABA to pursue them further.

While these facts indicate there are activities underway on various levels to improve and expand the delivery of legal services to the elderly, they also show that a vast need for such services remains. Further actions to meet this need must be forthcoming. The Congress has an important responsibility to promote and develop a comprehensive national effort. To assist you, our associations ask that you consider and study the following recommendations.

We have previously pointed out that existing legal services programs funded by the Legal Services Corporation are not fully utilized by the elderly for a number of reasons. We suggest appropriate legislation that would require any federally funded legal services program to create a special component that is designed to assist the elderly. Our associations' "legal counsel" project has successfully demonstrated that retired persons can be trained and be utilized as paraprofessionals in providing legal services to the elderly. The staff attorneys on the project have estimated that they were able to increase their caseload by 30 percent to 50 percent by working with volunteers. The creation of a special component, such as the "legal counsel" project will help to increase the utilization of existing legal services by the elderly.

We have also stated that a retired person who has a legal problem under a public benefit program may not be eligible for assistance under a legal services program and yet cannot secure a private attorney because the case may not offer sufficient monetary awards. We suggest that consideration be given to establishing conditions, in addition to income, to determine eligibility for assistance under a federally funded program. Other possible conditions are the percentage of income derived from public benefit programs or age.

In our discussion of the substantive legal problems of the elderly, we stated that the most prevalent and serious legal problem affecting this group is the denial of their rights under local and federal programs. Our associations' "legal counsel" project has demonstrated that entitlement to public benefits is a primary concern of retired persons, regardless of income. A retired person who is attempting to determine his eligibility for certain benefits cannot obtain unbiased legal counsel from the government agency that is administering the federal program. The establishment of a special office within the Government agency, which provides unbiased legal assistance to the elderly on benefit entitlement, may help to alleviate this problem.

The Administration on Aging has attempted to place the State agencies in a leadership role for the development of legal services. As we pointed out, the Older Americans Act now requires all States to spend a percentage of their title III funds on only one of the four items specified under the law. This

means that the State, if it so determines, may allocate no title III funds for legal services. In light of the pressing need for such services, perhaps the law should be amended to insure that a percentage of title III funds will be spent on legal services.

We have pointed out that the elderly may not know that they have encountered a legal problem and, even if they do, they may not know assistance is available. Furthermore, our associations' "legal counsel" project reports that it has become abundantly clear that a continuous effort is required to keep the name of the project before the elderly who need the services. The "legal counsel" project also reports that it has received letters from across the country requesting legal assistance. For these reasons we find that the public, particularly the elderly, must be made more aware of legal services. We believe specific legislation may be needed to insure that sufficient funds are available to inform and educate the public about legal services for the elderly.

In conclusion, we believe that important steps have been taken to alleviate the problem of inadequate legal services to the elderly. However, more action is required. I hope that our remarks and suggestions will be helpful to you in considering what future action is needed. Thank you.

Legal Problems of the Elderly

1. *Social Security Old Age Benefits.*—Many individuals are unaware of their eligibility to receive benefits or of their entitlement to higher benefit payments. An individual, even if he does feel that he is eligible or is entitled to higher benefits may not know how to determine such or to contact the appropriate officials. A legal services program should advise the elderly of their eligibility and assist in benefit computation.

Many individuals are unaware of their right to appeal adverse determinations by the Social Security Administration, or are unfamiliar with the appeal process. A legal service program should be able to assist and to represent those who may wish to make a formal appeal.

2. *Supplemental Security Income.*—The problems that have arisen under SSI have been described as severe.[1] Only 2.3 million people of the estimated 4 million elderly who are eligible for SSI are receiving benefits. As of January 1975, there were approximately 27,000 appeal hearings pending concerning SSI, a majority of which were eligibility claims filed by elderly persons.[2] Being a relatively new program, many people are uncertain as to the basic provisions of SSI.

Therefore, a need does exist to alert the elderly of their right to benefits under SSI and to explain the program. Assistance can also be provided to those elderly whose checks have been lost or delayed.

3. *Medicare.*—A major issue is the wrongful denial of reimbursement for medical expenses and the interpretation of those provisions which limit or extend benefits (e.g., items and services which are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of malformed body member). Issues also arise as to the delayed determination of benefits and the scope of services covered.

4. *Medicaid.*—Medicaid is a joint Federal-State program in which the states are given considerable latitude in determining eligibility requirements and the scope of services provided. Consequently, issues have arisen regarding eligibility, the denial of benefits based upon residency requirements, in addition to those issues arising under medicare.

5. *Food Stamps.*—Elderly persons, although eligible under the food stamp program, have not been provided with proper information or are reluctant to enter the food stamp office and apply. These individuals who are experiencing extreme financial difficulties are entitled to this relief. A legal services program should provide basic eligibility information for food stamps.

6. *Public Housing.*—Many older persons, faced with ever-increasing costs, cannot afford decent housing. A legal services program should assist those eligible older persons to obtain public housing. The older person, as well as all tenants, are entitled to the quiet enjoyment of their premises and should be protected from arbitrary action or harassment by the public landlord.

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[1] House Report 94–67, p. 9.
[2] *Ibid.*

7. *Landlord-Tenant.*—The older person may be uncertain of his rights to decent housing or his rights to evict a tenant who will not pay the rent and move out. The older person may also not know how to proceed in order to enforce these rights.

A legal services office should advise the older person requesting assistance as to the duties and responsibilities of the landlord to maintain the premises in a habitable condition, the law and regulation concerning rent increases and conversion of apartment units to condominiums, as well as advice on eviction procedures.

8. *Real Property Taxes.*—To alleviate the income drain caused by property taxes upon older persons with fixed incomes, the States have provided property tax concessions to this group. Such advantages can, however, be lost if the property has been assessed at an unreasonable amount. A legal services program should provide basic information on property tax relief and assessment appeal procedures.

9. *Pensions.*—Congressional studies have shown that persons rarely receive back what they contributed to a pension plan. These findings prompted the enactment of the Retirement Income Security Act of 1974. However, this act does not provide relief for those persons who retired or became disabled prior to the effective date. These individuals are not assured of their benefits and may require legal assistance.

10. *Consumer Problems.*—Older persons, as well as all consumers, can become victims of deceptive practices in the selling, pricing or advertising of goods and services, buying on credit or may wish to enforce their rights under a warranty or guarantee. The older person may become involved in a dispute with an insurance carrier or health care provider over the coverage included within a policy.

An older person may require assistance in negotiating with a merchant over the repair or replacement of a defective good or to lower a repair bill to conform with estimates. Assistance can also be offered in negotiating with insurance carriers. Older persons would also be provided with information regarding the small claims court and how to use it to obtain relief.

11. *Age Discrimination.*—Discrimination based upon age can occur within a wide range of areas, e.g., employment and discharge, consumer credit, housing. The older worker can enforce his rights under the Age Discrimination in Employment Act which applies to persons between 40 and 65 years of age. Older workers must be advised of the coverage, prohibitions, enforcement, procedure and relief as set forth within the act.

Senator KENNEDY. All right, now, we have a panel who are professional and knowledgeable and active in the delivery of legal services in the State to the elderly; J. J. Donovan, director of the nursing home ombudsman project for the Massachusetts Department of Elder Affairs, retired attorney, who in his ombudsman post is establishing a clearinghouse to help people locate nursing home openings, and who has also initiated a furlough program where nursing home residents forced to be hospitalized can be assured of a bed upon returning to the nursing home. This program is funded through the Older Americans Act. Bob Spangenberg is a member of both the Boston Bar Association and the Massachusetts Bar Association, former executive director of the Action Plan for Legal Services, who, during that period, conducted a study on the legal needs of low-income persons in the Boston area, and provided the court information on the legal needs of elderly citizens. Gerald Wall is a staff attorney for the Council of Elders Legal Service Program.. who filed suit on behalf of the public housing tenants to prevent the Boston Housing Authority from imposing rent hikes. The injunction was issued to prevent those hikes from taking place and now remains pending in the courts. James Bergman is New England regional director of the legal research and services for the elderly program funded by the Administration on the Aging, under the Older Americans Act. Mr. Donovan, you may start.

STATEMENT OF J. J. DONOVAN, DIRECTOR, NURSING HOME OMBUDSMAN PROJECT, DEPARTMENT OF ELDER AFFAIRS, COMMONWEALTH OF MASSACHUSETTS, BOSTON, MASS.

Mr. DONOVAN. Good morning, Senator. My name is J. J. Donovan. I am the State nursing home ombudsman director in the department of elder affairs. The purpose of the nursing home ombudsman project is to provide a forum through which nursing home patients, or their next of kin or friends, can place complaints about nursing home care which we can process.

In a couplet, I can say that our purpose is to improve the quality of care which nursing home patients receive and to upgrade the safety of the environment in which they live. Early in our project it became apparent that it was important for us to work on the problems and also to provide information and referral for nursing home patients. We found that a problem involving the spouse remaining in the community soon became a problem for the nursing home patient and a subject of worry and concern and trauma, and therefore we expanded our operation to provide assistance in solving problems in the community.

The ombudsman developmental specialist has been recently created as an offshoot of the nursing home ombudsman project. The purpose of the ombudsman developmental specialist is to develop local resources which will provide assistance to nursing home patients by visiting them in the nursing home locale to determine what complaints and what problems exist, and how they can be resolved.

FIVE KEY LEGAL AREAS FOR NURSING HOME PATIENTS

In the past year we have added a legal service project to the ombudsman activity. This project is dedicated to providing legal aid in five areas for nursing home patients. The legal aid will also be available to the elderly in the community. The areas which we chose are those which required the greatest assistance. These are the areas of providing for the appointment of a conservator, the appointment of a guardian, guidance in incompetency issues, guidance where access to nursing homes has been denied, and assistance in preventing the involuntary nursing home transfers. Legal aid is also provided to assure that fair hearings procedures are followed. Finally, assistance in home ownership issues, so that the elderly may be informed as to the availability and procedures to be followed in obtaining assistance in tax abatements and in tax deferrals.

We concluded that it would be practical to develop a handbook in these five areas of concern for the elderly, and we are now in the process of its completion. This handbook will be distributed very shortly through the Home Care Corp. and area agencies on aging, which will assist in developing local resources.

A survey was made of the Commonwealth of Massachusetts through which we determined that the cape and islands area offered the best possibility of success on an initial local resources project. Working with Dr. Jim Peace and with Margaret McAdams, we initiated the activity in the Hyannis office of the Home Care Corp. The pattern

which will be developed in the Home Care Corp. on the cape and islands will be used to develop a similar program in the other seven public health regions where Home Care Corp and area agencies on aging will provide legal aid to the elderly.

In certain areas, we have found that more assistance is needed than in others—for instance, in the area of conservatorships and involuntary transfers, and in the use of paralegals. We believe that vast new areas of assistance can be opened up to aid the elderly by pursuing these objectives and we intend to so do.

I think, further, that this testimony fairly well sums up my comments for this morning.

Impact of Transfers on Patients

Senator Kennedy. Very good. Mr. Donovan, what about the transfers; could you tell us a little bit about that?

Mr. Donovan. Senator, I would be glad to elaborate on that point. We have found that elderly people are admitted to some nursing homes, and I stress some nursing homes, because this is not characteristic of the entire nursing home industry, and are kept only as long as they or their relatives can pay the cost of private care. They are admitted when they have a sum of let us say $12,000 or $15,000 in personal property, $10,000, $12,000, or $13,000 more than the maximum allowed under the criteria for public assistance. They are often asked to sign a contract under the terms of which it is stated that they will not be kept in the nursing home as publicly assisted patients. These patients pay an average amount of let us say $1,000 a month. Let us assume that for the purpose of this comparison that they had $12,000 in personal funds upon admission. About the end of the 10th month, when their funds have been spent and they have only $2,000 remaining, and where they now meet the criteria for public assistance, they are told that they must transfer out of the nursing home. They are told that the facility cannot keep them. Now, this harsh action causes unbelievable worry, trauma, and concern and a feeling of rejection. It is discrimination of the worst type in my view. It also creates two classes of citizens. The first-class citizens who can pay for their private keep in a nursing home and second-class citizens who are turned out when they become the beneficiaries of public assistance.

These elderly people, who are now nursing home residents, have, during their long and useful lives, paid their taxes, social security, raised their families, and have been upright, productive members of the community. But, they are not permitted to remain in the familiar surroundings of the nursing home where they have paid their way. Because they are no longer private paying residents, they are told that they must transfer out of the facility.

I believe, sir, that such contracts should be eliminated. I believe that this practice should be eliminated without a contract. There should be no discrimination when one passes from private pay to public assistance, and I believe that at both the State level and at the Federal level steps should be taken so that this very unhealthy practice can be eliminated. [Applause.]

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AVAILABILITY OF NURSING HOME BEDS

Senator KENNEDY. How many nursing home beds are available? How many on the waiting list in the State of Massachusetts?

Mr. DONOVAN. It is extremely difficult to determine because there is not a viable process in the Commonwealth for the constant updating of availability of nursing home beds. However, the computer arrangement in Westboro is rapidly approaching the point where the department of public welfare, which has the statutory responsibility in the Commonwealth of Massachusetts for placing publicly assisted patients, will be in a position to determine availability on a weekly basis. However, sir, I can say this; that a survey made by the department of public health in cooperation with public welfare about 2 years ago indicated that it requires an average of 7 weeks for a publicly assisted patient to obtain a nursing home bed when he or she is in an acute care facility and ready for discharge, as against an average of approximately 10 days or 2 weeks for private paying patients similarly situated. I believe you can see on the basis of these figures, which can be amply supported, that although I cannot tell you the exact number of beds, I can tell you that there is discrimination and that there is a feeling of rejection developing in the acute care hospitals just as it is in the example which I gave you of the nursing homes involuntary transfers.

Senator KENNEDY. Mr. Spangenberg.

STATEMENT OF ROBERT SPANGENBERG, ABT ASSOCIATES, CAMBRIDGE, MASS.

Mr. SPANGENBERG. Senator Kennedy, as you indicated I was for some years the executive director of the Boston legal assistance program and for the past 19 months have been working on a study of the legal needs of low-income people in the city of Boston; low-income people making up the 45,000 to 50,000 families in the city who qualify under the guidelines of the legal services program for the city of Boston.

We discovered very early that because of the unique needs of the elderly, a portion of our time should be devoted to studying solely the legal needs of the elderly in the city of Boston. I might say that this program, the study, was sponsored by the Boston Bar Association as a public service.

I think, also, I would like to mention a couple of other things in reference to the prior discussion that was had. I want to draw your attention to two specific things that we did. The first thing was we wanted to get a good fix on the kinds of problems the elderly have, and we did that two ways; First, we conducted a door-to-door questionnaire, which turned out to be a 28-page questionnaire, to 500 low-income families in the city of Boston, and of the 500 that we spoke to, we found that in 83 of these 500 households, there was at least one person of the age of 65 or above.

Consequently, we were able to talk with a number of elderly people making up about 16 percent of the sample of the survey. In reviewing the quantitative type of sample, you find, by the way, really two

focuses. The first was to look at the life of the low-income person over the past 5 years to find from their standpoint specific kinds of legal issues they had to face in the last 5 years. And second, to suggest to them a number of other kinds of problems that they had not recognized as legal that might require the attention of a lawyer or a legally trained person. So, we did that from their own recognition of legal problems. Beyond that I might add that when we talked about other kinds of problems, we talked in terms of something like four times the number that low-income persons recognize as legal problems that might conceivably be legal if the lawyer were available.

In addition to the analysis of the collection of that data, we went around from neighborhood to neighborhood in the city and spoke to a large number of community agencies; social service agencies, that deal with the problems of the elderly. As a matter of fact, we had an opportunity to discuss this aspect with more than 250 agencies throughout the entire city who were concerned about the delivery of social services to low income people.

Two Most Serious Legal Problems of Elderly

Now, based upon both aspects of the work, the questionnaire and the neighborhood interviews which, incidentally, came out the same, we determined, based upon our findings, that the two most serious problems brought to our attention in regard to the legal problems of the elderly were housing and income maintenance. Housing in two or three particular aspects; namely, evictions, rent increases, and code violations. And income maintenance, particularly with SSI, and medicaid.

We found—which I am sure is no surprise to people—that there are many low-income citizens in the city of Boston who qualify for SSI benefits, and were either not aware of the fact that they qualified or are not aware of what the qualifications are for SSI, and there is a large number of the elderly population who with some assistance and education should be receiving the public benefits provided by the Federal and State governments.

Medicaid Bureaucratic Problems

In the area of medicaid, we found a number of people who even today are having difficulty getting a doctor to give them care under the medicaid program, and all kinds of bureaucratic problems relating to medicaid, pay of the doctors, et cetera. We found those to be the two most prevalent and serious problems. Three additional categories were, first, relating to the question that Mr. Donovan spoke about, that is, conservators and guardians. This is a very serious problem in this State to find people who are qualified and have the interest in the elderly uppermost in their mind. This is a very serious problem.

We have the day-to-day living problems that the elderly face, which are not seen as quickly as the larger problems, such as consumer problems, assistance in drafting wills, questions relating to vandalism, and another very serious problem, and that is utility bills.

And, finally, there is a discussion of the special problems of 45,000 people who are living in nursing homes in the city of Boston, which is a figure that was supplied to us. Now, as far as the legal resources that are currently available in the city of Boston are concerned, the principal organization is, once again, the Federal legal service program, Greater Boston Legal Services, which has two aspects to it; the first is the day-to-day services which are provided by the six offices throughout the city, but that is a very, very small effort. The second part of it is the Council of Elders Legal Services program, which is operated in cooperation with Greater Boston Legal Services, which has an office in the Moreville House, but again, they only have four lawyers in that program which is intended to serve a very wide population, not nearly enough resources in terms of full-time attorneys.

Free Legal Services

Now, one of the things that we did in relation to the discussion of your prior panel, is in the course of our study, we contacted some 2,700 private lawyers who practice in the city of Boston. We asked them specifically to give us information about what kind of free legal services they had provided in the course of their practice over the last year. Even more important than that, in what kind of legal service, free service, as officers of the court, as members of the bar, they would be willing to contribute over the next 12 months. And it may well be that their response on paper will not meet the real need, nor will it meet the realities of the matter, but I can tell you that we surveyed 2,700 lawyers, and only about a third indicated that they had done any free legal services to older people in the past year, and yet two-thirds indicated a concern or willingness to provide some sort of service, so I think that what we all must do is to look at this resource, because I don't think that the Federal funds are going to sufficiently answer the total problem. If there are a large number of private lawyers out there who are willing to provide some sort of service, then I think the joining up of the public and the private bar in this effort is absolutely necessary.

Senator Kennedy. How are we going to do that?

Mr. Spangenberg. Well, I think—excuse me.

Senator Kennedy. How do you recommend that that be done? You have given us the figures, what do you need to get the two-thirds more involved who are being asked to participate?

Mr. Spangenberg. Well, one thing that we could do is to require that as a matter of admission to the bar that a lawyer devote a certain percentage of his practice to this service.

Senator Kennedy. That is a good idea, but we don't need Federal legislation to do that. That has to be done either by the local bar association or the State bar association.

Mr. Spangenberg. Or the Supreme Judicial Court in Massachusetts. They regulate the practice of law.

But I think I see somewhere down the line, although the American Bar Association has a special committee that has been working in that area, I think there needs to be a joint cooperation between those agencies that deliver these services and the Boston Bar Association.

Pressure has to be exerted through someone like the bar association. If it decides to do these things, it has a tremendous amount of power. Things will happen, and I think that pressure has to be put on that organization and I think they are ready to respond.

Senator KENNEDY. The bar association ought to be encouraging these legal services without being further jarred by people from the outside. But I will be glad to raise this. Will you make that study a part of the record?

Mr. SPANGENBERG. I certainly will.*

Senator KENNEDY. That will be helpful, and then we will get in touch, I will get in touch with the association and ask them what they would be prepared to do to try to take advantage of it. I want to hear from our other witnesses, unless it is on this point, Mr. Donovan.

Mr. DONOVAN. It is on this point. I would like to give an example of the type of cooperation which might be expected from the bar association. A short while ago we received a call from a social worker at Boston City Hospital. She said that a retired city of Boston employee was living in the Pine Street Inn and that he had $9,000 in retirement funds available to him, which he was seeking to obtain in one lump sum.

Now, I think you will agree that if you give a retired worker $9,000 in cash and let him carry it to the Pine Street Inn it would be just the same as exposing him to robbery or to other serious personal harm. We went to the judge of the probate court and asked him to speedily appoint a conservator. We then went to the secretary of the Boston Bar Association to ask if he would help us in obtaining the assistance of an attorney to file a petition for conservatorship, pro bono.

Within 4 days, and still keeping within the requirements of notice, a petition was filed. In 9 or 10 days a conservator was appointed and this man was protected from himself. That was a worthwhile approach and an example of what can be done by the bar association when one seeks their support. That is all.

Senator KENNEDY. Mr. Wall.

STATEMENT OF GERALD D. WALL, STAFF ATTORNEY, COUNCIL OF ELDERS LEGAL SERVICES, BOSTON, MASS.

Mr. WALL. Thank you, Senator Kennedy, Members of the U.S. Senate Special Committee on Aging. As a staff attorney with the Council of Elders Legal Services program, I have been exposed to a considerable variety of problems facing the elderly in the city of Boston. Often, the existence of a legal problem is clear. The older person has been served with a legal paper saying that a lawsuit against him has been started; they have been notified of a cutback in a Government benefit and the notice says that they have the right to appeal to an administrative hearing officer or to a court; or they have been harmed in some way and they would like to take some legal action of their own to collect damages. There are many variations of these situations.

*Material not received at time of this printing.

However, there are many other situations in which the need for legal help may not be so obvious. The person knows he or she has a problem, but does not know where to turn for help. The person knows he or she has a problem, is aware that there is help available, but for one reason or another is afraid to seek out that help. Probably the most blatant example of persons whose legal problems are ignored are residents of nursing homes and rest homes. Less obvious is the example of the shut-in, who is not able to or who, due to isolation, does not seek out help.

As far as I am concerned there is a solution to these problems. First, adequate legal services must be available. Second, older persons must be educated that the services are there and that they don't have to be afraid to use those services.

Legal Problems Facing Older Americans

Up to now I have been rather general in my presentation of the problems encountered in delivering legal services to the elderly. I will now be more specific as to the type of legal problems facing older persons which I feel should be addressed by this committee and by persons and groups interested in the legal problems of the elderly.

For example, the elder does not know that he or she is receiving the correct amount of supplemental security income or some other Government benefit to which he or she may be entitled. It may not be possible for the older person to determine if the benefit is accurately calculated, and, even if the older person does seek an explanation, it may be filled with such complex terminology that he or she cannot understand how the determination was made.

Then there is the case of a person who applies for supplemental security income and is told that he or she cannot possess more than $1,500 in liquid resources if single or $2,250 if married, or own a home worth more than $25,000. Instead of allowing the applicant to be more self-sufficient and to feel an entitlement to these minimal benefits, he or she is stripped of the few resources that were accumulated over a lifetime and now is totally dependant on the Government bureaucracy.

One of the more disturbing situations is that of a person who begins to have difficulty managing his or her own affairs. The only persons available to provide assistance would do so solely for their own gain. Although the older person should be able, with minimal help, to live his or her own life in their own home, he or she is forced to either live in a nursing home or find himself or herself under the control of a hostile person.

No less disturbing is the plight of the older person who is fully capable of handling his or her own affiairs but has limited income. The rent has increased because he or she has moved and the home is no longer covered by rent control. They are faced with accelerating gas, oil, and electricity costs and are further threatened by the possibility of a large property tax increase which the landlord assures them he will pass on to the elderly tenant. The older person applies for public housing but is told that the waiting list is so long that this is impractical.

The older person who resides in public housing, but has been told that his income has been reviewed and his rent must now be increased

substantially, also has a problem. This is the very situation presently faced by elderly persons and others who are tenants of the Boston Housing Authority.

BOSTON HOUSING AUTHORITY RENT INCREASE CASE

On or about June 30, 1976, numerous tenants of the Boston Housing Authority were notified that their rents would be increased in accordance with a review of their income. Among the tenants are a substantial number of older persons, for whom, in many cases, the rent increases represent a significant financial hardship. Our office, and other offices of the Greater Boston Legal Services, received numerous complaints about the proposed increases. As a result a lawsuit was filed against the Boston Housing Authority during the week of July 26, 1976. That same week, the Boston Housing Authority decided to delay the increases until a further review takes place. On July 29, Judge E. George Daher of the Boston Housing Court enjoined the Boston Housing Authority from further implementation of the rent increase until the court determines that the proper procedures are being followed.

The lawsuit does not challenge the legal right of the Boston Housing Authority to raise rents. Rather, it challenges the method by which the rent increases were being implemented. In particular, the lawsuit asserts that affected persons must be given adequate explanation as to how their rent increases are computed and an opportunity for a meaningful hearing prior to implementation of the increase. This is particularly important because many tenants' rent were incorrectly calculated. What is asked for is no more than the tenants are entitled to under the State regulations governing public housing, and the due process clause of the U.S. Constitution allows.

At the present time rent increases are suspended. Negotiations between the housing authority and attorneys for the tenants are in progress in an attempt to reach agreement on a procedure which will adequately protect the interests of the tenants. Thank you. [Applause.]

Senator KENNEDY. Just as a point of information, the hearing is going to adjourn at 11:40, so we have about 17 or 18 more minutes left here. However, if you have to leave, feel free to do so. OK, Mr. Bergman.

STATEMENT OF JAMES A. BERGMAN, NEW ENGLAND REGION DIRECTOR, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY PROGRAM, NATIONAL COUNCIL OF SENIOR CITIZENS, INC., BOSTON, MASS.

Mr. BERGMAN. Thank you, Senator. My name is James Bergman. I am with the legal research and services for the elderly program, which is part of the National Council of Senior Citizens. Since I have been given permission to submit written testimony, I will do that and will summarize my comments from the written testimony.[1]

[1] See p. 178.

First, I think that most of the people who have testified today have eloquently stated what the problems are that are faced by older people which require legal assistance to resolve. I think that Mrs. Cass and Frank Manning have done a very eloquent job and the last thing I am going to try to do is to improve upon their comments. Instead, I would like to talk about the response in New England, and especially in Massachusetts, to the legal problems that have been pointed up here today.

It is interesting to me that New England, as well as probably California, according to most people who are knowledgeable, are supposed to be the leaders in the country in providing legal services to older people. In fact, that probably is the case, but I think it is one thing to be a leader when the competition isn't too tough, and it is another thing to be a leader when the competition is tough. In this case, I am afraid the competition is exceedingly weak.

New England may, in fact, be a leader in providing legal services to the elderly and to low-income people, but the fact is that the response has been exceedingly meager. I would like to highlight three programs that have been especially good in providing legal services to older people to point out what can be done when a good program is funded. I might add that the interesting thing is that the programs that have been funded over the last 8 or 9 years have almost exclusively been funded by either title III of the Older Americans Act or by the Office of Economic Opportunity through the original LRSE program. I might add that I was fortunate enough to have been the director of the original Council of Elders legal program where Mrs. Cass helped teach me about the ways of the world. I may have been born and raised in Wisconsin, but I grew up under Mrs. Cass and the Council of Elders.

Council of Elders Legal Program

As I said, the Council of Elders legal program was funded by that original OEO program, and the other programs that I will mention have been funded exclusively by title III of the Older Americans Act. And that by itself, I think, tells a little bit of a story of how legal services for the elderly have developed in this country.

The original Council of Elders LSRE program, which began in 1969, was somewhat unique in three different ways at that time. One was that it hired older people as paralegals, and found out very quickly that that was probably the best way to do outreach. It was also one of the best ways to find and help older people.

Second, it took an approach that I think was different from most of the programs in that it hired a downtown law firm instead of having staff attorneys. Thus, with a combination of older people as paralegals—and I think the oldest at the beginning was 79—and a downtown law firm which was an exceedingly strong law firm in the city, the legal project had a very good one-two punch.

The third thing, the program, while it handled direct cases, focused very much on legislative activities as a means of attempting to resolve problems affecting many elderly persons. For example, while it may be that a person's major problem is income, once you have gotten him adequate social security benefits and old age benefits, this person still

might be living on nothing more than about $210 a month. Now, that is pretty inadequate, and maybe the best solution is to go to the legislature and fight for increases in old age benefits, which was one of the things at that time the program did, along with groups like Frank Manning's organization.

We also worked with Frank on drafting the original legislation to set up a State Department of Elder Affairs, feeling that if we could focus attention at that high a level in State government, we could probably get better and more resources for older people. I think that the Council of Elders legal program demonstrated that legislative action is a very important part of any legal program for older people, because the program can hit the problems of thousands of people in the same time span that it would take to handle maybe 5 to 10 individual cases.

Cambridge-Somerville Legal Services

Another example of a way of approaching the legal problems of older persons has been carried out by the Cambridge-Somerville legal service program under a title III grant for the last 2 years. That program is focused very much on what is called high impact litigation, or class action suits. And it has been successful in getting a Federal judge to order the Cambridge office of the Social Security Administration to take no more than 45 days to process SSI applications for persons who are not disabled. As most of you know, when SSI came into being, we all received tens and hundreds of complaints from people who filed their applications, but it took months and months to get those applications handled so that the persons could get on SSI.

In one class action suit the Cambridge office was ordered to process all applications within 45 days, and now they somehow are able to do it in 30 days in most cases. I think it proves the point that you can use that kind of litigation to get the job done for more than just one person. That same program also filed a suit which challenges the privacy issues created by title XX applications. The suit basically makes the point that if you require people to give information that they don't want to give—and I think Mrs. Cass very eloquently put it, that older people don't always want to tell you everything—that they will often refuse to provide the information even if it means that they will be denied services which they need. I think that while that case is still in court, it has highlighted some very important issues, and Congress has already begun to respond to some of the privacy issues.

Statewide Legal Service Programs

A third kind of program that has been started, and in fact runs in New Hampshire, Vermont, Maine, and Rhode Island, is statewide legal service programs which handle mostly individual legal problems of the elderly. Normally these programs have begun under a title III grant to hire an attorney who is also the director, and then they supplement the programs with VISTA volunteers and CETA employees who serve as paralegals. The result in those programs in each case is that they handled individual cases so that more and more older people could get access to legal services.

The New Hampshire program, I think, is a good example of how that can be done. The program is operated by New Hampshire Legal Assistance, but has a special elderly component within it so that when people apply, they are not applying necessarily to New Hampshire Legal Assistance, which some older people may have objected to because it is a so-called poverty program, but they are applying to a specific program which serves the elderly. While the legal project staff may use the New Hampshire Legal Assistance offices as their base, they go to meet elders in title VII meals sites, in senior centers, in elderly housing units—anywhere that older people might be. The attorneys and the paralegals go to these group sites, but they also go to the homes of senior citizens, and when you are dealing with rural areas, the willingness of a legal program to go to the home and to the apartment of an individual is critical if the program is going to serve people who need services. To sit in one office in Concord, N.H., would never serve the people of New Hampshire.

I think these programs have been very successful, but again, the response has been meager in Maine, Vermont, New Hampshire, and Rhode Island, which all have statewide legal programs. Legal programs for the elderly in these four States have a total of 10 attorneys, and 13 paralegals, for an older population of over 525,000 people. This is the model for the country, and yet those are the figures which confront us.

Seven Lawyers for 937,000 Older Persons

In Massachusetts, we have seven lawyers and 12 paralegals for over 937,000 people over 60, and of those seven lawyers, four of them are in Boston, and of the 12 paralegals, 9 of them are in Boston, so that the model for the country is a very meager model. The programs may be doing a good job, but you can see the coverage.

I think it is legitimate, though, to mention what the legal service programs are doing that are not specifically geared to the elderly. Basically, the response is the same as it was in the late 1960's when OEO estimated that about 6 percent of the total caseload for legal service programs, for OEO programs, was elderly. In talking with legal service programs in the New England States in the last 6 months, we determined that basically that has not changed. The average still runs from 4 percent to 10 percent of the total caseload. Thus, there has been virtually no change in the last 7 years in the proportion of older people who get served by legal assistance programs, and yet the elderly population has risen by 1 to 2 percent up to about 15 percent of the total population, and the elderly still represent about half again as many poor people as younger people do. It appears that legal service programs which are supposed to focus on low-income persons are, in fact, not making such a response in terms of the elderly. I would wholeheartedly endorse the Senator's suggestion that the Legal Service Corp. be mandated by law to begin to provide services at least in proportion to the number of low-income persons in the population, because I think there is no other way they are going to respond as quickly as they need to.

I think on their side it can be legitimately said that up until a year ago those programs were funded basically at the same level they had been in 1969, but now that they are getting increased funds, I think more action should be taken.

Private Bar Association's Response

I would like to deal very briefly with bar association's response by citing a case that recently came to my attention. A gentleman in western Massachusetts who is 67 years old, happens to be blind, hard of hearing, has a pacemaker, and walks with crutches, only with great difficulty. The gentleman just recently had a complaint filed against him in court for stealing a dog. It just so happens that the gentleman denies that he stole the dog, but does admit that he would like to have that dog because he thinks it's the same German Shepherd that he had raised and trained himself to be a seeing eye dog, and which was either stolen from him or else ran away.

In any event, the person who finally ended up with the dog had it stolen from him and has now filed a complaint against this gentleman, thinking, in fact, that he tracked it down and wanted it back so he took it. The gentleman, I also should mention, is on SSI, so he is not exactly a wealthy individual. When he went to court he asked for a public defender to be appointed and was told that they would like to but unfortunately he had too much money in the bank, so no public defender.

He then went to Western Massachusetts Legal Services, the Legal Service Corp. funded program, and was told that they also would like to help him, but unfortunately it was a criminal complaint and by statute they can only handle civil complaints.

The gentleman, knowing that he was going to have to appear in court, and knowing that if he didn't appear he would probably be convicted, or stood a good chance of being convicted, sought out through the Home Care Corp. in western Massachusetts, a lawyer, and finally found a private attorney who said that he would be happy to take the case for the nominal fee of $200 on a complaint that was for theft of property worth less than $100. The gentleman is going to retain that attorney. He is going to go to court. He is going to pay that $200 out of his own pocket because it is the only way he can get justice done. And yet I think it typifies some of the problems in the response of the private bar in this State and other States.

Inflexibility of Fee Schedule

The three major things that the case highlights are: (1) The inflexible nature of the fee schedule which the private bar maintains, and the fact that in many cases the private attorneys are not willing to take into consideration the needs of the individual client that they are dealing with; (2) I think it points out the inflexible nature of some of the federally funded programs that provide legal services; while I understand the need to set certain levels so that the programs don't promise more than they can deliver, there must also be some flexibility built in so that when a gentleman like this comes in he

doesn't get denied service; (3) the third point is that as title III begins to fund more legal programs for the elderly, there is going to be more pressure from the private bar, I am afraid, to indicate that there ought to be some kind of cap put on it, some kind of means test, some kind of limitation, so that private attorneys do not have their place taken by Government funded attorneys. I hope that this case will point out the necessity for never putting that kind of limitation on the title III program. If there had been a title III legal service program in western Massachusetts it could have served this gentleman, because it would not have had limitations, income or any other kind of limitation, except need.

Senator, I think I have probably gone beyond my time. I would like to mention one other thing, though, and that is that one of the real needs, when you have this few attorneys working on elderly problems, is for legal backup centers or resource centers where attorneys can specialize in problems of the elderly so that they can be on call to the programs that are serving elderly individuals directly.

I think that a very good case example is the SSI advocacy center.

Senator KENNEDY. I will give you another minute.

Mr. BERGMAN. OK. The SSI advocacy center has been funded for 2 years by the State department of elder affairs through title III. It has focused specifically on SSI cases, and it has done an outstanding job of handling 50 to 100 cases a month. Now, because the State agency will not have additional funds for them, they will have to cut off services for older people on September 30.

I think this is the kind of program that should be continued as a backup center. If there is anything which you can do, Senator, to impress upon the Administration on Aging the need for continued funding of the center, it would be much appreciated. Thank you.

Senator KENNEDY. An excellent statement. SSI is an interesting story. The Social Security Administration stated that they were going to need about 14,000 new personnel when they put SSI in. They wanted those personnel so there wouldn't be delays and redtape. OMB turned that down. As a result, we have an administrative nightmare. At the same time the administration was recommending 300,000 public service jobs. What they should have done is requested 285,000, put the 15,000 in running the social security and taken it off of the backs of the elderly people here in this country.

That is the kind of basic and fundamental mismanagement that affects the elderly. I am sure our panel throws up their arms about governmental inefficiency, inequity, and unfairness.

At this point in the record, the prepared statement of Mr. Bergman will be inserted.

[The statement of Mr. Bergman follows:]

PREPARED STATMENT OF JAMES A. BERGMAN

As you are aware, the legal research and services for the elderly (LRSE) project of the National Council of Senior Citizens is presently funded by the Administration on Aging to assist State and area agencies on aging and the legal profession to develop new and expanded legal services programs to serve elders. Secondly, the LRSE project provides specialized assistance to agencies on areas of law especially relevant to older persons.

In my testimony I will draw upon my own experiences in the field of law and aging and even more so upon the substantial experiences of the LRSE program since its inception in 1968 under the direction of Mr. David H. Marlin. I will attempt to provide a brief overview of the legal problems which especially confront elders in Massachusetts, as well as in other parts of the country, the role that lawyers and paralegals can play in helping senior citizens to overcome these problems, and some indication of how fully that need is currently being met by the existing legal service system and the barriers that presently prevent that need from being more fully met.

Legal Problems Confronting the Elderly

Not surprisingly, since income, health, and housing are essential for sustaining life, these are the three most important problem areas which older persons confront which often require legal action to resolve. Since others will discuss these problems, I will not say anything more about them. Instead, I would like to discuss briefly three not so well publicized problem areas elders confront which require legal help in many cases to resolve.

First, the elderly are frequently silent victims of consumer frauds and abuses. Like younger persons, the elderly are prone to signing contracts for home repairs or land sales without reading the fine print. But, senior citizens are particularly and more uniquely vulnerable to consumer abuses in the purchases of hearing aids, prescription drugs, mail order or newspaper-advertised insurance policies, eyeglasses, dentures, wheelchairs, funeral arrangements, retirement villages, and cures for arthritis and cancer. For a variety of reasons, including lack of mobility and embarrassment that the "wisdom of age" did not protect them from being taken, elders all too often silently endure the financial burden of consumer abuses instead of seeking legal counsel to obtain relief.

As an example of the kind of consumer frauds faced by older persons, I would like to cite a case we discovered this spring.

An elderly woman from Cambridge, Mass., went to a "free hearing test" offered by National Hearing Aid Centers where she was tested and informed that she needed two hearing aids. While the woman insisted that she did not want to decide anything that day, the dealer put wax in her ear to make an ear mold and asked her to sign her name and address. Without realizing it, she had signed a contract to purchase one hearing aid for $429. The next day, she called the dealer to state that she definitely did not want the hearing aid. The dealer insisted that she try the aid for a day and that if she didn't want it, she could return it. Instead of allowing even the promised 1-day trial period, the dealer, upon delivery of the aid, insisted that the woman pay in full for the aid, which she did under the high pressure of the dealer. The woman subsequently made several attempts to get the dealer to take the aid back, but he avoided her. Finally, she retained a lawyer with her own funds, and as a result she got $300 back. Thus, even though a doctor certified that the woman did not need a hearing aid, and even though she finally got some of her money back, she lost $129 for the hearing aid, plus the legal fees.

This is just one of 47 such documented hearing aid cases which our LRSE project uncovered in 8 weeks this spring as we prepared testimony for presentation before the Federal Trade Commission at hearings they held in Washington on proposed hearing aid regulations. While in the case I have cited, the person finally sought legal assistance, this is unusual. Embarrassment at having been swindled and fear of being considered to be incapable of handling of their own affairs often stop senior citizens from seeking assistance, especially legal assistance, when consumer abuses occur.

A second area of great concern, which most people do not presently recognize as a problem, is the treatment older persons receive from the utility companies. First, the constantly increasing telephone, gas, and electric rates and the rate structures which penalize small users versus large industrial users eat away at the fixed incomes of older persons, but these are services which senior citizens cannot do without. Secondly, utility companies more often than we realize do in fact discontinue essential service to older persons even when the outstanding bills are so small that they cannot reasonably justify health-destructive shut-offs. Making this an even more serious problem is the fact that in Massachusetts, telephone service may be terminated without a hearing for the person affected.

Finally, in many States, the laws concerning guardianships, conservatorships, powers of attorney, and medical commitment procedures do not protect the elderly individual so much as they protect the estate of the persons for his/her heirs or they provide a means of physically isolating a "problem" person from his/her family or neighbors.

THE RESPONSE IN NEW ENGLAND TO THE LEGAL PROBLEMS OF THE ELDERLY

In response to these problems some excellent and innovative legal programs specifically for the elderly have developed in New England in the past 7 years. Interestingly, these programs have all been funded either through the original LRSE program which the Office of Economic Opportunity first funded in 1968 or through title III of the Older Americans Act. In some cases the title III funded programs have been significantly supplemented by ACTION funds, for VISTA lawyers, or persons who were later trained as paralegals, and by CETA funds.

As you have already heard today, the Council of Elders Legal Program in Boston was one of the original LRSE projects funded by the National Council of Senior Citizens in 1969. Like the other original LRSE projects throughout the country, it served both as a direct service program and as a model for future programs to follow. Today, the program is funded by the Legal Services Corporation and is sponsored by the Council of Elders and operated by Greater Boston Legal Services.

The CoE LRSE project was one of the first to use elders as paralegals, and it continues to do so today because their value has been repeatedly demonstrated, as Dick McCusker has already indicated. Unlike many of the original LRSE projects, the CoE project concentrated on legislative action to meet the needs of many of the older persons it represented. Backed by the CoE board of directors—which was 100 percent elderly—The CoE legal project played a significant role, along with Frank Manning's Legislative Council for Older Americans, in getting increases in old age assistance and in creating the cabinet office of elder affairs in Massachusetts. Speaking as the original director of the CoE legal project, I think the program demonstrated beyond any doubt that a major activity of legal programs for the elderly should be legislative action.

Taking a law reform approach, the title III funded Cambridge/Somerville legal services program for the elderly has concentrated much of its activities on high impact or class action litigation. It has been quite successful in this approach in that it has gotten a decision from the Federal district court requiring the Cambridge social security office to process all nondisability SSI applications in no more than 45 days. As you know, some older persons SSI applications took months to be processed, causing great hardship to the elderly person so affected. In addition, this legal project has filed a suit which challenges the Massachusetts' title XX application forms, charging that the information requested is an invasion of the older person's right to privacy. Both of these suits, and others like them, when successful can provide relief to hundreds or thousands of elders.

In Maine, Vermont, and New Hampshire, statewide legal projects for the elderly have been established through title III funding. Each of these projects has used the title III grant to hire a lawyer to direct the legal program and to pay for some of the support costs, and has then supplemented the title III funding with VISTA's or CETA employees.

The New Hampshire program, which is a part of New Hampshire legal assistance, has been operating since November 1975, and consists of a lawyer/director and seven paralegals, four of whom are elders. The project has concentrated so far on handling individual cases and has done a very effective job of outreach by having its paralegals establish office hours at title VII nutrition sites, at elderly housing developments, at senior centers, and at other locations frequented by older persons as well as utilizing New Hampshire legal assistance offices. As in Maine, the New Hampshire elderly legal project director circuit rides throughout the State to supervise the paralegals and to represent clients who require a lawyer's services.

The Vermont legal aid program for the elderly was funded in May of this year and is now beginning to handle individual cases. This program consists of one experienced lawyer/director and six VISTA lawyers. The VISTA lawyers will each be based in an area agency on aging office, but will also have office hours in locations such as the New Hampshire and Maine programs.

Each of the projects that I have described has attempted—successfully, I think—to establish legal programs which are specifically identified as being for older persons and have purposefully set up office hours in locations used by elders. Each has also made a special outreach effort, and each makes it a practice to make house calls.

Thus, while some of the projects specialize in handling mainly individual cases, some concentrate on high impact litigation, and the original CoE LRSE program focused on legislative action, each places the special needs of the older person foremost in the way in which the services are made available. Again, the use of elderly paralegals has been a major means of doing this.

As I stated initially, all of these projects are either title III funded or were initiated by the original OEO/LRSE program. And, as successful as these programs and three similar ones in Massachusetts and Rhode Island are, together they represent a very meager response to the need for legal services for the elderly. In fact, together the four statewide legal programs for the elderly in Maine, Vermont, New Hampshire, and Rhode Island have a total of 10 lawyers and 13 paralegals to specifically represent a 60+ population of 523,804 persons. Massachusetts, with a 60+ population of 937,247, presently has five elderly legal projects consisting of 7 lawyers and 12 paralegals, with 4 of these lawyers and 9 of the paralegals serving Boston only.

In the past 8 months our LRSE project has worked with State and area agencies on aging, legal service programs, older persons and others to develop title III applications for new and expanded legal projects for the elderly. Hopefully some of these will be funded this year. However, even if all of the Massachusetts projects were funded, these new projects would together have barely double the present number of lawyers and paralegals in the existing elderly legal projects.

So far I have mentioned legal projects that serve only the elderly, and I have not mentioned persons who are served by legal assistance programs funded by the Legal Services Corporation or persons who retain private attorneys. In my work with legal assistance programs in recent months, all of them have stated that they recognize that they presently serve a disproportionate number of low income younger persons versus senior citizens. This has been true since the beginning of these programs in the 1960's, and it has been impossible to change significantly until now due to the previous lack of any increases in legal services funding and the fact that the caseloads were already filled.

Figures from OEO for the late 1960's indicated that nationally the elderly 60 and over were receiving only about 6 percent of the legal services provided through OEO funded legal services programs. Yet, in 1970, an estimated 14.1 percent of the total population was 60 and over, and most studies indicated that half again as many older persons as younger persons had incomes below the poverty level.

As of today, nationally, close to 15 percent of the total population is age 60 and over (in Massachusetts, 16 percent of the population is 60+), and older persons continue to be disproportionately represented among those persons living below the poverty level. Yet, legal service programs in New England themselves estimate that persons 60 and over receive only between 4 percent and 10 percent of their total services, which, I should reemphasize, are focused on low income persons. Some examples of estimates of the percentages of elderly persons served by legal assistance programs are the following: Greater Boston Legal Services, 10 percent; Western Massachusetts Legal Services, 4 percent; Central Massachusetts Legal Services, 5 percent; Legal Services for Cape Cod and Islands, 5–10 percent; Vermont Legal Aid, 6.5 percent; and New Hampshire Legal Services, 6 percent.

Thus, while legal assistance programs presently provide some services to low income elders, they need to make a concerted effort to increase their proportion of services going to older persons. Now that some increased funding from the Legal Services Corporation is available, these programs should build upon the experiences of the elderly only legal projects to increase their services to older persons. In fact, Congress should seriously consider mandating that this occur.

At this time, most bar associations admit that they do not know how well the private bar has responded to the legal needs of the elderly. However, I believe that some conclusions may be guessed at based upon the experiences of social service agencies serving the elderly and based upon the income levels of older persons. First, since so many elders have low, fixed incomes, and since lawyers

and bar associations have resisted advertising their fees or adopting sliding fee scales based upon the incomes of clients, I think we may reasonably conclude that the private bar has not done any better, and probably worse, than legal assistance programs in serving the elderly.

Secondly, I personally know of very few social service agencies serving the elderly who have been approached by private lawyers who have offered to provide pro bono legal services to elders who need them. In the few cases where I know that that has occurred, they have usually been lawyers who sit on the boards of directors of the agencies and are willing to do some free legal work in emergency situations. Since Massachusetts alone has about 16,000 lawyers, according to Massachusetts Bar Association estimates, if pro bono services for the elderly were widespread, I do not think it would be as hard as it is to discover examples.

Estimated Need for Legal Services by the Elderly

So far I have discussed the types of legal problems older persons face and some of the response to that need in New England. I have not attempted to estimate the full need, simply because such estimates are difficult to back up. However, as quoted in *The Law and Aging Manual*, a 1974 American Bar Association/American Bar Foundation study estimated that 37.3 percent of the adult population has one or more legal problems per year (excluding traffic violations). If this is true, and for the elderly this may be a low estimate since so many elders are low income and dependent upon public benefit programs, then of the 1,461,051 persons aged 60 and over in the five New England States, 544,973 are likely to need some type of legal help each year.

According to a 1975 study quoted in *The Law and Aging Manual*, the experience of legal service programs has shown that about 325 cases per full-time attorney per year is reasonable. Based upon that estimate, approximately 1677 lawyers would be needed in the five New England States to meet the estimated current needs.

Broken down by each of the five States, the following figures apply:

State	60-plus population	Estimated number of persons needing legal services in a year	Estimated number of lawyers needed to meet this need
Maine	172,919	64,499	198
Massachusetts	937,247	349,593	1,076
New Hampshire	121,665	45,381	140
Rhode Island	158,677	59,187	182
Vermont	70,543	26,313	81
Total	1,461,051	544,973	1,677

I should note that the estimate of 325 cases per year per lawyer does not include consideration of time an attorney might devote to legislative activities or legal education programs which are also vital in meeting elders needs. Thus, the above estimates of need for attorneys are probably somewhat low.

On the other hand, if paralegals were available to assist lawyers in handling cases it would very definitely be possible to reduce the number of lawyers needed to serve the elderly. While it is difficult to estimate the number of cases a paralegal can handle per year, under the supervision of an attorney, it is not unreasonable to assume that 100 to 200 cases could be handled by a full-time paralegal, and in some cases the number may be even higher.

It should go without saying that the above estimated need is nowhere near being met presently.

Remedies To Meet the Need for Elderly Legal Services

The most basic requirement for fulfilling the unmet legal needs of older persons is, as always, money. This could be approached in two ways: (1) Provide older persons with a guaranteed annual income which is high enough so that they may purchase the essentials and the services they need, including legal services; or (2) provide much greater Federal support for legal services for the elderly.

Since I do not expect to see a guaranteed annual income for elders in the near future, and since this committee frequently hears the plea for more funds, I will only make four brief suggestions for Federal action now to increase funding for elderly legal services:

(1) The Legal Services Corporation should be mandated by Federal law to serve low income persons in direct proportion to their percentage of the low-income population, with age, race, and ethnic origin being the criterion by which this standard is applied. This would force a readjustment of the present inadequate service going to elders. Certainly such a mandate should be accompanied by increases in Legal Services Corporation funding levels.

(2) Congress has already taken very significant steps in the Older Americans Act amendments of 1975 by making legal services one of the four priority services under title III, and by continuing to increase funding for title III. If more funding is provided through title III and Congress reenforces its desire to see all four priority services funded, then additional legal service programs are certain to develop.

(3) In order to persuade the private bar to become more involved in serving the legal needs of older persons, Congress should study ways of establishing pre-paid or group legal services plans which in all probability would have to include at a minimum Federal regulation and at a maximum Federal financial support.

(4) Since elderly persons trained as paralegals have proven their value in elderly legal projects, Congress should encourage this approach by amending title IX of the Older Americans Act to strongly suggest that some of the persons employed under this program should be employed as paralegals in elderly legal projects—possibly projects funded by title III. In fact, in this hearing room today are many senior aides who are employed through title IX, and many of them have already expressed an interest in being paralegals.

There are other problems inhibiting the attempt to meet the need for legal services for the elderly which are not merely a result of lack of funds. I would like to cite a case which I recently learned about which illustrates some of the problems.

A 67-year-old blind man from the western part of Massachusetts has just recently had a criminal complaint filed against him charging that he had stolen a dog. He denies it, claiming that he does not have the dog, but wishes that he did since the dog he is accused of stealing is the one which he believes he trained himself to be his seeing-eye dog and which later either ran away or was stolen from him.

The accused gentleman is not only blind, he is hard-of-hearing, has a pacemaker for his heart, and requires crutches to walk. For financial support, he receives SSI.

When the complaint was filed against him, he asked that a public defender be appointed to represent him, but he was denied because it was claimed that he had too much money in his savings account—even though he qualified for SSI. He then went to Western Massachusetts Legal Services who also had to deny him service because the Legal Service Corporation does not allow the program to handle criminal cases.

Finally the man found a private attorney to represent him—at a cost of $200, for defense in a complaint charging theft of property worth less than $100. Seeing no other choice, the gentleman is going to pay the $200 out of his meager SSI income so that he can receive a fair trial.

A rare case? Maybe the man's physical ailments and the specific accusation are unusual, but the other circumstances are all too common. I would like to simply list some of the common problems this case highlights, and suggest some remedies.

(1) *Unreasonable income limitations:* While in this case, it was the public defenders who had the unreasonable income limitation, in many cases the Legal Service Corporation funded programs have equally low limits. While these limits are not totally without merit, if they are inflexibly applied, they can be very unreasonable, as in this case.

The Older Americans Act requirement that services funded through title III must be available to elders regardless of income is a much better approach.

(2) *Unreasonable fees of private attorneys:* The $200 fee being charged to the blind gentleman appears to have been set without any recognition of his financial situation, and in my opinion is outrageous. Unfortunately, this is just one more

example of the rigidity of the private bar's fee schedules, and their lack of willingness to take the initiative in both advertising their fees and specialties and in setting flexible fee schedules. I am not sure if there is a legislative solution to this problem, but certainly any pressure this committee can bring on the private bar in these areas would be a positive step.

(3) *Lack of unreasonable restrictions on elderly legal programs:* This case illustrates the wisdom in the title III programs which do not have income or any other limitations on who may be served, as long as they are elderly. If a title III legal program had been in existence in western Massachusetts, this man could have been served at no cost to him. In the future, lawyers and the private bar may attempt to restrict the provision of legal services under the title III program. I hope that this case will always stand as a reminder to Congress to resist such pressures.

Before concluding I would like to mention two other areas which, I believe, deserve more attention if the elderly are to receive high quality legal services.

A major deficiency at this time in the field of legal services for the elderly is the lack of training materials and courses for lawyers and paralegals. Law schools provide virtually no background in aging or in substantive areas of law pertaining to the elderly—the most obvious area being the programs under the Social Security Act. Few colleges or universities offer specialized courses for lawyers or paralegals serving older persons. As far as I am aware in New England, only New Hampshire has used title IV–A Older Americans Act funds for paralegal training. As a result, each legal service program for the elderly must reinvent the wheel whenever it trains new lawyers or paralegals to work with the elderly. And, persons who wish to become trained paralegals or social workers who wish to develop a better knowledge of how to use the legal system for their clients are confronted with nowhere to go to receive this information.

Just as our LRSE project has received many requests from the elderly law projects to fill this training void, we have received numerous requests to serve as a regional elderly law backup center. The problem, simply stated, is that lawyers handling 300 to 350 cases a year and also administering legal projects for the elderly do not have time to keep abreast of all the new laws and cases relating to the elderly and to do detailed legal research on more than a few areas of law each year. As a result, the representation available to older persons is not always as excellent as it could be. Elderly law backup centers in each region of the country—possibly established through Older Americans Act model project funds—could begin to fill this gap.

A good example of such a backup center is the SSI Advocacy Center, attached to the Massachusetts Law Reform Center which specializes in handling SSI cases in Massachusetts. The SSI center handles an average of 50 to 100 SSI cases per month and handles only SSI cases. As a result of this specialization, the elderly served are certain of quality representation, and secondly, other lawyers and paralegals throughout the State may call upon the center's staff for backup on their own SSI cases.

The SSI center has operated for over 2 years with title III administrative funds as a project of statewide significance. As successful as it has been, the Massachusetts Department of Elder Affairs will not be able to refund it this year because it has no funds available for this purpose. As a result, the SSI center will have to close its doors to the elderly on September 30 of this year. I don't know if there is anything you can do, Senator, to help the SSI center to continue, but I hope that you will try.

Even if you cannot help the SSI center, I believe that its success underscores the need for backup centers of its type.

Thank you very much, Senator.

Senator KENNEDY. At this time I would like to recognize Linda Noconiam, who is representing Congressman O'Neill; Fred Rose, who represents Congressman Early; and Ed Moore, representing Congressman Burke.

All of the House Members are voting today on the Supplemental Security Income Reform Act to insure cost-of-living increases in SSI. If there is such a thing as a good excuse, they have it today. [Applause.]

Now, we are going to hear, if we could, from Emily Murphy, then from William Cohen, and then from James Frost. We shall give them a minute each—if they would just like to step up here. We have the reporter here. Each is entitled to—I'm just sorry on the time. I have to get on back. We are having an antitrust bill that is before the Senate. It will give the State attorney general the power to bring an antitrust action when the individual harm is only a few dollars, but the total sum in terms of the consumer is $20 million, $30 million, $40 million.

There is a filibuster on this afternoon, and the Judiciary Committee is trying to break it. We will be voting on it tomorrow, but we will be debating it this afternoon. It, too, is an important bill for the elderly. As I have to take a 12:15 plane, I am going to have to leave here in about 5 minutes.

Emily, we will give you a minute. And any of the rest of you that would like to have a comment or statement made a part of this record, we will leave the record open for 30 days. Just write me a note and it will be included in the record. OK, Emily.

STATEMENT OF EMILY M. MURPHY, NORTH ANDOVER, MASS.

Ms. MURPHY. Senator, it's a pleasure to meet you, and I want to thank you for all the efforts. Especially our senior aid program. We in North Andover have a town that very seldom needs anything, but the council on aging is very active, and we are mostly all volunteers, and a year ago we had quite a confrontation with the board of health, because we wanted to have a clinic for the elderly which we had started and it was for 2 years with volunteers, and we needed some money, and, of course, there was a definite denial. So, we went to the Legal Aid through the home care program in Lawrence, Merrimack Valley Home Care, and through their efforts and our own constant communication, the program was very well resolved and we have a wonderful clinic that handles something like 400 people in 2 or 3 months. So, that is one of our own experiences with Legal Aid.

The other little note I have here, according to lawyers, I think that publicity of some kind would result in having volunteers.

Senator KENNEDY. That is good. Very good, Emily. William Randolph Cohen.

STATEMENT OF WILLIAM RANDOLPH COHEN, BOSTON, MASS.

Mr. COHEN. Senator Kennedy, my full name is William Randolph Cohen, and I am the Massachusetts department junior vice commander, Sons of Union Veterans of the Civil War. I sent you a letter by certified mail on July 24. Not knowing what happened to that letter, I visited your office in person a little over a week ago. I found out that that letter was turned over to Samuel Thompson of the Boston Housing Authority.

He sent back a response to your office. The original was supposed to come to me, but it never came to me. I was given a copy of that letter and the response to that letter was all out of line with that letter that I sent you.

Senator KENNEDY. Let's try to follow up. I will be glad to try and follow up with you, and will do so. And I want to commend you for

your role as junior vice commander, Sons of Union Veterans of the Civil War.

Mr. COHEN. Also I sent you a letter on the 21st asking for copies sent from your office or anybody else. I am the only truly registered commander of the Massachusetts department of veterans of the Civil War, and I am trying to do things for senior citizens, like myself, who live on a fixed income. I live in the Boston Housing Authority community.

As you have already been told by Gerald Wall, the rents are being increased enormously. The Boston Housing Authority, I understand, can go up to 25 percent of our income, and that would put a cramp in the $288 which is received from SSI, and that leaves us with very little to live on. It is hard to live for senior citizens, or anyone else, with food and clothing and telephone and other necessities of life. I have appealed to you and to Senator Brooke to take steps to change the legislation on that amendment to lower the 25 percent to say 12½ percent. Fifteen would be OK, too.

Senator KENNEDY. Let me ask you, Mr. Cohen, could you go down right after this meeting to my office—I have to go right back to Washington—but if you see Barbara Soliotis at the door there, and we'll arrange a meeting for you with Dave Wynn. Let's get busy on this. I have some good attorneys up here that will help me if I have any problems. I want to just give two people a final chance to talk, but see Barbara and we will set something up right away, if you would be kind enough to do that. I regret and apologize if we haven't been able to be as responsive as we would like, but I give you assurance that we will do our very best. I want to thank you for commenting. OK, James Frost. Jim, I will give you about 45 seconds.

Mr. FROST. We have submitted our written testimony, Senator.

Senator KENNEDY. Very good. Your statement will be entered in the record at this point.

[The statement of Mr. Frost follows:]

STATEMENT OF JAMES FROST, COMMISSION ON AFFAIRS OF THE ELDERLY, BOSTON, MASS.

Mr. Chairman and distinguished members of the panel: My name is James Frost, and I am here today to speak on behalf of the city of Boston Commission on Affairs of the Elderly. As you may know, Boston has approximately 120,000 persons age 60 and over. This is a large group of people and one that certainly deserves every legal consideration and benefit.

Older persons as a group seem to be subject to legal problems, particularly given their increased dependency upon Federal, State, and local programs, each of which has its own particular regulations and restrictions. A reliance upon public agencies for housing, transportation, health care, and income maintenance, too often creates a corresponding submission to rigid eligibility standards, complicated reporting forms and confusing and misleading procedures and regulations. Without being overly dramatic, an elderly person's fate can sometimes literally be determined by his or her ability to wade through a plethora of application forms, income statements, and so on. This bureaucratic maze does at times seemingly preclude an individual from obtaining the benefits that are legally his.

Mr. Chairman, I am sure that you are aware of the fact that many elderly persons suffer because of their inability to deal with the public and private agencies obligated to respond to their needs. The Boston Commission on Affairs of the Elderly would, therefore, be happy to support any and all efforts that can be made to alleviate legal problems for our senior citizens, particularly in the following areas of need:

(1) *Housing.*—Recently, many of us witnessed the frustrations of Boston's elderly housing residents who were faced with proposed rent increases. This is just one example of the type of housing issue that would lend itself to legal intervention.

(2) *Income maintenance.*—We are all aware of the many problems beseiging social security and supplemental security income recipients. Many times elderly persons are not aware of deserved benefits or, perhaps even more important from a legal point of view, the various appeal systems open to them. Competent legal assistance in this regard could be the critical difference in determining a recipients income.

(3) *Medical care.*—Even the most experienced and sophisticated reader is often confused trying to interpret private insurance plans and policies, let alone the complex medicare and medicaid programs. One hopes we have not reached the stage where it takes a lawyer to determine medicare eligibility but, unfortunately, that day may not be too far off.

(4) *Employment discrimination.*—The Federal Age Discrimination in Employment Act of 1967 bars employees from denying job applications or dismissing employees solely because of age. This act has not been vigorously enforced and, unfortunately, is not well known by many employees or older persons. Legal aid and assistance may be necessary to bring employers into compliance with provisions of the act.

Mr. Chairman, I could go on. There are many other areas of need unique to elderly persons. Almost all of them require trained and sophisticated legal intervention and assistance.

The American Bar Association has determined that 23 percent of all Americans have a civil legal problem at least once each year. One would hazard the guess that this percentage is even higher for our senior citizens, particularly the elderly poor. Thus, we feel safe in saying that thousands of elderly persons in Boston need efficient and meaningful legal services, hopefully of the type that can be made available for little or no cost. This latter point is imperative in light of the high incidence of poverty amongst so many of our senior citizens.

We would hope that the members of the Special Committee on Aging and the full Congress respond to the problems I have mentioned here today. Boston deserves nothing less than the very best effort that can be brought to bear by the Congress to address the legal needs of our senior citizens.

Thank you for your time and consideration.

Senator KENNEDY. Here's a wonderful note: "If possible, I would like to testify, very briefly, honest. Norma Walsh Gramer." How can I say "No"?

STATEMENT OF NORMA WALSH GRAMER, BOSTON, MASS.

Ms. GRAMER. I understand. Thank you very much. OK. My name is Norma Walsh Gramer. I'm a member of the State advisory for the elderly, the ABCD board on the elderly subcommittee, and mayor's, you know, the whole thing. I am interested. I am concerned. I care. I just wanted to say we appreciate all of you coming down. It's good to have sincere people looking out for the elderly. And I am in strong favor of expanding legal services for the elderly. The point I can tell firsthand, when I worked with the commission on affairs of the elderly in the city of Boston. All of you know that elderly don't want to tell everybody their business. They don't want to let everybody know what is happening.

In my capacity in city hall, they quite often had legal problems, and I would refer them to the local BLAP office, but they were hesitant because they didn't feel as though the lawyers there would have the sensitivity. With specifically geared programs for the elderly there will be more help, and we thank you very much.

Senator KENNEDY. All right, that is very good. Now, there will be some forms right down here. They are all addressed, and if you didn't have a chance to speak today and you would like to, just fill that out. Write on the back of it. You can fill out another couple of pages if you would like. Give your name on the bottom and then we will make that a part of the record.[1] We try to make it easy. Just take it with you.

Now, just a final point. We are going to fight the reduction of funds for legal service. The administration has requested the reduction of money. We have already appropriated the money, and we are going to make every effort to defeat the administration request to cut back the Legal Service Corporation. We want you to know that. I am sure the Congressmen will be talking to you, if you are in their areas, about that in particular. We will also work on earmarking funds for the elderly in the appropriations made to the Legal Service Corporation.

Third, we want to work for mobile legal service units and for more units permanently located where large numbers of elderly reside, staffed by paralegal aides.

POSSIBLE FEDERAL AND PRIVATE ACTIONS

We have talked a little bit about the private bar. I will ask other members of our committee to join me in requesting their cooperation in providing legal services for the elderly, and in requesting a response from them, indicating what they have already done. I think, in the areas where it has been good, the people ought to know about it. I am sure there have been many instances where there has been superb service, and we ought to know about it, as well as where the service has been inadequate.

We will also explore problem areas with the LEAA, the Federal Government's principal instrument for providing assistance to State and local communities. One of the things we didn't explore very thoroughly today is the relationship of senior citizens and the problems of crime. I think that there are areas in which LEAA can provide some additional resources to help protect the elderly.

The Senate will also be working on the passthrough provisions, which the House is acting on today. We will explore some legislative solutions to assure adequate notice for housing residents, and to prevent entire social security increases from being eaten up by rent increases alone. There are opportunities for action at the Federal level. This ought to be an area of priority, and we will work with you and your groups, your State groups, your local groups, and national groups to gain support for these legislative actions.

As a result of the hearing we had 5 years ago, we were able to spark some movement. It is still not nearly enough. We have talked about Boston and Massachusetts and New England being ahead of some parts of the country, but we have also heard about how far yet we have to go. I want you to understand my full commitment to this program.

This is something I am interested in. I know you are. I appreciate your patience and your sharing with us during the course of this hearing your own concern for your fellow citizens. The committee stands in recess. Thank you, very much. [Applause.]

[Whereupon, the hearing was adjourned at 11:40 a.m.]

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[1] See appendix 3, p. 201.

APPENDIXES

Appendix 1

STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF DOROTHY KING, ASSOCIATE DIRECTOR, SSI ADVOCACY CENTER, BOSTON, MASS.

The SSI Advocacy Center has assisted the elderly and disabled and their advocates with supplemental security income (SSI) for over 2 years. My comments and suggestions concerning the legal issues of importance to them draw on this experience.

If the SSI program is to fulfill its promise to provide direct and simple income maintenance to the needy elderly, much change should be made in its current substance and procedure. I will briefly discuss several of the areas which are of particular importance to elders and which are ripe for litigation or legislative change.

Delay.—The application process for an elderly person can be full of delays and inefficiencies. It can take several months for the district office to verify income, resources and household expenses. Except in a few areas, like Cambridge, where case law has enforced a 45-day time limit for processing applications (*Santos* v. *Weinberger*, No. 75–166G, D.C.MA), there is no statutory or regulatory time within which the Social Security Administration must act on a claim. The hardship which long delay causes can be alleviated by litigation forcing a reasonable time limit construction upon the statute and regulations. I also recommend legislation to establish a 30-day time limit for processing nondisability applications for SSI.

Nonreceived, Lost or Stolen Checks.—When through a computer error, a postal error or otherwise, an SSI recipient does not receive a regular monthly check, the computerized procedure for a replacement takes so long that recipients lack the essentials of daily life. Pursuant to Federal litigation, the Boston Region of SSA made a study of checks not received, lost, or stolen before negotiation. Of those cases where a substitute check was issued, the report noted that it took from 8–18 days after the recipient reported the case before she or he received a check. A 3-week wait for a check which represents a minimal income supplement can easily place the life of an elderly person in jeopardy. Our office and the Chelsea-Revere legal services office have brought a mandamus action against the Social Security Administration and the Department of the Treasury requesting that the court recognize an obligation to issue checks immediately to those recipients. *Moore* v. *Mathews*. D.C. Mass. No. CA–75–2555–T.

It is recommended that the district offices have prewritten checks available for the immediate replacement of their nonreceived, lost, destroyed, or stolen checks. The SSA itself, in the report mentioned above, suggested the use of the district office imprest funds to replace checks. Legislation should also be drafted requiring the local offices to arrange for the replacement, within 3 days of reporting, of checks lost or stolen before negotiation, or never received.

Resources.—The Social Security Act allows a person to be eligible for SSI only if their home is valued below an amount "the Secretary determines to be reasonable." 42 U.S.C.A. § 1382b(a)(1). The Secretary's determination is that any person is ineligible for SSI who lives in a house valued at over $25,000, 20 C.F.R. § 416.1216. In the low and moderate income neighborhoods of the northeast, houses are often if not always valued at over $25,000; thus, many individuals otherwise eligible for SSI receive no benefits. The $25,000 upper limit, although reasonable

in many sections of the country, operates in a very discriminatory manner in urban areas with a high cost of living. The regulation forces the elderly to choose between their homes and the minimal SSI benefit.

The reasonableness of the Secretary's determination should be challenged at the same time legislation is introduced directing that the Secretary establish upper limits for the value of homes which reflect the current market values of low-income homes in various areas of the country.

Imposition of a 6-Month Rule on Eligible Couples.—The so-called "6-month rule" provides that two eligible individuals who have previously resided together as husband and wife, and who have not been separated for 6 months, shall be considered to be an eligible couple for SSI purposes (42 U.S.C. § 1382c(b)). That means they receive a lower benefit and have their income counted in a less advantageous manner to determine eligibility and benefit level.

I can think of no justification for the requirement that two individuals who have ceased to live together shall be considered to still be living together for a 6-month duration. The financial burden this imposes on two eligible individuals is considerable. Because the spouse's income is deemed to the eligible individual even *if it is no longer available*, the financial burden imposed is cruel and unconscionable. A not uncommon situation encountered by advocates in this State is that in which a husband disappears with the couple's savings, leaving the wife with no source of income save her half of the couple's benefit, about $204 per month. If one member of a couple is forced into an institution, the other member has the full burden of supporting her or himself on the couple's grant for 6 months. If the institutionalized spouse has other income than SSI, it lowers the couple's SSI grant, only half of which the noninstitutionalized spouse receives. The spouse in a nursing home may need all of his or her social security and SSI to pay the nursing home, leaving his or her spouse with a pittance.

I recommend the elimination of the "6-month rule." Eligible individuals no longer residing in the same household should be entitled to receive benefits computed on an individual basis, beginning with the month after the month of separation.

Representative Payee.—Under the statute and regulations, social security has broad, discretionary powers to appoint and select a representative payee for an SSI recipient. 42 U.S.C. § 1383(a)(2), 20 CFR § 416.601(a)(1). There are no specific guidelines for the agency in the selection of a representative payee, other than that he or she evidence interest or concern. See 20 CFR § 416.610. Once the decision to make representative payment has been made, there are no specific guidelines regulating the conduct of the representative payee, and no enforceable remedies if the payee is determined to have misused benefits.

The decision to make representative payment is made solely at the discretion of the district office, as is the selection of the representative payee. The recipient is afforded no prior hearing in which to raise objections, if any.

The constitutionality of this denial of personal and property rights without a prior hearing is ripe for litigation. I also strongly urge legislation which would (1) require an impartial hearing *prior* to the decision to have a representative payee appointed, (2) establish guidelines for qualification as a representative payee, (3) require periodic written reports accounting for payments certified to the representative payee, and review of the necessity for representative payment, (4) establish enforceable penalties for misuse of benefits on the part of a representative payee, and provide for enforceable methods of restitution of misused benefits, and (5) require immediate issuance of duplicate checks in cases where funds have not been used for the benefit of the recipient.

Conclusion.—All the SSI problems outlined above can be alleviated by legislative action. If the changes are made, it will be possible to avoid the lengthy and costly litigation involved in challenging the practices and procedures of the Social Security Administration. I have recommended a few important changes. Several other problem areas which I have not had time to touch upon are: inadequate notification of termination and reduction of benefits, inequitable deeming of a spouse's income, reduction or termination of benefits upon temporary institutionalization, coercive methods of recouping innocent overpayments, and unrealistic liquid resource limitations.

ITEM 2. STATEMENT OF LEWIS M. LEVENSON, EXECUTIVE DIRECTOR, SOMERVILLE-CAMBRIDGE HOME CARE CORP., SOMERVILLE, MASS.

Mr. Chairman, I am executive director of the Somerville-Cambridge Home Care Corp., a nonprofit corporation with local management responsibility for elderly services available under titles III and VII of the Older Americans Act and title XX of the Social Security Amendments.

We are entering the third year of a subcontract relationship established with the Cambridge-Somerville Legal Services, Inc., to provide access to appropriate legal services by the elderly in our area. Title III funds made available to us through the State's Department of Elder Affairs have been used for this purpose.

Our experience of the last 2 years has demonstrated that legal services for the elderly clearly perform two different functions: subsidization for personal legal services needed by the elderly poor, and class action advocacy proceedings necessary to protect the elderly from administrative restrictions imposed on other groups.

The needs of any local area—and Somerville-Cambridge is no different in this regard—far exceed the ability for those needs to be met through present or foreseeable levels of funding for title III. Local pressures must therefore tend to push aside the class action function when allocating the basically inadequate funds to local services. Yet the broad issues of society which can be resolved through class action advocacy clearly is an investment in the future with a very high cost-benefit effectiveness ratio.

We are also designated as an area agency on aging and are therefore most conscious of and sensitive to the conflict between local priorities and issues which transcend the local area for benefit, but must be funded through diverting funds otherwise available for more directly visible benefit.

Legislation to create a separately funded title within the Older Americans Act to address the class action advocacy situation would remove pressure from the local areas that is not fair or appropriate for them to be subjected to. The most appropriate linkage would suggest funding to the area agency on aging level to ensure a close working relationship with the range of service providers in that area and thereby assure a comprehensive and integrated recognition of problems and development of solutions. Elderly residents of other areas would benefit through the formal reporting linkage between the area agency and the State agency, as well as the less formal communications network between area agencies, and that among legal service programs.

In other words, funds expected by the Congress to be directed toward the legal service concerned with responsible class action advocacy should be distributed outside any state allocation formula otherwise used for title III.

Such legislation would permit the proper development of the reservoir of awareness, skills, and cooperative interagency working relationships that can effectively provide a focus of the energy needed to make progress. Without such legislation, we must be concerned that there is little incentive to take such elderly issues seriously. The tendency otherwise is toward inadequate funding of available services, compounded by the reality that a sizeable chunk of that inadequate funding must be spent simply to bring the legal staff on board as to the elderly issues.

ITEM 3. STATEMENT OF PATRICIA A. CANTOR, MANAGING ATTORNEY, COUNCIL OF ELDERS LEGAL SERVICES PROGRAM, BOSTON, MASS.

I am managing attorney of the Council of Elders Legal Services Program (COELSP) a legal assistance project for low income elders in Boston. We are funded by a grant from the Legal Services Corporation and operate as a cooperative undertaking of the Council of Elders, an elders' social service agency, and Greater Boston Legal Services. The office consists of four full-time lawyers, one full-time and eight half-time paralegals, and two secretaries. We provide a full range of legal services for seniors with civil, nonfee generating cases. We conduct an active outreach program to inform elders of the availability of the service and to encourage them to use it.

LEGAL PROBLEMS OF THE ELDERLY

Low-income elders have many of the same problems as low-income younger people. Yet, these problems are frequently compounded by the older person's lack of mobility and frailty.

For example, a typical case involves someone who is being threatened with eviction. Usually the elder is in ill health, has occupied the apartment for many years and is totally surprised and unprepared for dealing with the problem. The case becomes even more difficult because often people are afraid of exerting their rights. Our program works very hard to provide social service support, especially through our connection with the Council of Elders, while fighting the eviction on legal grounds.

The most frequently encountered problem involves housing, rent increases, evictions, and unsafe conditions. Because of the high cost and poor condition of most of the housing occupied by our clients, people are unable to obtain suitable accommodations at rents they can afford to pay. Social security and supplemental security income issues comprise another large segment of our caseload. These include denials of applications, alleged overpayments and other irregularities in receiving checks. We also see many people with consumer problems; and we do estate planning. Nursing homes are a growing concern and we are seeing increasing numbers of clients in that area.

ROLE OF LAWYERS AND PARALEGALS

Experience has demonstrated that older paralegals teamed with generally younger attorneys is an extremely effective way of serving the elderly. The combination enables us to provide high quality services, build rapport with clients, and strengthen the overall program.

Paralegals function under a lawyer's supervision and are actively involved in all aspects of cases. They do initial intake interviewing; prepare papers for hearings; do factual investigations and negotiate on behalf of clients. They also carry the bulk of our outreach effort.

Lawyers handle the more complicated problems and, of course, all of the litigation. They also participate in on-going training of paralegals in substantive areas of law.

Both paralegals and lawyers working together deliver a total client-service package.

ARE THE NEEDS BEING MET?

Presently, Council of Elders Legal Services Program is the only agency in Boston that is focusing on the legal problems of the elderly poor. We are trying to cover the entire city with relatively few resources. So far, I believe we have been very effective at beginning to make a dent on the problem. However, the need far outdistances our ability to meet it.

In order to adequately fulfill our responsibility to serve all needy elders, Greater Boston Legal Services has prepared a proposal for funding an expanded program under title III of the Older Americans Act. The proposal has been submitted to the area agency on aging and we are waiting for the outcome.

ITEM 4. STATEMENT OF THOMAS CASEY, COMMUNITY SERVICES COORDINATOR, MERRIMACK VALLEY HOME CARE CENTER, INC., HAVERHILL, MASS.

For the purposes of this hearing, I am representing both Merrimack Valley Home Care Center, Inc., and Merrimack Valley Legal Services.

It is our joint opinion that the elderly, due to their unique legal needs, are being, to an extent, neglected under the current legal services structure in the Commonwealth.

An attorney must acquire a certain sophistication in dealing with the legal problems of senior citizens. Due to increasingly large caseloads most attorneys employed by the Legal Services Corporation, in Massachusetts, are prohibited by time factors from acquiring this sophistication.

We would be very quick to point out that this is not due to a lack of desire or ability, but we would stress the *time* factors involved.

Merrimack Valley Home Care Center, Inc., and Merrimack Valley Legal Services have submitted several joint proposals for legal services for the elderly consumer. These funding sources include:

A. National Senior Citizens Law Center.
B. Department of Commerce, Title X.
C. Massachusetts Commission for the Blind.
D. Office of Manpower Affairs.

Due to funding limitations on the part of these sources there is no flexibility for the separation of legal services so that elderly problems can be addressed separately.

An argument could be made that legal services is a priority under title III of the Older Americans Act. But so is transportation. If any local area agency is striving for a viable transportation system, the majority of their funds would, because of cost factors, be pretty well designated to a transportation priority.

Specific service requests that would be geared mainly to senior citizens and have had some difficulty being negotiated would include, wills, guardianships, estate planning and the whole area of social security, Blue Cross-Blue Shield benefits. It is unfortunate that senior citizens, by virtue of their age, have such unusual legal problems. This facet is compounded by the fact that these problems arise when their emotional, physical, and financial resources could conceivably be considered to be at a low ebb.

It is the joint opinion of Merrimack Valley Home Care Center, Inc., and Merrimack Valley Legal Services that the Older Americans Act be amended to include a separate title to deal specifically with the legal problems of the elderly consumer.

Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM WALTER H. CROSS, SUPERVISOR, SENIOR VISTA VOLUNTEERS AND PROGRAM FOR LEGAL SERVICES; VICE PRESIDENT, MASSACHUSETTS ASSOCIATION OF OLDER AMERICANS, INC., BOSTON, MASS.; TO SENATOR EDWARD M. KENNEDY, DATED AUGUST 31, 1976

DEAR SENATOR KENNEDY: For the past 9 years I have worked with and for senior citizens in Massachusetts.

As supervisor of a senior volunteer program, sponsored by the Massachusetts Association of Older Americans, and funded by ACTION, the Federal umbrella agency for all Federal volunteer programs, we are all too familiar with the many problems of the elderly population.

One-third of all older Americans are below or hover at the poverty line.

The average single senior citizen has approximately $75 a week to live on and the average couple about $105 per week.

Twenty-five percent of all suicides in the U.S.A. are committed by people over 65.

This segment of our population are living in constant fear and without hope.

Legal representation, except for very isolated cases, are nonexistent. This segment of the elderly population is unable to recognize when legal assistance can be utilized and unable to obtain it if they do. Due to barely existing on their poverty income, the idea of using existing legal services is never considered.

To even begin to provide legal services for the elderly, a network of communications with the elderly should be established to advise them of the availability of such services. In my opinion this could be accomplished through local councils on aging, community action agencies, and other nonprofit agencies that are servicing the elderly.

I have serious doubts that this should be administered through the State Department of Elderly Affairs, but rather through a nonprofit statewide agency with a proven track record of reaching out and acting as advocates for the elderly.

Seniors who have been involuntarily retired should be trained to act as paralegals. The senior volunteer program has proven that the elderly will more readily communicate and confide with members of their peer group.

One of the most valuable services legal services could perform would be to work within the framework of the many categorical programs available to assist the elderly. These programs are a nightmare of complex eligibility requirements, and thousands of seniors are not participating even though eligible, due to lack of knowledge.

I regret that I was unable to attend the hearing. However, looking at the agenda, I think that my testimony in written form can supplement the oral testimony already provided.

Attached are recommendations for legislative proposals to eliminate many of the inequities in the supplemental security income programs, which if adopted, could help thousands of the low-income elderly.

Also, the amendment to H.R. 8911 offered by Representative Richard L. Ottinger to "increase SSI benefits to reflect certain expenses," namely to furnish to eligible individuals housing expense assistance whose housing expenses exceed 33⅓ per centum of his or her annual income, the benefit otherwise payable under this title, section 17, part A of title XVI of the Social Security Act, shall be increased by an amount determined at a rate which is the lesser of "(1) $600 or (2) the amount by which such individuals annual housing expenses exceed 33⅓ per centum of his or her annual income."

Also enclosed is a copy of a letter* to the writer, which is self-explanatory, and is evidence of the value of the new SSI ombudsman office in Boston, which was established through your efforts.

Mrs. Thompson was most happy to permit the use of her name. She did call me William instead of Walter but otherwise it is very gratifying for all concerned to receive appreciative acknowledgement of the value of this office.

It also emphasizes the problem of obtaining efficient service from many social security offices since the inception of SSI in January 1974.

Sincerely,

WALTER H. CROSS.

[Enclosure.]

The following are legislative proposals to improve SSI administrative and operational functions and to improve the lives of SSI recipients. Some of them have costs while others have savings or no cost. Many have excessive paper work.

EXCLUSION OF CERTAIN RESOURCES IN DETERMINING SSI ELIGIBILITY

Exclude the value of a home, automobile, and household goods and personal effects in determining the amount of resources for purposes of determining SSI eligibility.

Our letter dated June 22, 1976 referred to H.R. 8911 and the catastrophic result of the current practice of some social security district offices reevaluating homes of the elderly using 100 percent assessment ratio, even though the individual town uses less than 100 percent. *Time is of the essence* regarding the immediate correction of this inequity in order to enable thousands of seniors to remain in their homes.

RETROACTIVE SSI PAYMENTS

Exclude from assets SSI retroactive payments beyond 45 days from the date of application.

Example.—Mrs. E. F., Newton, Mass., applied for SSI, February 1974; declared eligible, February 1975; received retroactive payment of $1,300 February 1975; deposited check in the bank which brought her assets to $2,300. Notified by social security in July 1976 that assets were over the $1,500 limitation in 1975 so her SSI would be terminated. At the time of this notification of termination assets were under $1,500 as purchased furniture in February 1976.

She was never notified that this $1,300 retroactive payment would be declared as assets if deposited in bank. If she had received her award 45 days after filing application she would never had $1,300 to deposit.

This was caused by negligence of social security district office and again retroactive payments beyond 45 days should be excluded from assets.

ONE-THIRD REDUCTION

Eliminate the provision for reducing the benefit standard by one-third for living in another person's household. This is penalizing OA–SSI recipients living in the household of another approximately $54.75 monthly income.

INTEREST AND DIVIDENDS

Exclude from countable unearned income, interest and dividends from resources that an individual owns when determining an individual's eligibility and SSI monthly benefit amount. This is a program simplification proposal designed to eliminate the need for making monthly redetermination of eligibility or benefit changes based upon small changes in unearned income.

Under the current SSI program, even though maximum assets allowed are $1,500 for an individual and $2,250 for a couple, the maximum monthly interest at 5 percent would amount to $6 and $9 respectively. However, this category of client comprises not over 10 percent of SSI recipients. The vast majority have at the most bank accounts of not over $400 with monthly interest of about $3.

To determine the exact amount and deduct it from monthly SSI checks is costing the social security district offices for excess paper work and labor an estimated $7 to $10 for each client. Also, it is contributing to the backlog of

*Retained in committee files.

unprocessed claims by utilizing labor time that should be devoted to more important problem. As a matter of fact, many social security district offices are straining their operational capabilities by trying to enforce this regulation.

Amendments to reduce the administrative burden of the Privacy Act.

With respect to the Privacy Act, there is need for legislative changes in a number of areas such as the scope of the present provision for accounting for disclosures and the requirement that a record of disclosures be maintained for five years or the life of the record whichever is longer. Excessive paper work with considerable cost has been the result of the implementation of this act.

ASSISTANCE NOT TO BE COUNTED AS INCOME

Do not count as income for SSI purposes payments including vendor payments based on need in supplementation of SSI by public agencies or private nonprofit charitable agencies.

ITEM 2. LETTER AND ENCLOSURE FROM JAMES P. PISCIONERI, EXECUTIVE DIRECTOR, HOME CARE CORP., SPRINGFIELD, MASS.; TO SENATOR EDWARD M. KENNEDY, DATED OCTOBER 7, 1976

DEAR SENATOR KENNEDY: This agency was not able to attend your most recent hearing in Boston regarding legal problems of the elderly. In lieu of presenting specific testimony, I am enclosing a number of specific legal problem cases that elders have encountered in our planning and service area.

This Home Care Corp. has a title III contract for legal services with Western Massachusetts Legal Services. This contract has not been expanded even though the cases have become more involved and demanding. The agency has requested additional funds from the State agency, but they have not been forthcoming.

The program operates with one paraprofessional and local attorneys donate their time for court cases. It has been an effective program, but limited due to the funding. I hope these cases will assist the testimony provided at the recent hearing.

Sincerely,

JAMES P. PISCIONERI.

[Enclosure.]

LEGAL SERVICES CASE EXAMPLES

CONSUMER COMPLAINTS

Mrs. S., 81 years old, living in subsidized housing, a telephone customer for 50 years with no record of unpaid bills had her phone service cut off by the telephone company at the same time as she received her then overdue bill. Agreement was reached as to how this would be paid—phone company rescinded agreement—service restored when law suit was threatened.

SOCIAL SECURITY-SUPPLEMENTAL SECURITY INCOME

Mrs. S., an invalid was grandfathered in when the Federal Government took over from State welfare in January 1974. This account was not resolved at the correct amount for 8 months. There were erratic payments of odd sums from time to time with the excuse being the computer. Undue hardship was caused by this situation, such as unpaid bills making it necessary to apply to loan companies.

Mrs. B.'s husband passed away and she applied for SSI. Was told she was ineligible as she received income ADC for her granddaughter. Mrs. B.'s daughter gave us the above information. After several telephone contacts with social security, we were told no information could be given as why Mrs. B. could not receive SSI—explanation, confidentiality. We learned Mr. and Mrs. B. had been receiving SSI as a couple before his death. After his death she believed she needed to file as an individual which was unnecessary as the computer should have picked this up and ADC is not considered income. Our last contact was to the effect it was under advisement, but no information could be given to legal services as it would still be a breach of confidentiality. Mrs. B.'s daughter is to contact us as to whether information will be released to her.

Mr. E. has been receiving SSI of approximately $20 a month for nearly a year. He receives other small pensions which had been checked out before SSI payments started. Recently he has received notices from social security that he was ineligible. Another letter he had been overpaid, another letter stating he owed $239 in overpayment, more than he had actually received. We will check into this matter for him.

Mrs. Y. filed and was given SSI and a medicaid card. She made dental appointments and had her eyes examined for new glasses showing both the dentist and her optician her card also the fact she would be receiving SSI. The following month she was notified she was ineligible—then the next month she would receive SSI. All of this confusion caused our client to be hospitalized as she has a very bad heart condition. She was able to get her dentures and glasses and then SSI was cancelled.

HOUSING

Mrs. C. was living in substandard housing paying a rent of $125 a month. Rags were stuffed between the inside windows and storm windows to keep the cold air out. The ceiling paneling in the kitchen hung down in places about a foot. The bathroom walls were damp from leaks from other apartments and in flushing her toilet the water came down on her head. The ceiling had fallen in the hallway. All of this had been brought to the landlord's attention to no avail.

Case taken to housing court, judgment for our client and housing given to her immediately by order of the judge in Twin Towers.

Mr. and Mrs. U. had paid a deposit for an apartment, then found that water came into the basement and since Mrs. U. suffered with arthritis they could not take the apartment. The landlord was notified, but refused to return the deposit. Case taken to court—judgment in favor of our client—deposit returned.

Mrs. K. had been living in her apartment for a number of years and very happy until a new landlord came in and later refused to make any necessary repairs. Code enforcement inspected the house and gave the landlord notice. The landlord and his wife entered the client's apartment, became very abusive and raised her rent excessively. Our letter to the landlord stating the statute under harassment and the tenants rights has subdued the landlord for the present. Threatened court action was the deterrent.

Mr. and Mrs. M. had lived in this apartment for 12 years. Landlord could not afford to maintain this housing as formerly. The bank was foreclosing and they received an eviction notice.

The housing court gave Mr. and Mrs. M. a 6 months stay with 4 months (the last) no rent payments—this money to be used toward moving expenses and security payment in other housing.

CONSERVATORSHIPS

Miss T., an elderly person living alone in an apartment became incapable of taking care of her needs. Her money disappeared, she was found wandering in the street and later found in her apartment with gas jets on and unlighted.

We located a nephew who was willing to become conservator. Mrs. T. had been taken to Northampton for a few days. During that time we were able to go into court to get a few waivers and the nephew appointed conservator in one day.

Miss T. was later transferred to Municipal Hospital and the nephew made a final accounting to the court within 30 days.

Mr. D. had a conservator when we were called in for assistance. The conservator had most of our client's money for her own use and was neglecting Mr. D. to the point he needed daily attention.

We first received a restraining order against the conservator, then had her removed by the court as conservator.

The division of the blind requested us to have conservators appointed for three of their clients in nursing homes for the purpose of cashing their checks and rendering necessary services.

This turned out to be a lengthy procedure taking months in court to accomplish this request, so much so that one client, Mrs. B., died during this time.

Mr. T. and Mrs. H. have had a conservator appointed by the court.

INSURANCE

Mrs. Y. went to Florida for a short stay and also an elderly man who had roomed in her home for many years. While in Florida, Mrs. Y. took out insur-

ance for them both—a health insurance for Mr. C. and life insurance for herself. Later Mr. C. became ill and passed away. Mrs. Y. went through the necessary formalities which the insurance company required and received notice that no payments would be made nor a refund. Mrs. Y. had paid the premiums for 1 year.

Mr. C. passed away 3 months after the policy was taken.

Mrs. Y. came back to Springfield and requested our assistance. We looked over Mrs. Y.'s policy and it was felt there was an element of fraud—the insurance company was contacted with no results. The attorney general's office was contacted, who in turn contacted the insurance and the year's premium of $168 was returned to Mrs. Y. as there had been misrepresentation.

No refund was given in regard to Mr. C.'s policy—the Florida Insurance Commissioner stating "there is not a legal obligation for the company to refund the premium—cannot be apportioned in case the risk terminates before the end of the term for which the insurance was granted."

We were not in agreement but felt we had no alternative but to close the case.

Mrs. C. and Mrs. H. took out insurance policies with a company advertised in the paper. Mrs. H. told Mrs. C. her policy was for $1,000 at time of death and she would be the beneficiary so the funeral expenses would be paid. Mrs. H. died and Mrs. C. made funeral arrangements for that amount. The insurance company sent a check for the premiums which had been paid with interest which amounted to $354. The undertaker's bill was over $700 the cemetery over $300. Mrs. C. came to us greatly upset by this turn of events and she was in no position to pay the balance as she was just receiving social security.

The policy did have a clause, one had to be insured for 2 years, Mrs. H. passed away about 20 days too soon and there was an amount of $1,260 to be paid.

We were able to have the funeral home and cemetery to write off the balances.

FORECLOSURES

Mr. M. is considered legally blind has lived in his home most of his life, but in recent years could not work and was trying to live on a small amount from welfare. He was unable to pay on the mortgage the bank was going to foreclose—his real estate taxes was long overdue. He wanted to rent his house to American International College but they were not interested. We contacted the bank assessor's office and A/C for him. He was able to get the money to pay the interest due the bank and on his taxes. He is still living in his home, the bank has not foreclosed but it is imminent. It will be some time before any action will be brought. The value of the property is minimal.

SMALL CLAIMS COURT

Mrs. V.'s problem concerned a party fence which a neighbor removed. Mrs. V. had paid for a portion of this chain fence. The neighbor refused to return or pay Mrs. V. for her section. Threatened to build a wall which would infringe on our client's property and began a series of harassment. Small claims court found in favor of our client—defendant paid cost of fence and damages.

COLLECTION AGENCIES

Mrs. S., a blind client and her son who was an alcoholic lived in a subsidized apartment. The son did cause damage to the apartment and subsequently died. Mrs. S. went into a nursing home. The apartment owners formally requested payment for damages from Mrs. S. who was only receiving a small social security payment. It was then put into a collection agency. The collection agency agreed not to press for payment but write it off when we presented the circumstances.

Mr. L., a client, age 82, came into the office with his postman who from time to time would call on Mr. L. who lived alone was deaf and nearly blind to go over his mail which he occasionally received which looked important. An attorney who was acting as a collections agency for a large department was threatening Mr. L. with a court order for nonpayment of a bill of $68 which Mr. L. had forgotten about since it had been several months previously. We contacted the attorney who said suit would not be brought if the bill was paid, but would not write it off. Mr. L. will make small monthly payments.

Our housing attorney is working on a proposed draft lease for the elderly in public housing pertaining to double locks on first floor windows, better lighting and additional security officers. This is expected to be published by November 1976.

Wills have become a real necessity for the elderly whatever their possessions to give to friends, if no family, or to friends if family has neglected them—at least one a month.

Many elderly have recourse in the court but fear holds them back—(1) never have been in court—(2) fear of retaliation. This fear needs to be uprooted.

ITEM 3. LETTER FROM GERALD D. WALL,* STAFF ATTORNEY, COUNCIL OF ELDERS LEGAL SERVICES, BOSTON, MASS.; TO SENATOR EDWARD M. KENNEDY, DATED OCTOBER 14, 1976

DEAR SENATOR KENNEDY: On August 30 I had the opportunity to testify before your committee studying legal problems of the elderly. At that hearing I discussed the kinds of serious legal problems facing older persons that should be dealt with by legal services programs. I did not, however, testify as to how such programs could best be funded.

One method mentioned at the hearing for funding legal services programs for the elderly was through the Legal Services Corporation. This alternative was criticized by James Wechsler, director of legal services for Cape Cod and Islands in a letter dated September 15, 1976. The experiences of this office support Mr. Wechsler's opinion that additional, outside of the Legal Services Corporation, sources of financing legal services for the elderly are necessary.

At the present time, the major source of funding for this office is the Legal Services Corporation. However, it is inadequate to allow us to meet the needs of eligible elders in the area we are responsible for serving—the city of Boston. This is so because of the large elderly population in Boston and also because of the extra attention necessary to properly serve elders.

Other sources of funding should also be looked to because of the special needs of older persons. Many of those needs exist because of past governmental and industry policies which have in many cases stripped the older person of the will or of the means of dealing with the complexities of daily life.

In addition, the elderly poor often are the same persons whose productivity and creativity during their younger years resulted in the high standard of living enjoyed by many others today.

Because of these facts, the availability of effective legal assistance for the elderly must be insured.

This can only be accomplished by giving special attention to programs of legal services for the elderly and seeking new sources of financial support for these programs.

Thank you again for the opportunity to bring this to your attention.

Very truly yours,

GERALD D. WALL.

ITEM 4. LETTER FROM PAUL V. CASEY, SPECIAL COORDINATOR FOR ELDER SERVICES AND LEGAL SERVICES TO ELDERS, OLD COLONY ELDERLY SERVICES, INC., NORTH ABINGTON, MASS.; TO DAVID A. AFFELDT, CHIEF COUNSEL, SENATE SPECIAL COMMITTEE ON AGING, DATED SEPTEMBER 13, 1976

DEAR MR. AFFELDT: Pursuant to our conversation at Senator Kennedy's hearing on "Legal Aid to the Elderly," I wish to advise you of our ongoing, innovative program of legal assistance to the elderly.

We are using a 15-passenger mobile classroom, which is owned by CETA in the city of Brockton, Mass. We have operated all summer in southeastern Massachusetts. We have secured the services of an extremely able attorney, Mr. Ryan

*See statement, p. 171.

of 11 Beacon Street, Boston, Mass. He is a semiretired attorney and has attracted a great and devoted following among the elderly of this section of Massachusetts. We believe our efforts are worthy of funding and would appreciate the help of your office. We realize that we have only until September 30, 1976, to request funding.

However, we feel that appropriate funds for such a project requiring paralegal training, additional attorneys, etc., would require funding in the sum of $200,000 to adequately serve the vast area and target population of elders in southeastern Massachusetts with its far above national average of indigent elders.

Sincerely,

PAUL V. CASEY.

ITEM 5. LETTER FROM EDWARD W. GORFINE, CHAIRMAN, COMMITTEE ON LEGAL SERVICES TO THE POOR, MASSACHUSETTS BAR ASSOCIATION; TO SENATE SPECIAL COMMITTEE ON AGING, DATED AUGUST 30, 1976

GENTLEMEN: The Massachusetts Bar Association welcomes the opportunity to express its members' support for elderly legal service programs throughout the Commonwealth of Massachusetts. This highly specialized area of law, dealing with social security, medicare and medicaid, nursing home and home care problems, deserves the strongest possible financial support from our Federal Government.

This organization is doing everything it can to educate its members in providing volunteer legal assistance to the elderly through its speaker's bureau, volunteer outreach advice and wherever possible representation in landlord and tenant matters; as well as to provide board membership on legal service programs throughout the Commonwealth funded to provide more intensive representation before administrative boards and courts of law.

Our membership will continue to review various programs and increase its volunteer efforts to provide sorely needed legal representation to the elderly.

Respectfully,

EDWARD W. GORFINE.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR KENNEDY: If there had been time for everyone to speak at the hearing in Boston, Mass., on August 30, 1976, concerning "Improving Legal Representation for Older Americans," I would have said:

The following replies were received:

EDWARD E. ALESSI, BEDFORD, MASS.

I am making a statement relative to legal services for the elderly as a representative of L.I.F.E., Living Is for the Elderly. L.I.F.E. is an association of nursing home residents whose primary purpose is to improve their lives and the lives of other nursing home residents. We strongly feel that legal services should be made more readily available and accessible to older people especially the nursing home resident. It's a service that is very necessary yet can become rather costly if an individual has to pay for it him/herself.

The service should be brought to the home since our experience has shown that most nursing home residents will not go looking for a lawyer, and many are not aware of the kinds of service that a lawyer could provide to them. It would be important then to bring the service to the home via paralegals visiting homes on a regular basis to establish trust and rapport with both residents and staff and to identify the legal needs of people. This use of paralegals would allow the trained lawyer to make better use of his time. Why does a nursing home resident need a lawyer? Property settlements, wills, insurance, competency proceedings to insure the rights of the individual, financial matters, etc.

Lastly, there is a great need for protective services for nursing home residents, especially for the incompetent person, who in the eyes of the law, is viewed as competent. This person needs the protection of a guardian, conservator, or other person who would act on his/her behalf. We have found a sizeable number of nursing home residents who are not able to exercise their rights or use poor judgment yet are said to be competent. These people could thus be easily taken advantage of by others. We would also feel that similar situations exist with elderly in the community.

MARGARET GILMAN, BOSTON, MASS.

Because I had to take a neighbor to the Massachusetts General this morning, I was unable to go to the hearing this morning. I tried to write a few words while we were waiting for her appointment.

Personally, I have no complaints because the Council of Elders Legal Department located at 102 Norway Street, especially Mr. Phil Coles and Mr. McCusker have been very helpful whenever I have needed legal advice. Other elders also appreciate the promptness and cooperation of this branch of the Council of Elders.

When I asked people in other areas, however, I received some serious complaints. The most often mentioned "gripe" was that they often had to wait a very long time for results. The interviewers were often rude, suspicious, and

subjected people to lengthy cross-examinations. In fact, some people felt that the legal advisor was distinctly annoyed by having to defend the elderly.

Thank you for asking me to make this report. I am truly disappointed because I could not be there in the Gardner Auditorium this morning.

I am a Republican, but I feel very strongly that when an elected official supports such a good cause as honest and sincere aid to the elderly that we should all "go to bat" for it regardless of our political affiliations.

DANIEL MADIO, LAWRENCE, MASS.

I am with the Merrimack Valley Home Care Center. I am the director of the Senior Aides Program for that area, and I can assure you that it is a viable operation that has demonstrated its value to the elderly of the Merrimack Valley.

In their outreach work, the Senior Aides endeavor to determine the problems troubling the elders and assist in the resolution of those problems. Among the problems uncovered is the great need for legal assistance.

We do have in the Merrimack Valley a legal service available for the low-income elderly. However, their funding severely limits the amount of services available to these elders.

Because of this limitation, and the apparently expanding need for these services, I propose that consideration be given to a program that will train elders, who are seeking part-time employment and who wish to be useful citizens, to learn the very basics of law and in turn be assigned to para-legal services to do much of the spadework now required of any attorney, thereby relieving the attorney to perform the actual practice of law.

Furthermore, I can foresee the possibility of these elderly paralegals being employed by private industry—at industry's own cost—thereby creating jobs for the elders and at the same time hopefully reducing the cost of legal services to the elderly who would not qualify for the services because of income limitation through the present legal aid.

The paralegal program is not a new concept. There is presently one such program in Connecticut. It is my sincere hope and desire to initiate such a program for our Massachusetts elders.

I would be more than pleased to go into greater detail with any representative of your office.

GERTRUDE K. WEINER, BOSTON, MASS.

I am senior attorney of the Greater Boston Legal Services.

I have served in the area of legal assistance to the poor from 1932, specializing for many years in legal services to the elderly.

The legal needs of the elderly cover the same large areas that all people have, whether they are young or old. In addition, the elderly become special targets of oppression in the areas of housing and consumer fraud.

The elderly accept these impositions upon their legal rights without fighting back.

The elderly division of the Greater Boston Legal Services has been the fighting advocate protecting the legal rights of the needy poor of Boston.

The elderly poor of Boston number approximately 22,000, or 30 percent of the total elderly population of the city. With our limited funds we can only serve the tip of the iceberg.

We are the advocates who help secure the maximum benefits in social security, supplementary security income, welfare, medicare, medicaid, food stamps, and social services for the elderly.

We are the advocates who help to establish the need of the elderly for housing, and help secure housing for them at not more than 25 percent of their income.

We urge you to consider the expansion of these services so that legal assistance may be available to more of the elderly 22,000 people in Boston, rather than to just the tip of the iceberg.

ANNIE YOUNG, DORCHESTER, MASS.

Why go up on rent when we don't get any service. I have filled out a form over 2 years ago telling what needed to be done in my apartment. The baseboards are falling down and we don't have sufficient lights outside; and when we need lights in the halls sometimes it is as long as 2 weeks being repaired. It has been a month one time before we got a light in the back hall, it is bad enough when we have lights and still worse when we don't have any; we need all the lights burning on the outside. We elders are having it rough now; they have put drunks all around us and the young disability drunks, and they draw the young drunks from all over Dorchester and we can't rest day or night. If we want to sleep late in the morning we can't. At 5 a.m. in the morning they start coming in cars honking their horns and racing their motors and swearing and loud talking and if we call the cops they won't come. They will say someone will be right down but they never come. We don't know what it is to sit on the benches in the shade, for the young and old drunks have them occupied. When the drunks can call the cops they come. I called once and whoever answered hung up on me. They come sometime two or three times a day or night when they call. We don't have any protection whatsoever. When I moved here they weren't letting any in here but the elderly, but now anybody can move in. My apartment is leaking and the grass needs cutting, it has been cut twice this year.

ALFRED G. ZEMGALS, BILLERICA, MASS.

I would like to have asked how to enforce the senior aide's right to investigate elderly complaints without being refused information by some town agencies: Housing authority, Veteran's Administration, and welfare department.

Reference: Ombudsman Manual, Departus. Elder Affairs, Regulation #99-4-0009, Section c, point 3 and 4.

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THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 6—ROCKFORD, IOWA

AUGUST 18, 1976

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CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida
DICK CLARK, Iowa
JOHN A. DURKIN, New Hampshire

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
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JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

The Nation's Rural Elderly:

Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove, Iowa, August 17, 1976.
Part 5. Sioux Falls, S. Dak., August 18, 1976.
Part 6. Rockford, Iowa, August 18, 1976.
Part 7. Denver, Colo., March 23, 1977.

(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

THE NATION'S RURAL ELDERLY

WEDNESDAY, AUGUST 18, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Rockford, Iowa.

The committee met at 3:35 p.m., pursuant to notice, in the United Methodist Church, First Avenue and Third Street NW., Rockford, Iowa, Hon. Dick Clark presiding.

Present: Senator Clark and Representative Charles E. Grassley.

Also present: Deborah K. Kilmer, professional staff member; David Harf, legislative assistant to Senator Clark; Margaret S. Fayé, minority professional staff member; and Donna Gluck, resource assistant.

OPENING STATEMENT BY SENATOR DICK CLARK, PRESIDING

Senator CLARK. Thank you very, very much. I really appreciate those of you waiting so very long for us. I apologize.

We have had five such hearings. This is the sixth of six hearings that we are holding in Iowa, Nebraska, and South Dakota.

I am afraid I got a little ambitious. I wanted to ride on one of these minibuses from Sioux Falls to Canton, so I did. I thought I could get down there and back to the Sioux Falls airport, but we didn't get to the airport until about 2 o'clock and you were waiting here at 2:30. Although the plane is pretty fast, by the time we got across Sioux City we were later than planned.

I sincerely apologize for being this late. As a reward, I am going to save you a speech. Instead, what I want to do is just tell you in about 60 seconds what the purpose of these hearings is and then ask Congressman Grassley if he would like to make a statement. We will then go right on with the first panel. In fact, while I am speaking, I wish the first panel would come on up and have seats here. I know John Beer, Paul Schroge, Mr. and Mrs. Judd and, I think, Harry Empting are here. Please come on up here while we are visiting.

We are very pleased to be here in Rockford. These are, of course, official hearings of the Senate Committee on Aging. Our professional staff is here at the table and all of the information is being recorded on a tape here by a stenographer.

"FAIR SHARE OF SERVICES"

The purpose of these hearings, incidentally, is to try to find out what we ought to be doing in Government, uniquely for rural elderly people. Many of the Federal programs that have been developed over the years for the elderly, as well as others, have been primarily for the

purpose of metropolitan areas and, as is so often the case, people who live in the countryside, or people who live in small towns have not necessarily gotten their fair share of these services.

Now increasingly over the last few years we have been able to extend some programs, particularly congregate meals programs, some of the minibus programs, and so forth, into some of the smaller towns. We have a very long way to go, and that is what this hearing is all about; what kind of transportation needs we have, what kind of nutrition needs, what kind of health care needs, employment, and so forth.

Today our two panels are going to be emphasizing senior multipurpose centers, and then the second panel is going to be talking about housing. Again, housing and senior centers in small towns—that is the whole emphasis of the hearing, so we are delighted to have you here.

I would like at this time to give the microphone to Congressman Charles Grassley.

STATEMENT OF HON. CHARLES E. GRASSLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Representative GRASSLEY. Thank you, Senator Clark. It is good to be here with you.

A year ago the Select Committee on Aging of the House of Representatives held hearings in the third district, so I know that I met some of you at that point. We discussed some of the same problems that Senator Clark is interested in hearing from your testimony.

I am not going to read my opening remarks. I am going to submit them for the record, Senator, if I may have permission to do that.

Senator CLARK. Yes.

Representative GRASSLEY. I had eight pages of remarks and they will be made part of the record, so if you have the record sent to you after it is printed you will be able to read them at that time.

I told you, Senator, I would have to leave for an appointment. I have to be there by 4 o'clock, so I will be leaving all of you. The gist of what I was going to say, Senator, revolves around the point that Congress, I think, basically has made a good start on programs for the elderly. I find, however, from oversight hearings held in the House Committee on Aging, that congressional intent has not been carried out as much as it should be. I will use just one example.

ADMINISTRATIVE REDTAPE

The point of my off-the-cuff remarks here is that I think that we have to alert the senior citizens in our district, in our State, and particularly their advocates that there are plenty of good programs on the books that are not being adequately made use of by them. Some of this is due to the administrative redtape in Washington. No. 1 is the combination of section 8 under Housing and Urban Development and section 515 under the Farm Administration.

Two years ago Congress mandated that those programs ought to work in tandem. We were just forever and ever trying to get the administrative redtape worked out and getting the necessary agreements signed so that that very good program could actually be doing some-

thing for people in need, particularly in the rural areas. I look at section 209 of the program. My remarks speak to that program as it is supposed to encourage better use of 202 funds. That is another example of a program where we have to work to make sure that the administrative machinery works as we had intended.

I am sure Senator Clark wants to hear your ideas, and of course I do, about new things that need to be done. We also want your thoughts for the record on how you think existing programs could be better administered, particularly as the bureaucracy in Washington is slow in sending down directives to the people at the lower levels of Government.

Senator Clark, I thank you for the opportunity to participate in this program and I will be looking forward to reading the record.

[The prepared statement follows:]

PREPARED STATEMENT BY REPRESENTATIVE CHARLES GRASSLEY

Mr. Chairman, members of the committee, as a member of both the Select Committee on Aging in the House, and the Subcommittee on Housing and Community Development of the House Banking Committee, today's hearings are of particular interest to me. Just last year, the select committee held hearings in Iowa, and the trend of the testimony pertaining to housing for senior citizens was very interesting and enlightening. It became abundantly clear senior citizens prefer to live out their lives in familiar surroundings, if at all possible, and without constantly moving about. In other words, they prefer to live in their own homes as long as they possibly can, and as independently as is possible.

As a representative of over 60,000 senior citizens, I feel it is my responsibility to assist those who want to stay in their own homes to do just that. Clearly, there are a number of ways in which legislators can be helpful in this respect.

For example, programs already exist to assist older persons, via low-interest loans and grants to keep up their residences, and to insulate homes in order to keep utility bills under control. Less directly, but of equal importance, is our ability as legislators to keep down the rate of inflation, to eliminate laws which restrict the amount of income older persons can earn due to their receiving social security, and to minimize the estate tax burden on an elderly heir is crucial to assuring that the older person has enough funds to keep up his or her home. Last, but not least, the provision of social services, and companionship, through the establishment of multipurpose senior centers could well prevent many older persons who might need some sort of outside assistance from having to move into a more care-intensive surrounding.

Of course, some senior citizens, of their own choice or due to necessity (financial or physical), may seek shelter outside their own homes. Various Federal programs exist to assist many of these in finding suitable homes at a reasonable cost. I believe it is the responsibility of Congress to assure that such housing meets the variety of needs that an older person can be expected to face, in as efficient and economical manner as is possible.

Various Federal housing efforts are designed to meet this objective, though it is not clear that the objective is being met. For instance, there is a section of a Federal housing program administered by HUD which instructs the Secretary to consult with the Secretary of HEW in order to insure that housing projects are designed in conjunction with federally funded social service programs, administered through State plans for the elderly. The purpose of this section is not only to insure the coordinated delivery of housing and social services to residents of the federally backed project itself, but also to insure community participation in such services. I have recently written the Secretaries of the two Departments to determine what progress has been made toward meeting the requirements of this section, and feel that Congress must take the lead in seeing that its objectives are met.

ADDITIONAL HOUSING FOR LOW INCOME

Much work remains to be done, although some successes have already been realized. For instance, in June the Departments of Agriculture and Housing and Urban Development reached an agreement which should result in additional

housing for low-income, rural citizens, particularly the elderly. More will be said on this and other related matters in the text of my statement.

I am anxious to hear the comments of witnesses here today, and would greatly appreciate any suggestions you might make which could assist Congress in carrying out its efforts on behalf of senior citizens.

At this point, I'd like to briefly discuss some of the Federal programs which exist to assist elderly persons to keep up their homes, meet rental payments charged for clean and decent housing, to receive services, and intereact with others at specific sights designated as multipurpose senior centers.

The section 502 and 504 programs, administered by the Farmers Home Administration, provide low-interest, long-term loans to assist with the purchase or repair of an owner's dwelling. The 504 program is of particular import for senior citizens because the interest rates on loans are very reasonable, and some grant money is now available. Funds appropriated under the 504 program can be used for home insulation, roofing repairs, electrical repairs, etc. In addition, the borrower or grantee need not bring his or her dwelling up to standard, which often is unrealistically costly and stringent. The 504 program, I believe, has a great potential to help senior citizens remain in their own homes.

In my opening remarks, I referred to a section of the Housing and Community Development Act of 1974 which is intended to promote the coordinated delivery of housing and social services to the elderly. Formerly, if social services were offered to elderly citizens receiving Federal assistance, members of the community not living in the assisted housing could not receive such services because they were paid for out of rent receipts.

However, the implementation of section 209 means that State plans for the delivery of services under the Older Americans Act or the Social Security Act may now be drawn up in conjunction with housing authorities. As a result, services might be offered at the sight of federally-assisted housing and yet elderly citizens who do not live in that housing could benefit. This, I believe, would mean much more interaction between the older person living in an assisted unit and his peers in the community. In addition, under the Older Americans Act and the community development block grant programs, funds are available for the establishment of and the provision of services through multipurpose senior centers. These, as mentioned above, could be located in federally assisted projects, particularly those developed under the 202 program (to be discussed below). Congress, this year, increased the funding for such centers in the appropriations bill for the Administration on Aging in HEW.

Extremely Valuable Program

The 202 program basically provides Federal loans to nonprofit sponsors for the construction of housing for senior citizens. In conjunction with the section 8 housing assistance program which provides rental assistance to low-income households, this program should prove extremely valuable. It is fairly new, however, and thus not enough experience has been gained to assess its impact on meeting the needs of senior citizens.

The 202 program now contains some very important aspects which should prove of great value to senior citizens. For example, a senior citizen can now have a nonelderly person living with him or her in an assisted unit if that person is essential to the care of the senior citizen. Also, if a couple of which one member is a senior citizen, and the other is not, move into a 202 unit, and the older person passes away, the living spouse may continue to reside in that unit. This should prove of great value to spouses who might fear eviction due to the death of the companion, as well as the traumatic aspects of moving to a new home at an advanced age.

Finally, the Departments of Housing and Urban Development and Agriculture recently entered into an agreement which should facilitate the development of multiunit complexes for rural citizens, particularly those living on limited incomes. The agreement involves the Farmers Home section 515 mortgage interest subsidy program and the HUD section 8 assistance program discussed earlier. In October, I learned that the two agencies had the responsibility for administering these jointly, but were hindering their administration due to bureaucratic haggling. As a result, I began consultations with the two agencies to eliminate a number of administrative roadblocks. In June, an agreement was finally reached. Final regulations to carry out the agreement should be issued shortly. As a result, the development of rural housing for low-income citizens should increase.

All of the programs I've described, if administered efficiently and forthrightly can help make the senior years pleasant ones for many. Congress must

see to it that they are administered properly so that senior citizens do not suffer, and so that taxpayers' money is not wasted.

Senator CLARK. Thank you very much, Congressman.

Now we are going to hear from this first panel on senior centers. What we are going to do, so we will have some time for discussion, is to ask people to try to limit their remarks to about 4 or 5 minutes. Then, if you have more than that prepared, we will be happy to put your full statements in the record.

We are going to hear first from John Beer who is a member of the State Advisory Committee on Aging and a resident of Hampton, Iowa. As I understand it, Mr. Beer will discuss the housing needs of the very rural areas, such as Hampton.

Mr. Beer, we would like to hear from you first.

PANEL ON SENIOR CENTERS

STATEMENT OF JOHN M. BEER, STATE ADVISORY COMMITTEE ON AGING, HAMPTON, IOWA

Mr. BEER. Senator Clark, Representative Grassley, members of the staff, other distinguished guests, ladies and gentlemen, in March of last year we had a meeting to discuss the needs of senior citizens, and they came up with five major ones including the handyman, chore services, transportation, senior centers, and the homemaker health aide services. I have not agreed with that myself. One of the greatest needs, I think, for some of the older citizens is companionship. All of these other services, to me, are supplemental to that one thing.

Now, speaking of housing, I live here near a little town—a town of about 150 population. In that town are five widow ladies living alone. Four of those ladies were married to men who worked for a living; they put in their whole life drawing wages. They accumulated enough to buy a little home. The homes of three of the instances are hardly livable—they need a lot of repair work. In fact, one of them, I think—if you repaired it, it would cost more than to build a new house. That, I would think, is vitally important—the same as in most small towns in the area.

In the town of Hampton, they had a survey they made several years ago which showed 300 people living alone, many of them in substandard housing. There were a great many more—I don't remember the number—of senior citizens who were not living alone. The program which was put out a year ago, I think, to help them with their housing needs—I have had quite a bit of trouble trying for the implementation of that.

In fact, one lady that I know of personally applied for help. They came to her in February—tried to call her. She didn't answer the telephone because she was in the hospital with pneumonia, and I was not very well pleased with that situation.

FACILITIES ARE INADEQUATE

There are other things in regard to senior centers. The senior centers go a long way toward helping alleviate the other conditions that exist and give people an opportunity to meet together, to have fellowship meals, or congregate meals in a senior center. In many of the small towns the center usually has a card table and some of them have a pool

table. They are small, out-of-the-way places without the equipment for anything more than that. They are far from adequate for the purposes outlined.

I had suggestions from the director of social services for housing needs such as low-cost housing, rest homes, and such as that. That left the problem of low-cost housing. The housing which we have is usually too high priced for that person who is living on social security in a home.

The next problem is to get to these people, and they don't like to be pushed around.

Senator, I think I have probably used up my 5 minutes.

Senator CLARK. That is a good start and we will be coming back with questions a little later.

Paul Schroge, I think, is a retired resident of Rudd. He is actively involved with the senior club at Rockford. As I understand, Mr. Schroge is going to explain the senior club's efforts to renovate the building that they have been given to use as a senior center, and the obstacles that they face in the process of doing this.

Paul, you go right ahead.

STATEMENT OF PAUL SCHROGE, RUDD, IOWA

Mr. SCHROGE. Senator Clark, ladies and gentlemen, and neighbors, I don't know just how to start this thing, but I tried to think of what would be interesting to everybody. I have some statistics here—population of area 2. The people 60 years or over make up 19 percent in area 2, which is quite a large number. Floyd County has 18 percent of people 60 years and older. The town of Rockford has 24.3 percent of people over 60 years old, and that is a town of about a thousand people, more or less. That gives us quite a few people to try to serve.

We have a very active group down here and our meeting place is right on Main Street. We are just a block from the post office, if that means anything to a lot of you. We are very small and we need more room. We have had some visitors here in the last 6 weeks. We had 52 of them there one afternoon, so you know that our people are interested in getting this center and would like to keep it going. I am enjoying the work that I am doing with these senior citizens. Of course, I am not a senior citizen yet; I am just a little bit younger than that.

Senator CLARK. That is the way we all are.

Mr. SCHROGE. I will be 69 in September, so you can guess from there on.

We have been fortunate dealing with the township trustees and, I think, the city of Rockford. We have had some buildings given to us. They are not actually given to us—they are on contract with a 99-year lease. We would like to redo these buildings. We could make them into a very good deal.

CONVENIENT LOCATION

One building joins right on to us. We have a pool table and we need another one pretty badly. We could move that over there and we could have a nice big senior citizens gathering. We have as high as 65 and 70 when we have pot luck, so there is a lot of interest here. As far as location is concerned, I don't believe that we could get a better location for our senior citizens center than we have right in Rockford,

because it is right on Main Street where we have a meeting. They can go downtown to the congregate meals which, at present, is working out as good as we can expect. Maybe if we remodeled and got things arranged we could have the congregate meals at the center. At the present time it is just impossible for us to do this.

I can't think of anything else that I could add to this right now, only that for us to do this, this meeting comes at a nice time so that we can say something on that and maybe get a little help.

I think that is all I have to say, Senator Clark.

Senator CLARK. That is fine. I do want to say—since this is on multipurpose senior centers and you are talking about the needs that you have particularly, and Mr. Beer as well—for the first time now we have authorized and appropriated funds under the Older Americans Act that is called title 5 in which we provide for funding for the support of the acquisition, alteration, and/or renovation of these centers. Now that does not mean that everybody can get everything they want, but it does mean for the first time that we have acknowledged that this is a high priority.

I know in the next 4 months, in this period between now and the first of October, Iowa has been allocated almost $75,000 for that purpose. Then, beginning October 1 of this year through October 1 of next year, there will be an appropriation of almost $300,000. Now that is for Iowa alone I am speaking of and, although that is not going to go a long way, it is an important beginning. I think it does say, at least, that the Congress has seen what people have been able to do in these centers and feels that it is important.

Now we would like to hear from Mr. and Mrs. C. E. Judd of Thompson. Mr. Judd also has some experience in this whole business and we particularly would like to hear about those experiences in Thompson.

STATEMENT OF C. E. JUDD, THOMPSON, IOWA

Mr. JUDD. Senator Clark, Governor Blue, ladies and gentlemen, some wise person has said that a nation's greatness can begin with the manner in which it treats its old people. Most societies cherish their senior citizens, provide for them in their homes, and seek their advice. This was true in this country until about 30 years ago. Now our affluent society geared to the extravagances and conveniences of the young forces these people into comparative isolation to shift for themselves.

In many cases relatives have abandoned them, they are without transportation, and many live in poverty. These peoples have many problems and frustrations, but their most common complaint, regardless of health or economic status, is loneliness.

My remarks to the committee are directed to the need for senior centers, particularly in the small communities. The concept of the Government providing meeting places for senior citizens is certainly not new. A long time ago when I was young it was common practice to provide these meeting places in county and city buildings. The courthouse often contained a large meeting room on the ground floor dedicated to the Grand Army of the Republic and was available to senior citizens at all times.

These rooms were popular gathering places for the older folks. They had organized meetings. They had various kinds of recreation, reading material, and a place for sewing and quilting. With the coming of

many new government services, the courthouses and town halls became too crowded to afford the luxury of a meeting place for old people. In some places the men gathered at the barber shops and pool halls, but these establishments no longer tolerate them.

Competition High for Available Space

It is very difficult in a small community to provide an adequate meeting place. In most cases the town councils are generous with the space they have but there are many demands for these meetings and they cannot be designated primarily for senior citizens, nor can they tolerate such groups who just want to spend an afternoon leisurely. In some communities the room made available is at the end of a difficult stairway.

In Lake Mills the senior citizens were elated when it was announced that provision was made for a center for them. The senior citizens did considerable work in planning to make the center a reality. Later it became a community center, rather than a senior citizens center. Apparently after some negotiation, the senior citizens have use of the center along with the rest of the community.

In many cases senior citizens in rural areas are reluctant to ask for help from government agencies—Federal, State, or local. They feel that in doing so they would be surrendering their independence. In Leland there is a strong senior citizens club which refuses to participate in any program or activity involving public funds.

Senator Clark. What town is that?

Mr. Judd. Leland.

Many professional people do not adequately understand senior citizens and they are often inclined to treat them as a kindergarten class assuming that a certain period of time can be devoted to reading, another period for exercise, and another for handicrafts—and all present will have to take part or receive a failing grade. These older people vary greatly in their backgrounds, education, mental and physical capacities, and do not all care to do the same thing at the same time.

However, I must say that our area agency staff is to be commended for their hard work and understanding of older people. A senior center should allow ample time and space for each to do his own thing, either alone or in small groups. The area agency on aging working with organized groups can be most effective in bringing its programs to the elderly if there is a senior center in the community, and in this manner the whole program can be more visible.

It is desirable for the entire community to recognize the presence of its seniors and generate support for their programs through public funding from county and local tax funds. Thus, the lives of these people can be enriched and the goals of the Older Americans Act of Congress can be attained.

Senator Clark. Thank you very much.

Do you have a statement, Mrs. Judd?

STATEMENT OF MRS. C. E. JUDD, THOMPSON, IOWA

Mrs. Judd. Yes. Senator Clark, Governor Blue, and friends I wish to direct my remarks to the senior center at Thompson where we live. Winnebago County has about 2,650 people over 60 years of age accord-

ing to the 1970 census, and of these about 650 are below the poverty level. About 10 percent of the population reside in the Thompson area. The percentage below poverty is about the same as the average for the county. The town of Thompson has a population of around 700 people.

A few years ago Mr. Judd and I made a count of the senior citizens living alone in their homes and there were 56. We may have missed a few. This did not include those who are over 60 who were living with either husband or wife.

In 1969 some of the seniors and other concerned people of the community decided it was time that the community took a hard look at what they were doing for their senior residents. Many things have been done for the young of the community, including much playground equipment, a swimming pool is in the process of being built, various summer recreation activities were being planned for, but nothing was done for the elderly; they were on their own. As a result, the senior citizens club, called the Young at Heart, was organized in the fall of 1969 with 65 members. The community and the town council were very helpful and a lot of interest was generated in this project.

A building which was located on Main Street would be available for our use. It was located on street level with only two or three steps up to the door. This we could use for fixing it up. It had first been used as a hotel but through the years had many tenants, sometimes standing empty, and each had taken its toll. It was in a state of disrepair.

It was then owned by the Veterans of Foreign Wars who had purchased it in part by donations from other groups and individuals. They did not have the money to repair the building so it was offered to the community for use as a place for group meetings. All they wanted to retain was the basement which they fixed up as a bar with an outside entrance and they wanted to retain one small room that they could use to store their equipment.

Repairs Made in Joint Effort

The Lions Club and the senior citizens made extensive repairs to the building. They remodeled and repaired the front of the building, put in new doors, covered with plywood, carpet, and so forth. They paneled some of the rooms and painted others. They put in new ceilings and windows. They built a kitchen with cupboards, counters, and a sink, and remodeled a bathroom.

Organizations and individuals donated an electric stove, refrigerator, a hot water heater, a piano, a pool table, and other various supplies. As the membership of our seniors group is made up of people of many varied interests and skills, we were able to do a lot of the work ourselves or sometimes we got our kids to help us. We have card parties, food sales, coffee breaks, and rummage sales besides donations from members and others who raise the needed money to buy supplies.

The Young at Heart Club spent about $1,000 from their treasury besides the many, many hours of work during the years. The Lions Club members also spent much money and time. As a result, we ended up with an adequate and cheerful center. There was much more repair being planned as time and finances would allow.

The town council was very generous and paid the bills for the heat, light, and water. We were able to get chairs, large tables, card tables, games, coffee pots, coffee pot liners, and so forth, from Federal and

State funds through the State committee on aging as it was then known. These moneys were administered by the OEO and Mr. Christian, from Mason City, was a great help in this.

When all was going fine, the VFW must have decided that it was rather a lucrative thing they might have in their building so they notified each organization that they would be charged a fee for the use of the building. The seniors were to pay $10 each time we met and give 10 percent of the gross that we might have each time we had a fundraising activity. Other groups were to pay a larger amount.

A protest meeting was called by the organizations using the building and, as no satisfactory solution was arrived at, we all found another place to meet. The town council cut off their support for payment of the utilities so the building is again, after all these years, standing idle most of the time.

The town council again came to our aid and offered us the use of meeting rooms in the town hall for our meetings. We are able to meet here once a week in the afternoons from November 1 to May 1, and in the evenings the rest of the year. It is a very tightly scheduled place, though we are most grateful for what we have.

Hot Lunches Provided

We have a congregate meals program in our town serving noon meals Mondays, Wednesdays, and Fridays. The Young at Heart is the subcontractor for these meals. We rent a small, old school building from the school board for the meal site. During the school year we contracted the hot lunch program to prepare the meals for us and during the summer we had our own cook.

We will admit that we used poor judgment in not having a written agreement instead of a verbal one with the owners of this building in which we had the meetings for over 3 years but, as other groups had been using it with no problems, we went along in good faith. Our advice to other senior groups with like arrangements is to be sure you have a written agreement stating in detail all arrangements decided upon or agreed upon, or what you might contemplate you would like to do. We all think it never could happen to us, but it can, and in many cases it is only four or five individuals who can call all the shots.

Senator Clark. Thank you very much. It sounds like you are really moving in Thompson. That is good.

Now I also want to hear, before we start our question period, from Harry Empting who is the coordinator for the senior citizens center in Mason City.

STATEMENT OF HARRY EMPTING, COORDINATOR, SENIOR CITIZENS CENTER, MASON CITY, IOWA

Mr. Empting. Thank you very much.

Senator Clark, ladies and gentlemen, what I want to talk about are some basic priorities. Recently there was a workshop at Fort Dodge and about 200 people attended. We were asked, "What are the three biggest problems with aging?" Those problems were, not necessarily

in this order: loneliness, fixed income, and health. What I have here is a flow chart and it looks like a Rube Goldberg deal with all the lines, but I will explain it.

What we have here is fixed income, health, and loneliness. What I have tried to show is how senior centers, in-home services, and the nutrition program connect into these three basic problems of the aging process.

What I wish to talk about is priorities. I don't think that you can talk about highfalutin programs without getting down to the basics. That is to say, people have to have a roof over their head, they have to eat properly, and they have to have some sort of social outlet. Now these are all basic requirements which all humans require; otherwise, they can die in more ways than one.

Priorities Must Be Set

In conjunction with priorities, I would like to get into workable programs. We have established a lot of priorities in the past without finding out whether they are workable or not. As an example, we talk about transportation as a high-priority item. I think transportation is a priority item; however, I think other areas such as senior centers, nutrition programs, and in-home services are much more important. Obviously you have to have some delivery of these services, but I think that we need to back up a little bit and get back to the basics in that there is really not that much money coming down the pipeline yet for all programs. I think it is important to implement the three previous areas because these are areas that the most needy people require the help in.

In the middle of the chart I have written "nutrition program, senior centers, and meal services". The nutrition program alone can provide a lot of the services that we are talking about. As an example, I have written on the chart that it can provide about the same services as senior centers. It can provide not only nutrition but social, recreational, educational, transportation, information, referral, and, probably one of the most important things, political awareness as well.

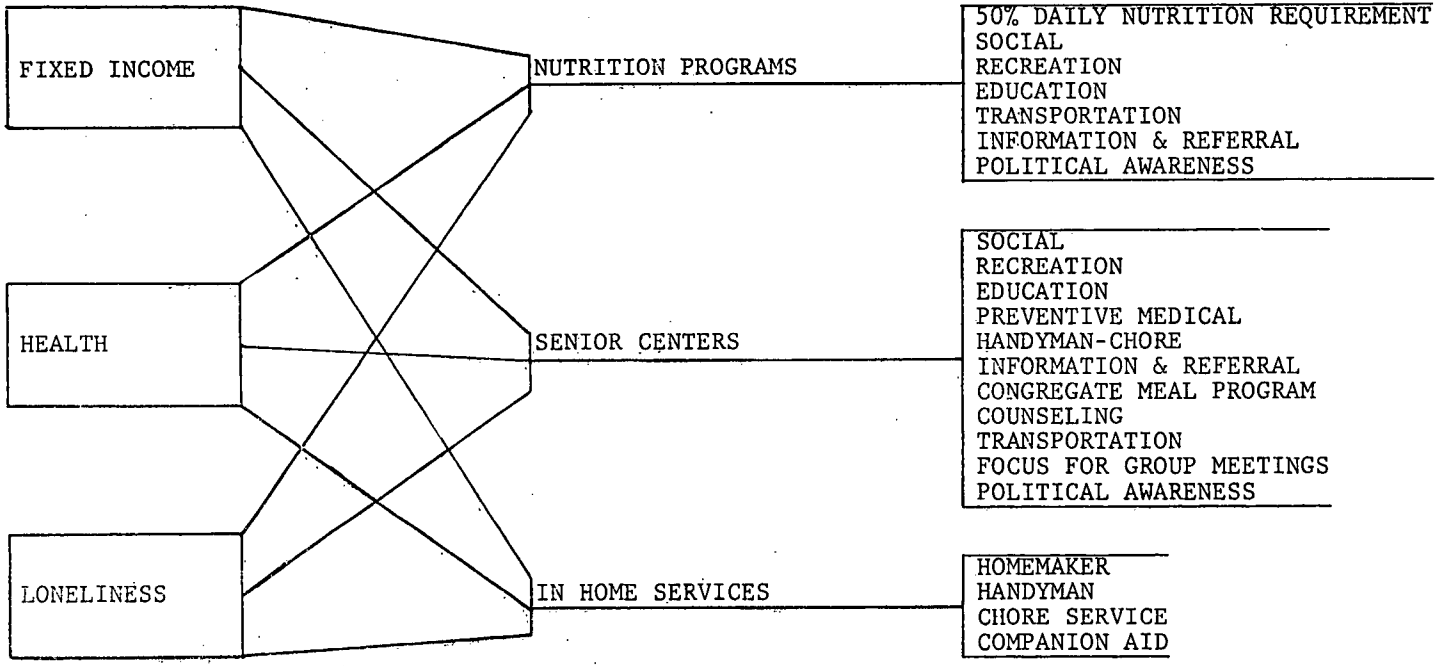
Another spinoff from implementing senior center programs is that out of the senior centers you can develop programs to combat some of the health problems and some of the fixed-income problems. That is, you can develop in-home services, services provided by seniors, preventive health clinics, et cetera. We have done it at our center very, very recently. These are some of the programs that I feel should have high priority. I think that our emphasis should be given to the basics, especially since there is not much money available. Basically, we should take a long look at our priorities.

That is all.

Senator Clark. Very good. Could we possibly have a copy of that for the printed record? It looks interesting and I would like to look at it and I am sure others would as well.

[The chart follows:]

SENIOR CITIZEN PRIORITIES BASED UPON 3 MOST AGREED UPON PROBLEMS



Senator CLARK. It is difficult to quarrel with your priorities, it seems to me, but I am wondering about this—just in remembering back the five hearings that we have held in the last 3 days. We put a very heavy emphasis on transportation. How would you evaluate that in comparison to the three priorities that you mentioned?

Mr. EMPTING. This position of mine is not very popular, and it is an interesting phenomena. I think what happens is that there is, let's say, 20 or 25 percent of the people that are out there that don't get to come to meetings. That is why I especially wanted to be on this panel today. I think we all should be aware of the needs of these missing seniors.

In other words, we get a certain category of senior citizens that attend these meetings. I think they express input from a lot of people—like area agency people and people like myself.

As an example, I used to believe that transportation was a high-priority item and I convinced a lot of seniors that it was. I still think it is a priority item, don't get me wrong. But, not as important as senior centers, nutrition programs, and in-home services.

I think that another aspect of confusion in this area is that there have been studies done on transportation and, to be frank, I question the sociometric methods that were used and I question those methods in determining a lot of these programs. Of course, the basis for initiating these programs is some form of sociometric method. I don't mean to get complicated here but research methods are where these programs start from and this is where we get off on a lot of weird tangents. I hope I have answered your question.

Senator CLARK. Thank you. Mr. Beer, do the people of your community around Hampton utilize the benefits of this Older Americans Act? I mean by that the nutrition program, the transportation program, or any of the programs under the Older Americans Act. Do you have such things as homemaker or chore aides? What are the most valuable things around Hampton that you see under the elderly program?

Mr. BEER. The social services department has the homemakers chore service and the homemakers aides, and they reach quite a few people.

As far as the nutrition program, I hesitate to say exactly, but I think several years ago before we had any programs the group of people connected with different churches got together and established what we called fellowship meals. Those meals are still going. We served 133 people in Hampton last Friday. In the other area I think the last meal they had was somewhere between 80 and 90. These are all self-supporting. The same thing is true of meals-on-wheels. We have between 20 and 25 meals served to shut-ins 7 days a week.

Senator CLARK. These are all done by local church organizations rather than by any Older Americans Act funds?

Mr. BEER. They are all done by local people some of the time, but most of the time it is donated. We hire a cook and have a little money in the treasury, incidentally.

MEAL SITE DIFFICULT TO OBTAIN

As far as the nutrition through congregate meals, we are trying now to establish a congregate meal site. It is very difficult to find the location of a site; I make a little effort to find one. Most of them—the cost was prohibitive. One hotel asked me for $1,100 a month for space in the

basement. Another building is available for $95,000 to purchase which would be adequate.

Senator CLARK. Yes.

Mr. BEER. My recommendation would be to build one.

Does that answer your question?

Senator CLARK. Yes. That is good.

Now, Paul Schroge. In Rudd, what services would you like to have available in the center that you don't have now?

Mr. SCHROGE. I am not speaking for Rudd. I live in Rudd, but I am the last address on the mailbox.

Senator CLARK. Your address is Rudd, but you operate here obviously.

Mr. SCHROGE. Yes.

Well, like I say, we have got the congregate meals now and I would say they are operating as good as could be expected under the conditions.

If we get this remodeling done—and I am sure we are not the only ones that would like to have some remodeling done—we have a good setup and could use some more services. We could use a little more transportation assistance and a chore boy. Some of the seniors can't do their own lawn mowing or cleaning the yards. They all try, but that is the kind of thing that is hard for a lot of them. We get along well. They are trying hard with the services we have.

I was reading that Charles City got transportation not too long ago. We have no transportation. There is no bus route in Rockford. Unless you have a neighbor or call a senior citizen, there is no way to do this. There are plenty of them available, but we are all a little bit independent. If we can have the bus come in and take us out rather than call on our neighbor, it would be very nice.

Senator CLARK. Is there a chance that that could happen in the future?

Mr. SCHROGE. Well, we have another meeting scheduled for the third week in September in Charles City. We are independent and we don't care to bother our neighbors for this service. I don't think the average person expects it for nothing; they are willing to pay a little something toward this service. Of course we have another meeting in September. I don't know.

Senator CLARK. How many people do you have in your club here in Rockford?

Mr. SCHROGE. Well, at the present time I think there are probably around 70 some odd.

Senator CLARK. How do you raise money? I understand you have got some unique ways to raise money. What do you do?

VARIOUS PROJECTS RAISE NEEDED FUNDS

Mr. SCHROGE. We have got the gals here that can really get it. They have different things. They sell coffee and doughnuts and donate a little bit. They are all good hard workers and they are all willing to do their share. Yes, we have had a lot of fun. The ladies have a little deal there where they have a hat show and, boy oh boy, those old gals are really it.

Senator CLARK. Well, what is a hat show, or should I not ask?

Mr. SCHROGE. Where is our narrator? They put on some of these things that they make, all the way from gowns—one thing and another. They put on six or seven different things. My wife is in on it and when she comes home she is a new gal. [Laughter.]

Senator CLARK. I am not going to ask you any more. I read that story in Time magazine about Mason City, so I am not going to ask. [Laughter.]

I do want to ask the Judds a question, however. I believe it was Mr. Judd, and I am not sure, who talked about sharing the senior center facility with other groups in the community. What kind of effectiveness did that have? I mean, is that a good idea or a bad idea? Do you recommend it in terms of a senior center being used more broadly for other people, too, or what kind of results do you have in that?

Mr. JUDD. I think it was a real good deal as long as it lasted. I think a similar thing could be set up with control in an incorporated group where no one could take the building away. I think it is an ideal thing.

Senator CLARK. We were just discussing here that under the new title 5 program that I mentioned earlier, we are going to have about $300,000 next year and about $75,000 for the remainder of this year.

Let me ask Mrs. Judd a question. If we had some more money, what one service would you like to see come to Thompson that is not there, or what one service would you like to see expanded? What don't you have that would be valuable there in Thompson?

Mrs. JUDD. I think it is a little hard to say because each one—their likes and their background are different. I do think there should be something for people who don't care to play cards or do that sort of thing. I don't know just what. I think we would have to work it out. I know we have some in our group—that it is very hard for them to hear, and we have others who have difficulty seeing. There could be some sort of program that could be for those people. Now I don't think it could be done with the whole group, but we could have a place where several people could do things that they like to do, instead of everybody having to sit there and do whatever the majority is doing.

Senator CLARK. What about health care in Thompson? Do you have that?

"NO DOCTOR IN TOWN"

Mrs. JUDD. No, it is very poor. We have no doctor in the town. We did have a hospital with two doctors in Buffalo Center, but that is closed and the doctors have gotten—well, they have heard so much about the fun the senior citizens have they decided to be senior citizens instead of doctors. I don't know what else. Their health got bad and they quit. There is really no health care there at all. It is a problem.

Senator CLARK. You have been very good witnesses and we appreciate having you here and hearing your testimony. Certainly it has been very valuable to us. Thank you very much.

Mr. SCHROGE. I have one other thing. I want you to know that the senior citizens of Rockford want you to feel welcome and to look the city over. We enjoy having you here. The Methodists donated this church basement for this. I am glad to have you here.

Senator CLARK. Let me say in response, on behalf of the people here, that we are very, very grateful to you. I know that our staff who have visited you eariler—you made reference to that—have had the greatest

cooperation from you, from the seniors here, from the Methodist Church, from Reverend Robinson, from everyone, and we are very, very pleased that you would go to this effort.

Thank you very much.

Now our other panel today is on housing, as I said. We are going to be hearing from Governor Blue, Joseph Kempf, and Lewis Jacobson.

Let me say, by the way, we have green forms here—I think they are back by the door—and those are available for anyone to make comments on. They will go into the official record. It simply says:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing in Rockford, Iowa, on August 18, 1976, concerning "The Nation's Rural Elderly," I would have said.

Just fill it in and, if you need two, three, or four pages, we will take that. Just mail it to me. You don't really have to remember what the Washington address is; just Dick Clark, U.S. Senate, Washington, D.C. We will be very happy to put that in the record as if it were given here today.[1]

So please avail yourselves of those. We are going to keep the record open for about 30 days. That is, they have to be in our hands within about 30 days to do that.

This is, as I said, a panel on housing. We are going to start off with one of the most distinguished citizens of this State and a gentleman who has contributed, I think, as much, if not more, to the interests of older Iowans than anyone I know. I am referring, of course, to Governor Robert Blue, the former Governor of Iowa and a longtime member of the Iowa Commission on Aging.

Governor Blue, we are just very, very pleased that you are here. I know of your particular interest in housing, which is a longstanding interest. I know that you served on a number of distinguished national committees on this subject, so we are very pleased to have you. Proceed in any way you think appropriate.

PANEL ON HOUSING FOR THE ELDERLY

STATEMENT OF HON. ROBERT D. BLUE, FORMER GOVERNOR OF IOWA, EAGLE GROVE, IOWA

Governor BLUE. In the limited time that is allotted, I want to make a few points.

The first point that I want to make is that housing is more than four walls, a roof, and the other things that we think of. Housing is its neighbors, its sidewalks, its roads, its sewer, its water, but most of all its services, and a building that is not located where services are reasonably available is not good housing.

Down at the University of Iowa we have an institute on urban affairs that has been making some studies on accessibility. The more I see the problems that are related to housing, the more I think the Federal Government or other governments would be well advised to require an accessibility study and report before they put money into housing projects. This may be done in connection with some of the projects. I think it is not being done everywhere.

[1] See appendix 2, p. 404.

The accessibility, of course, that I speak of is churches, lodges, doctors, lawyers, dentists, drug stores, grocery stores, schools, and all manner of things that people are interested in because older people are interested in the same kinds of services that other people are. If they are deprived of those services or of their location, then they are being made second-class citizens, so to speak.

Senator CLARK. By "accessibility," you just mean the ability to get into it, out of it, and use it for it to be effective for you; is that it?

Governor BLUE. Accessibility may be that the service is a block or two away and they can walk to it. It may be accessible 10 miles away if transportation is available to them. So it will vary whether the service is accessible, depending upon the means of transportation. In other words, many elderly people are fully ambulatory and they are unable to go where they want to go on foot in the community. Many other people who might be ambulatory so far as walking a reasonable distance cannot drive an automobile because of being handicapped. So the two people might be equally ambulatory, but one would have services available to him whereas the other one would not.

Senator CLARK. I see.

Governor BLUE. I think this is a very major point where the Government puts money into housing.

Senator CLARK. That is right, Governor.

Governor BLUE. In rural areas older people generally have to provide their own transportation. A survey has been made as to the public transportation in the State of Iowa, and it is very, very inadequate. You either provide your own transportation or depend on public transportation.

TRANSPORTATION: A MAJOR PROBLEM

A lot of elderly people, as I have just mentioned, cannot provide their own transportation for a number of reasons. One is cost. Another is because of vision. Another is because of insurance. So there are many people who quite naturally provide their own transportation, yet don't use it if they can buy it. There are others that are deprived of it because they don't have adequate resources to purchase it.

I do raise transportation as something that is as large a problem as housing. If we are going to provide public transportation, it is going to have to be subsidized.

We have had some transportation programs in Iowa and a number of them have been quite successful. We have yet to accumulate adequate figures as to cost, and I think this is one of the things that is a priority—to get transportation costed out so that we will know what we are talking about. At the present time we do not know what the cost of these buses and so forth are. I think we will have those figures fairly soon.

Now when you get into the housing that we do have, I think we have an outstanding program so far as the Department of Home Administration is concerned in the State of Iowa. The last, I think, is 200 projects scattered across the State from little communities ranging from $8,000 to $10,000 in size. I do fault them, however, for one or two things. One is they will not build, so far as I know, garages in connection with the housing. Well, if they build this farmers home

apartment in a small community where there is no public transportation and they don't provide a garage, we have winter weather that gets pretty rough and these older people can't go out and scrape the ice off the car and run into all the difficulties. So I fault them in this regard.

Senator CLARK. They won't build any garages at all in connection with these?

Governor BLUE. They won't do it now. I have known a section or two, but the policy now, as I understand it, is they won't. I think this is important.

Senator CLARK. I never realized that before.

Governor BLUE. Well, I have got some support for that.

Senator CLARK. I am sure you are right. I just had never thought of it before.

Governor BLUE. You see why I would emphasize that.

As far as I know, they do not make an access to the facilities and services that are available before they commence to finance it, and I think this ought to be done by them. They don't require contracts for transportation. I think when they build the project they ought to have some agreement to see that transporation facilities were available, whether it is locally provided or otherwise, when they locate these buildings. Many of them are located in very, very small communities and the service, if it is going to be provided—the Federal Government is going to have to participate in it.

Now another thing I would like to emphasize briefly is that I understand there is legislation pending before the Congress now with reference to the insulation of homes.

Senator CLARK. Winterization.

WINTERIZATION PROGRAM NEEDED

Governor BLUE. Yes, that includes insulation. I think this is very important for two reasons. One, the group or widows alone cannot do this themselves and they need help; they need a handyman to do this. They may not have the funds with which to provide the insulation. Most of these older homes are drafty; they use an excessive amount of heat. The cost of heating fuel is rising rapidly—it is very inflated in price—with the result that people on fixed incomes are having new problems so far as heating their homes. This could be minimized and serve a national purpose. It would take care of a lot of elderly people and it would also help meet the energy problem just as much as in lowering our speed limits.

Senator CLARK. I might say, Governor, we have had two or three witnesses this week who have come in and talked about this winterization program, and it has been one of the most successful that we have heard about. For a fairly reasonable cost they have been able to winterize literally hundreds and hundreds of houses that elderly people live in.

Governor BLUE. Most of those just consist of plastic over the windows and it has to be taken off in the spring—it is not permanent—whereas insulation in the house would be a permanent improvement.

I would recommend further in connection with this that if homeowners were willing to go ahead and insulate their own homes, that they would be encouraged to do this if they could receive a tax break

on it. I would think, so far as landlords are concerned, this would present a situation where Congress might very well say, OK, investment credit can properly be considered for this kind of an improvement. I think this would stimulate a great deal of winterizing that would have long-term benefits, so I would urge this pretty strongly.

The handyman service was spoken of.

Homemaker service—the Federal Government's position is to keep people in their own home. You cannot keep a great many of these people in their own home without the handyman service and the homemaker service. We have it scattered around to a substantial extent in the State of Iowa, but not nearly so much as is needed. This program needs to be expanded, I would say, in every community in the State. Iowa needs the handyman service and the homemaker service if we are going to adequately serve the high proportion of elderly that we have in the State.

Now the next thing that I would like to rush on to is multiservice housing. I call it the Federal Government, because they build a lot of individual separate programs.

They may work pretty well in high population areas, but elderly people, when they go into retirement and move out of their homes, they want to make that the last move. So if they move and if they are ambulatory, they want that kind of service. They also want connected with that service an infirmary or nursing care, and they want to be assured of what kind of nursing care that is going to be when they make their move.

Special Facilities Needed

A lot of our housing programs are not geared to that 202 program. It is an excellent program, but it does not extend itself to cover multifacilities. People are individuals; some of them want their own room, some of them want an efficiency apartment, some of them want two or three rooms, other people want the nursing services connected. When you run into moving elderly people into a group setting, then you run into personality conflicts, particularly so far as the seniles and the mentally retarded. I, therefore, recommend that there be special consideration given to building facilities for the mentally retarded and the seniles.

Now the seniles and the mentally retarded cause no problem when they are in the nursing some, but if you have them on an ambulatory basis and try to mix them with people like we have sitting around here in this meeting who are intelligent, active citizens, it just does not work. We don't have that kind of a program, but I hope that we can have something along that line.

I don't know whether I have anything else to say or not.

Senator Clark. I am going to ask you some questions in a little bit. Thank you very much, Governor Blue.

We are going to hear now from Joseph Kempf who is executive director of the Good Shepherd Retirement Association which includes four residential and nursing home facilities in the Mason City area. As I understand it, Mr. Kempf, you are going to talk to us about housing needs in the area, the number of units provided, the number of persons on the waiting lists, and general problems of housing for elderly in rural areas. You go right ahead.

STATEMENT OF JOSEPH C. KEMPF, EXECUTIVE DIRECTOR, GOOD SHEPHERD RETIREMENT ASSOCIATION, MASON CITY, IOWA

Mr. KEMPF. Thank you.

Senator Clark, Governor Blue, ladies and gentlemen, Good Shepherd consists of four complexes and it is a nonprofit organization sponsored by 12 Lutheran churches in the Mason City area. The health center and the geriatrics center are care centers that provide three levels of care for 287 people. The Manor downtown is a housing complex for elderly people and it has 116 apartments. Shalom Towers is a 93-apartment complex and 20 percent of those apartments are subsidized apartments.

Now, getting to the need as far as the elderly are concerned, if we are going to move our elderly out of the substandard housing or apartments, the only way that I can see this can be done so our elderly people can afford this is by subsidized housing. Our cost today in constructing apartment units makes it impossible for the people, at least the ones that come to our facility seeking housing. At least 50 to 75 percent of them cannot afford the cost of the housing. Our housing apartment rates for Shalom Towers are from $98 for an efficiency apartment to $145 for a one-bedroom apartment which I feel is quite reasonable. Still we have many elderly people on social security, their only means of income, who can't afford to live in these apartments. I will try to answer any questions you may have relative to housing for the elderly.

Senator CLARK. I will have some questions, I think, as we go along.

Now I would like to hear from Mr. Lewis Jacobson who is a resident of the Manor in Mason City, and I would like to know what his judgments are on this.

STATEMENT OF LEWIS V. JACOBSON, MASON CITY, IOWA

Mr. JACOBSON. Thank you.

Senator Clark, Governor Blue, ladies and gentlemen, in 1968 the Hotel Hanford Corp. of Mason City ran into financial difficulties, and while this was in progress the Good Shepherd Corp. in Mason City was looking for housing for the elderly. I was on the board of Good Shepherd at the time, so I knew what was going on. Good Shepherd acquired the hotel and converted it into housing for the elderly. They changed the name to the Manor and they restricted residency to people 55 years of age and over. It didn't catch on right away and we had a little difficulty getting the 70 units filled up. As a matter of fact, it went along at a rate for a couple of years at which it was not profitable to us. However, we managed to hang on to it.

In 1971, I was living in Nora Springs. My wife and I were both employed at the bank in Nora Springs. We owned a nice home, but my wife was becoming arthritic. This is a family thing and we knew from experience with other people's families that arthritis does not improve, it just gets worse. We needed to have less work than we required having our own home. We sold the home and we found an apartment to move into.

None was available in Nora Springs, but it is only 10 miles to Mason City so we took one of the apartments at the Manor in Mason City. We lived there 3 years and then, 2 years ago, we moved into a newly

finished apartment, so our accommodations are quite delightful at the present time.

An Ideal Location

We think this is ideal. We are located right downtown. We are located within a block or two of the shopping area and grocery stores. We are in a health club where a lot of our people spend a considerable amount of time. We have churches of various denominations within just a short walk to the facility. The post office is only a block away. We have a doctor's clinic only a block away and our dentist is located in the area.

Since this facility was once a hotel, there is considerable space on the ground floor that is not readily convertible into apartments, so it has been converted to use for the people who live there. We have 116 apartments and this accounts for about 200 people. These had originally been the sample rooms in the hotel and they have now been converted into cardrooms. We have a pool table down there and we have large rooms where we can accommodate a large gathering of people. We have a library there. It is a very convenient place.

We are provided with one meal a day at noon. We also can get our own breakfast. There is coffee furnished and we can make toast and get our own breakfast in the public facility if we care to do so. However, all of the apartments have facilities for cooking. There is a beauty shop and a barbershop within the facility. Most of the people are retired and it makes for a very congenial group.

By living at the Manor we avoid the usual maintenance chores that you have with a home. Heat, light, and air-conditioning are included in the rental figure, so we don't have that to worry about. The place is privately financed—it is self-sustaining and paying its own way. We think it is a very fine facility and we are happy with the Manor.

Senator Clark. Thank you very much. I want to ask you a couple of questions.

You talked about having left your own home and moving into the Manor. Is it a good idea? Are you happy with it? I am sure there are a lot of people here now or in the future who will say, "Well, I don't know about leaving my own home and moving into another place." Was it a good move for you?

Mr. Jacobson. I have been asked that more than anything else, and my answer is that it was a very fine move for us. We are very delighted. Now my wife and I don't sit home very well—we like to travel. As a matter of fact, since we both retired a year and a half ago we have driven the family car 60,000 miles into Mexico, the United States, and Canada. We traveled to the Mideast, so you see we don't stay home very long. A lot of the convenience is the fact that when we want to go away for the weekend or for 3 months, we just pull the door shut behind us and go.

Senator Clark. So both when you are there and when you are gone, you have a number of conveniences in terms of everything being taken care of for you.

Mr. Jacobson. Yes.

Senator Clark. Do you think there is much demand, for example, in Mason City or in this area for that kind of housing? I mean, is it your impression in talking with other people who are close to retire-

ment or in retirement that they would like this kind of facility, that they would like to move into it, or do we have an adequate amount now, in your judgment?

Many Resist Change

Mr. Jacobson. Oh, I think there is room for more of this. However, it is just surprising as you talk to people how tenaciously they will hang on to their home and do all that work and have all that worry, concern, and expense to maintain it. It just surprises me. I think this is a fine arrangement, but I do think that it might incur a change, and many people share my thoughts in this.

At the present time the Manor is full, and we have about 35 people on the waiting list. However, you never know exactly how many of those are happy. Some of them may come and make an application, then find out there is none available right now and will go someplace else and make other arrangements and not let us know.

Senator Clark. I suppose the best thing is to have everybody make their own choice if they really want to stay—if they really want to go to a place like the Manor or anything of that kind.

Can you tell us the range of cost in living at a place of this kind?

Mr. Jacobson. The range of what?

Senator Clark. Cost; rental. What is the cost to live there?

Mr. Jacobson. Oh, the range of cost. Well, it runs from about $135 to about $240. It is $135 for an efficiency apartment, and then it runs up to about $240 for two singles.

Senator Clark. Mr. Kempf, just to continue this same discussion, I understand that Shalom Towers is a housing unit for the elderly with 93 units. That was supported by section 202 of the Housing and Urban Development bill. Is section 202 a feasible housing program as far as Mason City is concerned? How could it be improved to meet the needs of the people in this area around Mason City, and in the rural areas in particular?

Mr. Kempf. At Shalom Towers, or any of the apartment complexes, we have many people come there who cannot afford to live there because their income is not great enough. So they go down the street and rent substandard housing apartments in the neighborhood of $55 a month instead of $98 a month. However, 20 percent, as I indicated before, are subsidized in Shalom Towers. The need we really have in Mason City right now is for subsidized housing. We could fill at least 200 units.

Senator Clark. I was going to ask about that.

Mr. Kempf. It is very substandard housing. People have to live in an apartment for $35 and $55 a month.

Senator Clark. Do you have any plans for expansion of these facilities?

Mr. Kempf. Yes. In fact, you probably are aware of the appropriations that were made for the next 3 years for the two programs under the section 8 program. I do not know, Senator Clark, whether those are subsidized programs or not. It was just passed recently.

Senator Clark. If you really had the section 8, that is, if you really had a program which would supplement rents so that no one would have to pay more than a quarter of their total income in rent, and the

Government subsidized the rents, you are confident that there would be at least a couple hundred people.

Mr. KEMPF. We could rent at least 200 or more and get the elderly people out of the substandard housing.

Senator CLARK. Are there any services provided for elderly people who reside in these facilities, other than just a room?

SERVICES LIMITED

Mr. KEMPF. Well, at the Manor we do have cooking facilities and we provide one meal a day. Otherwise, they can do their own cooking in the apartment. The only service we provide is recreational service.

Senator CLARK. You do have recreational services?

Mr. KEMPF. Yes.

Senator CLARK. Governor Blue, I know you are aware that Iowa has various housing complexes for the elderly that were supported by HUD. There is a section 202 complex in Mason City, another one in Garner, and I think there is also one in Eagle Grove. Are the HUD programs, in your judgment, good programs? Are they working in the rural areas or do you have recommendations beyond those you have already made for better use of housing funds for the elderly?

Governor BLUE. Well, as I indicated, I think the 202 program should be expanded to offer at least nursing home facilities. I don't know what their present rate charges are. One of the things about the 202 program is the low rate of interest, and this is one way that the Federal Government can subsidize the building without getting hurt as much as they would in some other ways. The 202 program has been successful pretty largely because it has appealed to nonprofit corporations. Isn't that your experience?

In fact, this is a necessity, and churches and fraternal and labor organizations have been willing to get behind this kind of a program and that, I think, is one of the strengths of it. It has sparked interest on the part of churches and these other groups and got them involved.

Senator CLARK. Now I know that this new section 8 program—or the section 8 program, actually, of the 1974 Housing Act—provided for assistance payments to families who were on lower than average income and is to pay the difference between the fair market price and what the tenant can actually pay. Is that valuable, and do you think that that will work if it were able to get that kind of program in rural areas of Iowa?

Governor BLUE. Probably. It will work the same as the double income or the double homestead credit works. The problem is that the forms which these elderly people have to fill out are complicated. Even if they were rather simple they would get confused and need help in filling them out.

Senator CLARK. The emphasis of your testimony today is really accessibility. You are saying that whatever program we have, whatever kinds of programs on housing or nursing care, whatever program we can consider, we ought to give more attention—as the Government in authorizing these programs, in writing the regulations, and in defining the programs—to what you call accessibility.

Governor BLUE. Well, I emphasize that strongly, but I am also saying that older housing ought to be rehabilitated, and the Federal Government ought to get concerned with rehabilitating an older building. That is what I was really pointing to when I said "insulated."

"It Is Not Normal To Live Alone"

There is another point that I could make. Somebody else suggested it today and I have thought about it a great deal. It concerns the large number of widows who are living alone in houses. You know, we were born into a family—we have a herd instinct. We were raised in a family, we go to school, we marry, we raise a family. It is not normal to live alone. A lot of elderly people down in Florida are shocking their children by shacking up together, so to speak, because of economic reasons. [Laughter.] This is common knowledge.

Senator Clark. Yes.

Governor Blue. No kidding. I can see no reason why it could not be socially accepted for two widow ladies to share a home together. They would have companionship, and two people can maintain themselves longer in a home than a single person can. This is not socially acceptable at the present time. I think it could be made socially acceptable and I think it would help solve the housing problem. I think it ought to be given some thought.

Senator Clark. Well, I want to thank this panel in particular for a number of innovative and interesting ideas about what we are doing, how the housing is being used, for what purpose, and so forth.

Let me try, in a couple of minutes, to summarize what we have learned here today. I thought the first panel—Mr. John Beer talking about what has happened in Hampton, in particular in terms of developing their senior center, was good. Paul Schroge talked about how his center was developed and some of the interesting ways that they raise money—some of the services that are provided there, and how far they have come.

I thought certainly Mr. and Mrs. Judd from Thompson expressed that that community has done a great deal in terms of really beginning now to provide a broad spectrum of services. They point out particularly that they still need health care in Thompson, and that is characteristic, I think, of almost every small community in Iowa, the Midwest, and all across the country.

I thank Harry Empting, the coordinator at the center in Mason City and I hope he has left his flow chart [1] with us so the committee can analyze the priorities that he recommends.

I also thank this panel—Mr. Kempf for talking with us about the Good Shepherd Retirement Association, some of the things they have done, and the fact that they still have a great demand for further expansion of housing units. I am grateful also to Mr. Jacobson, who is a user of one of these facilities, for his views on what he considers to be a great advantage, at least from his and his wife's points of view, in terms of flexibility—going into a place and being able to walk away from it for weeks or months at a time.

I also thank Governor Blue for a number of ideas regarding housing, with particular emphasis on preserving those that are there so that people who choose to live in their own homes can have decent housing, the emphasis on rehabilitation of older housing, and then something that is a favorite topic of his—accessibility of the facilities. Of course it does not mean much if the facilities exist if you can't get to them.

[1] See p. 380.

Testimony Summarized

Lastly, I would like to try to summarize really what it seems that we have learned not only from this hearing but from all of the hearings combined. As I say, we have had six hearings: four here in Iowa, one in Nebraska, and one in South Dakota. We have heard principally from people who are over 65 years old themselves in terms of what they feel, what has happened, where they have been, what is going to happen in the future, and what the Federal role ought or ought not to be.

We have heard from a number of people who live on Indian reservations, for example, up in South Dakota earlier today. Of course with the emphasis on these rural problems, we really heard about six or seven things that can be briefly stated.

First we heard over and over again the necessity for transportation, which is part of what Governor Blue is talking about in accessibility—the fact that we must have mobility. If you are stranded out alone and you need to go to a doctor, a hospital, you need to get prescription drugs, groceries, or simply to see someone, transportation is a key to that.

We have heard from witness after witness these last several days about the need for health care in the smaller communities. We realize now that we are never going back to a time when we had a doctor in every small town, or hospitals in the numbers that we once had. But we do need some kind of extension out into the rural areas so that we have the basic kinds of health facilities, so that we have registered nurses—some kind of center or clinic, as small as it might be, in the smallest communities.

We have heard over and over about the need for housing. We have not had a single witness who said if they had more housing they could not use it. Every community we have talked to could use more housing for older people—there is always a waiting list—so that has to be emphasized. And not only new housing but, as we have heard here today, rehabilitation of older housing. We have heard many, many times, and particularly from this first panel today, of the importance of a multipurpose senior center. That is one key to many of the problems that we are talking about. Such a center enables people to come together socially, and also to come in contact with these other services that are being provided under the Older Americans Act and under some other provisions.

We heard a great deal in the last 2 days about the importance of employment for people over 55. We heard about the green thumb program in South Dakota—and now it is being started in Iowa—that hires people over 55 to do a great number of different things. We have heard of other kinds of employment problems. Again, as we have seen in so many of these programs, it is not just a case of employment, it is a case of the psychological factors that go with it—the fact that you get up every day and go to work.

Mandatory Retirement Criticized

Certainly we have heard—a pet peeve of mine, at any rate—the fact of mandatory retirement. Society thinks that somehow when you get to be 60, 62, 65, or 70, that you have to retire. I think that is just total nonsense.

There was talk about discrimination on the basis of race or sex. The fact of a mandatory retirement is not a good idea, and we have heard a good bit of testimony about that as well.

We have heard about other things—the homemaker programs and the chore aides who make it possible for people to stay in their own homes.

Then last—and in some ways first—the fact that people just do not have adequate income. So many of these things could be available if they simply had the income. We know statistically that in State after State almost half the people over 65 who live in rural areas live below the level of poverty. That just has to change.

Those are some of the major things that we have learned in these hearings. We hope now that we can go back to Washington with this information and convince other members of the committee, other Members of Congress, and those in administration that it is important to look at the unique problems of rural America when we talk about the problems of the elderly. If we are going to pass a new kind of national health insurance, we better be very careful that we know how that is going to be applied in the smaller communities like this one, the one I was raised in, and others. We must be sure that we have accessibility of health care, not just in the metropolitan areas but in the rural areas as well. In each kind of legislation that we pass we must keep a consensus of this fact, and in the distribution of funds, so the small communities have the benefits that larger communities have.

We thank you very much for coming and we look forward to seeing you often in the future.

[Whereupon, at 4:55 p.m., the committee adjourned.]

APPENDIXES

Appendix 1

LETTER AND STATEMENTS FROM INDIVIDUALS

ITEM 1. STATEMENT OF JOHN SUTTON, PRESIDENT, WAPELLO COUNTY (IOWA) FARMERS UNION

I want to thank you for your leadership in bringing these important field hearings on the special problems facing elderly people in rural areas to Iowa, and to our neighboring States of Nebraska and South Dakota. We are glad you are asking the older people themselves to participate in the hearings, to tell you their story from their community, their county. They know the problems we have in our rural areas that complicate the lives of older people—lack of public transportation, lack of health care facilities and of doctors, lack of social services, lack of employment opportunities, poor housing.

When Senator Church, chairman of your commitee, called these hearings, he pointed out that approximately 8 million persons, or 27 percent of all Americans, 60 years and older live in rural and farm country. That would mean over 750,000 older people live in rural areas in Iowa. He said, "There is good reason to believe that many are served less adequately than other older persons by Federal programs meant to help them." I am sure your committee, and other Members of Congress, will keep this in mind when you work on the renewal of the Older Americans Act in 1978.

Farmers Union has long recognized the need for special help for disadvantaged people in rural America. National Farmers Union sponsored the first study of poverty in America in 1964 and 1965 which was published under the title "Pockets of Poverty." This pioneering report was followed by the monumental study "The People Left Behind" by the President's National Advisory Commission on Rural Poverty in 1967. We have felt it is important for an organization of family farmers to help provide the leadership to develop programs to meet the needs of less fortunate citizens in their communities.

When President Johnson launched his "war on poverty," we felt there was a need for an employment program to supplement the incomes of older low-income people in rural areas. Many people had lost their farms in the rapid mechanization and growth of farm size in the thirties, forties, and fifties. We lost about 90,000 farmers in Iowa between 1940 and 1969 according to figures presented at our convention last fall. They moved to small towns with limited employment opportunities and lower wage scales. So many farmers and their wives reached retirement age with little or no social security credit or other retirement income.

EMPLOYMENT PROGRAM INITIATED

Recognizing this need, Jim Patton, then president of National Farmers Union, Blue Carstenson of his staff, and Lewis J. Johnson, Sr., president of the Arkansas Farmers Union and a member of the National Board, went to Sargent Shriver, head of the Office of Economic Opportunity in 1965, and proposed that an employment program to supplement the incomes of older low-income people in rural areas be launched. They said Farmers Union would act as sponsor of the program.

And so Green Thumb was started in five States. We have wanted the program to come to Iowa for a long time and are so happy that a small Green Thumb program is being started this summer (49 job opportunities). I want to thank you, Senator Clark, Congressman Neal Smith, and others in the Iowa congressional delegation for your successful efforts to get Green Thumb started here and expanded to a total of 28 States, Puerto Rico, and the District of Columbia.

We are glad the program could be expanded to 6,070 job opportunities with the new grant effective July 1, 1976, and to know you are working for additional expansion next year if the 1977 fiscal year appropriations bill for the Departments of Labor and Health, Education, and Welfare is enacted into law.

But we would remind Congress that there are over 5 million Americans, 55 years and older, who would be eligible for employment under such programs as Green Thumb. We estimate there are 70,580 who would be eligible in rural, nonmetropolitan areas in Iowa. We have a ways to go.

We know our rural areas need the services provided by these Green Thumb men and women. In other States they do many jobs beyond the conservation and beautification, roadside parks and trails that the name "Green Thumb" implies. They work at a wide variety of essential, worthwhile facilities and services that local sponsors (local and county governments and nonprofit organizations) could not afford to have done otherwise—from deputy sheriffs to fire wardens, from nutrition aides to teachers' and library aides, museum attendants, painting the fairgrounds, or helping to refurnish the county courthouse. They serve as drivers for rural transportation projects. They do outreach work, taking people to the doctor, or to buy groceries, or to the senior citizen center for dinner and a visit. They work at housing repair and winterization for other low-income people. And always the work they do would not otherwise be done—so they do not deny jobs to younger people needing work, which is important with our unemployment rate still standing over 7.5 percent.

Green Thumb provides the opportunity for older rural citizens to participate in the life and work of their community and increases the security provided by the wages they earn. And their wages are spent on Main Street where it is estimated that each dollar turns over seven times before it leaves town. Rural communities gain and save about $10 for each dollar used on Green Thumb projects. The return to the Federal Government is at least $5 for each dollar expended in wages.

So we hope you will be able to expand Green Thumb and other such opportunities for our older people.

And we hope you will expand the other programs covered by the Older Americans Act. The nutrition program under title VII is a great investment for America because people well fed are able to meet other problems of being old and alone. Meals-on-wheels is so important to older people without transportation in rural areas and in our towns. But there are so many people who are not able to have these services—which might keep them out of the much more expensive nursing homes, expensive to themselves, their families, and the Nation.

You and others here can speak in more detail about the other programs developed under the Older Americans Act. But we know they are needed in rural Iowa as well as other places. And we know they are a good investment because if we can keep people in their own homes, in their own communities it is cheaper, better for them and their families and our society, and a lot cheaper too.

Again, we appreciate the opportunity for you to hold these hearings and for us to participate in them. We support you in your effort to make life better for our senior citizens.

ITEM 2. STATEMENT OF DONNA DAVIS, HAWKEYE VALLEY AREA AGENCY ON AGING, AND PEG ANDERSON, CHAIR, IOWA WOMEN'S POLITICAL CAUCUS

Problems of Older Women in Rural Areas

INCOME

First, the rural or small town older woman's problems start with the fact that she is female and therefore likely to be one of those who are or become the poorest of the old, themselves poor in much higher numbers than their proportion of the population. It's double jeopardy being old and female.

For example: Using 1970 census data from selected counties in northeast Iowa, we find that even in one of the richest rural counties, 20.2 percent of the older population was below the poverty level. When we look at the age distribution of that "rich" county's poor, we find that more than a third (34 percent) are 65 or older.

We know that most of these are women, because: (1) Women are a higher percentage of the senior population in general; (2) the rate at which females

outnumber males increases as they go toward later old age; (3) because poverty intrudes on those who live long (medical costs, etc.); (4) the poorer aged are often those who live alone and women are 65 percent or more of that group; and (5) because cultural and economic factors all her life have made the woman's earnings (and access to a good social security pension) considerably lower than a man's.

These women and others now 65 and older have generally been brought up to a higher dollar income, thanks to SSI (supplemental security income). But before we reassure ourselves with that and turn away, let's see what that new income level is: Under the July 1, 1976, rules for SSI, the maximum a person can have as income is $2,144 per year, plus medicaid and food stamps. That still doesn't put them above the poverty line in 1976.

This brings us to some recommendations we'd like to make today, regarding Federal programs designed to help low-income older persons. Many of these recommendations are available to you, Senators, and to the public in an outstanding report by the Federal Council on the Aging, entitled, "The Interrelationships of Benefit Programs for the Elderly," published in December 1975.

Participation of older rural families in means-test Federal programs is not as good as it could be. Although we do not yet have actual hard figures on this, the experience of the staff and volunteers of the Hawkeye Valley Agency on Aging shows that many older rural persons who are probably eligible for Federal benefit programs requiring a means-test do not participate. To prevent this in the future, the attitudes, culture, and education levels of older rural and small town people should be considered in the development, improvement, and administration of benefit programs. They should not be demeaning, threatening, or complicated to apply for and get deserved benefits.

RECOMMENDATIONS

(1) We recommend more uniformity in eligibility policies and application procedures, realism in benefits and in assets exclusion (adjust both to the cost of living; currently, SSI benefits are up, but with property reevaluations up and asset limits the same as when the program started, some people could be disqualified without any real income gains to justify it).

(2) We recommend that programs should not penalize people for trying to be more independent and supplement their social security incomes with earnings; such a system hurts most the rural poorer person who doesn't have an "excluded" additional pension income (frequently, the rural older woman).

(3) In consideration of the physical and psychological accessibility of various application centers for the several Federal benefit programs, we recommend the serious consideration of single-point application centers for all programs, located in each county.

(4) Recognizing the culture of small town life, we urge that publicly identifiable stigmas be removed from Federal benefit programs designed for low-income persons. (We hear reports every week of older women who, despite their need and full information about the program, will not take food stamps, because "everyone in town will know" that they are poor.)

(5) Even more effort should be made by administrators of benefit programs to simplify and clarify information on programs. Specifically, this means: Write brochures, speeches, and correspondence in plain, easy English. Print information and application materials in large print, not only because of eyesight problems of some older people but also because research has shown that easy-to-see information is more likely to be read by anyone. (Has anyone here ever had trouble reading and understanding a social security letter or pamphet?)

(6) Eliminate policies of benefit reduction rates (such as those for veterans and dependents benefits) that actually reduce benefits more than 100 percent of the value of the increased money (whether that money comes from working or from another Federal program, such as increases in social security payments).

(7) Correct the discrimination against aged widows whose husbands' birthdates were before 1912.

Finally, we recommend amending the Employee Retirement Security Act (1974) which still allows a worker to "opt out" of automatic survivor benefits for a spouse, without the consent or knowledge of the spouse (read: "wife"). And study the actual economic and social effects of discouraging survivor benefits for the usually longer-lived female.

HEALTH

Older rural people as a group have poorer health care than older urban people, probably for two reasons: First, less access to health care in the immediate area made lifelong preventive health care difficult and impractical. Second, the already high cost of medical care (out-of-pocket expenses for health care are higher now than before medicare) is compounded by the cost, not only of getting to the city or big town but also by the proliferation of specialized health care practitioners needed to treat the whole person.

Medical and health care costs are high for all older people (but proportionally higher for the poorer older woman who outlives a meager or even an adequate income). Medicare doesn't cover the costs of long-term, chronic conditions; it is these that often deplete even the moderately healthy retirement income.

What is needed for the rural and small town older person (who, you understand, is usually a female) is access to low-cost health care of a preventive type (such as health screenings) or for care of chronic health problems. That health care screening should include tests that meet important health care needs of older women: nutritional histories and analyses and Pap smears, as well as the usual blood, urine, and other screening tests provided in such clinics.

We know that the need for, and participation in, health screening or well-elderly clinics would be great in rural counties, based on reports of pilot project programs being run in Iowa right now; but they need to be more widespread. The recent opening of a donation-only community clinic, composed of volunteer physicians and nurses, in Waterloo brought calls and inquiries from many in small towns and rural areas in the surrounding counties; county councils on aging are talking about the need in their own counties. The known need is acute; the hidden need is no doubt much greater.

TRANSPORTATION

Like income, transportation affects almost everything else of significance in the lives of older rural and small town women, and here especially the fact of being female has had a profound effect.

In the generation which is now the 65-and-older age group in Iowa, there are a great many women who don't drive, not because of lack of money, but because of a sex-bias in their generation that discouraged either their learning to do so or their continuing the practice once it was learned. These moderate-income older women then join the substantial number of less well off (or physically unable) older women and men who need and use transportation services for the elderly in their counties.

The issue of how to provide transportation services to older people in rural areas has been much debated in Iowa. Mass transit approaches waste resources, due to excessive dead-head or down-time of large vehicles going empty over long country routes, and high operating, maintenance, and depreciation costs. The recommendation we would make, then, is that the Federal and State governments should provide more funds to aging programs to continue and expand urgently needed rural transportation for older persons and should focus on the use and development of networks of locally based volunteer drivers who are reimbursed for mileage and maintenance. This system is best equipped to provide door-to-door, on-demand escort and transportation services needed by older and often infirm users of the service.

HOUSING

In 1975, across America, housing costs equalled 35 percent of an older person's income on the average. At the same time, people under 65 spent only 23 percent of their incomes on housing.

Home ownership is the main asset of rural older persons, outside of their social security pensions. And yet in 1973, 60 percent of all substandard housing was located in rural areas; older people occupied one-fourth of these, a proportion far higher than their portion of the population.

So the question arises: Should we try to maintain and/or bring up to standard the housing of older women in rural and small town areas? Or should more moderate and low-rent housing for older people be sought for these counties?

Although with the existing boom in the housing market, it is no longer so difficult to sell large, older homes most rural elderly prefer to remain in the familiar surroundings of their own home. Solutions in these cases might include alternatives which do not require selling the home. These include funding handy-person services to assist in the maintenance of the home of an older person or in the adaptation of that home to physical disabilities of the resident. Title III Older Americans Act funds have made this kind of program available to more and more rural older women. Major repair and winterizing efforts, administered by the Community Service Administration programs (formerly, community action programs), in rural counties have helped a portion of the lowest income older population. It should be noted here that Farmers Home Administration low-interest loan programs to upgrade substandard rural and small town homes of elderly have not been widely utilized by eligible persons. One reason for this is the fear of incurring any debt in the face of low, fixed, or declining resources.

Moderate income housing through Farmers Home Administration loans to community sponsors have been popular in Iowa. However, increasingly we hear older women saying that the rents on these are too high for many of them. Rent subsidized housing for older people would better meet the need. Requirements that at least 50 units of housing be built at a time has discouraged the establishing of these HUD 202, section 8 housing projects in rural areas. But a solution is available. Rural counties can join together to set up a regional housing authority to sponsor new construction of rent-subsidized housing.

A final comment on housing: New projects designed for the benefit of older persons should be located as much as possible in a location that mixes the older residents with neighbors of other ages. Too often area agency on aging staff hear the comment, "I live here among only the old, the sick, and the dying. It makes me feel bad." The health consequences of this self-image can be powerful and negative.

SENIOR CENTERS

Income loss affects not only access to necessities but also the amount of social involvement and interaction a person can engage in. Friendships, one of the best things in life, may be free in and of themselves, but the activities which friends share often cost some money.

There is an appetite for social life in the small towns and rural areas that generates a better turn-out to social events than in the big cities. Senior citizens' gatherings in small communities in Iowa—a monthly potluck or dinner, or a daily title VII nutrition site meal—draw good crowds. We are not sure what the real reasons are but certainly the evidence is clear that such events and places, offering as they do the companionship, group involvement, and an opportunity for volunteer work and cooperation, are much valued. Rural areas seem to show a great obvious need for senior centers and a high probable use of such facilities. Indeed, where already developed, they provide the ideal place for a single-point information and service center that has so long been missing from the rural resident's life.

ITEM 3. LETTER AND ENCLOSURE FROM THOMAS D. GARRY, PRESIDENT, HERITAGE APARTMENTS, BANCROFT, IOWA; TO SENATOR DICK CLARK, DATED AUGUST 18, 1976

DEAR SENATOR CLARK: I am president of Heritage Apartments and we have built four six-plexes which now total 24 units, financed by the Farmers Home Administration, and they are located across the street from the community center and are rented to elderly citizens.

The Farmers Home Administration does not provide a community center in their projects. We have checked this out several times and most of the tenants could use the community center. The attached article applies to us and I ask, are we wrong in trying to build a better community for our senior citizens? We had cooperation in the past, but in the last 2 years all of our efforts are in vain. "Keep up your spirits," advised Ben Franklin at age 80, "and that will keep up your hopes." This we have believed for 2 years—we can't hold our breath much longer. The senior citizens would appreciate cooperation.

THOMAS D. GARRY.

Enclosure.

[Article from the Saturday Review, Aug. 7, 1976]

The Willy Loman Complex

(By Albert Rosenfeld)

Jacob Jensen (a fictitious name, invented by his psychiatrist) was, by almost anyone's standards, a happy and successful man. He was the second-highest-paid executive in the company where he had started as a stock boy, right there in the same town, 37 years ago. He had a lovely wife, lovely children and grandchildren, plenty of money, and excellent health, and he was a respected figure in his community. Now, suddenly, as he approached 60, his board chairman had given him a stark choice: early retirement or transfer to South America.

Jensen had never given a thought to retirement. There had always seemed plenty of time to get ready for that distant event. The quiet confrontation with the chairman of the board has so unnerved him, however, that he soon found himself in the office of Dr. Herbert Klemme, at the Menninger Foundation, for psychiatric counseling. Klemme, recognizing that Jensen was in serious emotional trouble, advised his employers that either of the alternatives they were proposing would be psychologically disastrous. The company relented and gave Jensen a lesser—though still important—job, and 2 years to prepare for retirement.

Even under these revised circumstances the patient got worse instead of better. Nine months later, writing Jensen's case history, Dr. Klemme summarized: "Mr. Jensen is . . . agitatedly seeking release from the pain he is experiencing. Because of the severity of his distress, I referred him to the very competent psychiatric facilities available in his local community. He is severely depressed and at this writing suicide is a definite possibility. . . . In my opinion he is also a prime candidate for a severe debilitating physical illness: stroke, acute coronary heart disease, cancer. . . ."

Do many people, in real life, commit suicide for such reasons—as the fictional Willy Loman did, under somewhat similar circumstances, in "Death of a Salesman"? Yes, they unfortunately do. A decade ago Dr. Sidney Cobb, of the University of Michigan (now at Brown), kept track, for 2 years, of 100 automobile workers who had been laid off from their jobs. Their suicide rate was 30 times the rate that would normally be expected. They were, moreover, afflicted with a considerably higher-than-average incidence of nearly all the major diseases. These were younger men than Jensen, and their unemployment was only temporary—though it may have seemed like forever to them, and the emotional effects were equally profound.

Case histories such as Jensen's are all too common.

But it should be emphasized that they are not typical. Nor, are they as common as was once believed. Dr. Robert N. Butler, Director of the new National Institute on Aging, says in his Pultizer-Prize-winning book, "Why Survive? Being Old in America," "There is much mythology built into the notion of an emotional and physical condition known as the 'retirement syndrome,' characterized by anxiety and depression. People who retire do not automatically develop declining mental and physical health. What social-science studies we have indicate such generalizations to be a fallacy." An intensive study made in 1957—at McGill University by James S. Tyhurst, Lee Salk, and Miriam Kennedy—of several hundred pensioners of the Bell Telephone Co. of Canada revealed that most retirees actually were able to make satisfactory adjustments. And, according to Dr. Bernice L. Neugarten, of the University of Chicago, writing 14 years later. "Three-fourths of the persons questioned in a recent national sample reported that they were satisfied or very satisfied with their lives since retirement."

Many people, in fact, seem to become happier, even healthier, after retirement than before—especially those who didn't care all that much about their jobs anyway and who have other interests they had always wanted more time to pursue. A retiree often has more opportunity to take care of himself, to eat and exercise properly, to get enough rest, to enjoy play and leisure without guilt, and still derive much satisfaction from continuing to work fruitfully—though, preferably, not too competitively. Most long-lived people do continue to work at something; it can be physical, mental, or both. Some people find themselves working even harder after retirement than before. Their attitude toward what they do is all-important.

Mark Twain used to insist that he never worked, only played. Challenged by friends who knew how many hours he spent writing, he would reply that writing was not work.

Even though the human organism does deteriorate with age, many people in their later years take up sports and other vigorous activities they never tried before, developing new skills, new muscular strength and physical endurance, new powers of coordination. Even sexual powers, though gradually diminishing, are still present and employable essentially throughout life. In many cultures, says Dr. Jean Houston, director of the Foundation for Mind Research, old age is expected to be the most satisfying stage of life—as with Browning's Rabbi Ben Ezra: "Grow old along with me!/The best is yet to be,/The last of life, for which the first was made."

New powers of mind may also be developed late in life—the ability to concentrate, to meditate, to turn off unwanted thoughts, to expand awareness and consciousness. In our society, says Dr. Butler, "we rarely find anyone paying . . . attention to the growth of wisdom in the individual" with age. Though people are slower to learn as they age, their intellects are generally unimpaired, and they are perfectly capable of new learning of every variety. Many of the brain's cells do die as we age. Even so, it's a cliché that we never use more than a fraction of our potential brain power. Most people in our culture have been trained mainly to use the left side of the brain—the hemisphere that deals with rational thought, logic, verbal skills, and the kind of mathematics computers can do, too—while neglecting the right hemisphere, which governs visual, spatial, integrative, creative functions and the kind of information processing that no known computer can yet simulate. (See "Left-Brain, Right-Brain," by Roger W. Sperry, SR, August 9, 1975.) While some of the brain's capacities may atrophy through disuse or never be developed at all through lack of stimulation, what remains may still provide new abilities, new insights, new asethetic appreciation. Pianist Artur Rubinstein is still playing brilliantly at 89—some critics believe with greater depth and sensitivity that ever. Grandma Moses didn't start painting until she was 74, and gained increasing worldwide fame for her creative efforts until her death, at the age of 101.

It should not be surprising that, in the absence of any chronic organic disease, a positive outlook on life can have a positive effect on both our physical and mental functioning. Nor, in view of what we now know of the intimate interrelations between "mind" and "body," should it surprise us that the opposite is also true—that many retirees, like Jacob Jensen, do not successfully make the transition.

After studying long-lived people in a diversity of cultures, Dr. David Gutmann, of the University of Michigan, concluded that "active mastery . . . is the ego state most clearly associated with longevity." Not power over others—but a sense of being master of one's own life and circumstances. In another study of longevity, covering 2,000 subjects over a period of 19 years, Dr. Robert Samp, of the University of Wisconsin Medical School, noted that an important ingredient was a continuing interest in the future.

When these two factors are missing, their opposites—helplessness and hopelessness—tend to take over. Thus the well-known "giving up" syndrome, with its serious physiological consequences. There exist many anthropological accounts of primitive tribes whose members go off and die simply because a powerful shaman has told them they will die, or because they have been cursed by a witch (Elspeth Huxley tells such a story of one of her father's Kikuyu garden boys in Kenya), or because they have learned, in the words of Dr. Jerome D. Frank, of Johns Hopkins, "that they have inadvertently broken a taboo," which causes "a state of panic and excitement leading to death in a few hours." There are also stories of American prisoners of war in Japan, Korea, and Vietnam who gave up in similar fashion. Dr. Barbara B. Brown, in "New Mind, New Body," tells the story of a convict who was appearing before the parole board, which recommended his immediate release from prison:

"A moment after release was ordered, a court deputy read a summons from another State ordering the prisoner to be transferred to another prison to serve an additional 10 years. As the order was read, the prisoner collapsed, dying. My friend, in the next building, arrived within minutes. Resuscitation procedures were instituted immediately, but it took all the resources of experienced medical treatment to recover the patient. There was no heart attack, no asthma attack, no cerebral stroke; there was, in fact, no physical reason that could be detected in thorough examination to account for the imminent death. The prisoner ad-

mitted that he could not face further imprisonment and had simply decided to die."

A classic experiment was done in 1957 by Dr. Curt Richter, of Johns Hopkins. A rat was thrown into a tank of warm water; it swam valiantly for 60 hours before succumbing to total exhaustion. Richter held a second rat in his hand; though it struggled mightily, it could not break his grip and finally stopped trying. At that point Richter dropped the rat into the water. It splashed half-heartedly, rather than swam, for a few minutes, then went down. In Richter's view, he had taught the rat held in his hand to be helpless. And it died, in the water, of sheer helplessness.

What happens, physiologically, to bring about such startling effects.

Back in prehistory, especially before our ancestors learned to fashion weapons, the human individual lived a life fraught with danger at every turn. In order to survive, he had to react instantly to any threat. There was no time to think about what the danger represented or to reason out his alternatives in dealing with it. As a rule, with an attack imminent from either an enemy or a wild beast, he had only two alternatives—to defend himself or to run away: the famous "fight or flight" situation. There had to be built-in biological systems that would alert and energize the body's resources to act with the necessary swiftness. We are the inheritors of the biological systems that still perform today much as they did then—though we can seldom fight or flee. Animals can often get rid of their frustrations by engaging in "displacement activity." A herring gull, for instance, if put in a threatening situation in which it can neither fight nor flee, will start pulling up grass with great energy. We may, of course, take out our frustrations on some innocent third party—but more usually we take them out on ourselves. If it happes frequently or continuously, the result can be any of a whole range of psychosomatic or psychogenic ailments, some of them serious and life-threatening.

Jacob Jensen, faced by his board chairman, probably reacted very much as one of his Pleistocene ancestors might have in the presence of a saber-toothed tiger. The alert signal went instantly from his cerebral cortex to his hypothalamus, the more primitive brain center that controls the autonomic nervous system—with its complex networks of sympathetic and parasympathetic nerves—which also encompasses the endocrine system with all its hormone-secreting glands. His pituitary triggered a whole series of hormone releases—especially the adrenal hormones—affecting almost every organ system in his body. Sugar and stored fats were mustered for the instant use of nerves and muscles. His blood pressure and pulse rate went up. His circulatory and respiratory systems were accelerated. Red blood cells multiplied to supply more oxygen to his cells and carry off the excess of carbon-dioxide wastes. In case of wounds from the expected attack, his healing apparatus and coagulatory chemistry would have to be mobilized. The digestive processes would come to a halt, being postponable in such an emergency. All this and more happened, quickly and spontaneously, Jensen probably tensed up and grew pale. His Pleistocene ancestors would probably have grimaced visibly, even growled. But civilized men in offices cannot behave in that manner.

Another way of describing the fight-or-flight reaction would be to call it a stress reaction. We do not think of it as stress, however, if we discharge it immediately. Besides, as Montreal's Dr. Hans Selye, the world's leading authority on stress, has repeatedly emphasized, a certain amount of stress is necessary to life and health. When it keeps happening, however, and when we cannot cope with it adequately, that is when we perceive it as stress. And that is when it begins to do its physiological damage.

Jacob Jensen obviously perceived himself to be in a stressful situation—the permanent loss of his job—that he was helpless to cope with. It meant constantly elevated blood pressure, elevated cholesterol levels (another consequence of stress), a harder-working heart and lungs, overactive glands: in a word, his body was in an abnormal state of constant emergency from which he could find no relief.

In instances such as the sudden death of prisoners and primitive tribesmen, it's been theorized that the passive, giving-up-the-struggle mood activates a parasympathetic reaction—little understood—that slows down a number of body functions, including the heartbeat. That the heartbeat can be slowed to a lethal level can be demonstrated by Dr. Richter's autopsy on one of his drowned rats: the rat's heart was still full of blood that it couldn't pump out fast enough; it had probably suffered heart failure through helplessness, thus was dying anyway before it drowned.

We can begin to see now some of the ways in which mind and body are related and why attitude and mood can have such far-ranging physiological consequences, both positive and negative. "Keep up your spirits," advised Ben Franklin at 80, "and that will keep up your bodies."

But spirits can be hard to keep up under some circumstances, particularly under the often anxious and troublesome conditions of retirement and aging. If the attitude and mood of older people have a lot to do with their state of health, those attitudes are frequently the result of negative attitudes toward them by the rest of society. It's well kown that our self-esteem often depends on how we are perceived—or think we are—by others. Most older people are not so fortunate as Jacob Jensen—who had family, friends, money, and other kinds of support to fall back on. Many have only themselves, and very little money or outside support. Dr. Leo E. Hollister, of the Veterans Administration Hospital in Palo Alto, Calif., believes that "unrecognized depression may be a more important problem in old age than organic brain conditions. . . . Poverty, isolation, and some drugs used in treating physical conditions may impair the mental capacity of the aged. Such reversible impairment often is thought to be permanent senility."

Depression, like stress (depression is, of course, a form of stress), has a striking effect on brain chemistry. Indispensable to the proper functioning of brain and mind are the substances known as neurotransmitters—those chemicals (notably the catecholamines) that are responsible for transmitting electrical signals across the synaptic gap from one neuron to another. (See "It's Not All in Your Head," by Seymour S. Kety, SR, February 21, 1976.) Lowered levels of some of the catecholamines—such as serotonin and noradrenaline—can, in fact, cause depression biochemically. Dr. Jay Weiss, of Rockefeller University, has made a special study of the effects of lowered norepinephrine levels in rats. Stress does lower norepinephrine levels to the point where the animal then is simply not able to organize itself to act protectively in a threatening situation; the chemicals necessary to transmit the messages across the nerve synapses are just not there—at least not in sufficient quantities to do the job. The same kind of deprivation could be taking place in those afflicted with the retirement syndrome.

Dr. Frank writes in "Persuasion and Healing" of a northern Australian tribe known as the Murngin. Among the Murngin, "when the theft of a man's soul becomes general knowledge, he and his tribe collaborate in hastening his demise. Having lost his soul, he is already 'half dead.'" Other tribe members perform mourning ceremonies and make clear what they expect. The victim's efforts, under the circumstances, are not to live, but to die.

Before we put down the Murngin as "barbarians," we should look to ourselves. When we force a still-vigorous individual to retire, do we not, in a sense, steal his soul? The more fool he, of course, for permitting his employment to become his soul, to be so easily stolen.

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

"DEAR SENATOR CLARK: If there has been time for everyone to speak at the hearings in Rockford, Iowa, on August 18, 1976, on "The Nation's Rural Elderly,' I would have said:"

The following replies were received:

MARY ASTOR, GREENE, IOWA

I know the needs of the elderly. I get into their homes—they trust me. Home improvement is important, so is transportation; but at the top of the list is medical aid. Persons living on social security should not have to spend $10 for a doctor appointment just to have something checked. We do, at our North Butler County nutrition site, check blood pressure once a week. I work under title VII Hawkeye Valley Area Agency on Aging and we have put to use everything that has been offered, such as transportation, handy person, and nutrition projects. I think we are far ahead of some, but this medical aid needs attention. We don't even have a county nurse—and only about three active doctors in county.

A. W. BEHRENS, MARCUS, IOWA

I, Msgr. A. W. Behrens, now of Marcus, Iowa, formerly pastor of St. John's Church, Bancroft, Iowa, and chairman of the Bancroft Low-Rent Housing Agency, state that I organized the Senior Citizens Club of Bancroft and the congregate meals program in January and February of 1975. This project has been most successful under the capable leadership of Adelia Ulses and now operates 3 days per week and is serving meals out of the community center. I have written many letters, made many phone calls, attended several meetings in Mason City and Des Moines in regard to this matter, and the minutes of the Bancroft Low-Rent Housisg Agency show an agreement that if the city of Bancroft would fund the operational costs, that the alteration would be approved. In the interests of the senior citizens of Bancroft, I sincerely hope so. The statement of understanding between the Administration on Aging and HUD concerning the nutrition program for older Americans means nothing on the local level if it is interpreted by rules and regulations contrary to the intention of the signers of the statement.

I can only hope and pray that the elderly will receive some benefit from this program.

GOODIE V. BLAIR, OSAGE, IOWA

Do we in Osage, Iowa, have to have the land to be able to borrow money for new apartments, or can we borrow for land to? We need more low-rent housing here. What we really need is housing that we can get government help with the rent. And shouldn't we have sidewalks to our apartment building? We don't. We have to walk the road or across bumpy ground and stone parking lots.

The Lutheran Church in Osage has meals for elderly once a month at $1.50. Riceville has them too, and an envelope to put what you can afford to pay into—no set amount. But lots of people are in our boat. Can't afford to drive that far and pay even $1.

Hamlin Garland is eight blocks from one grocery store and nine from another. Thank you very much for taking the time to read this and I will be looking for an answer.

G. ORLANDO BRENNA, ST. ANSGAR, IOWA

Enjoyed the hearing but was sorry there was no opportunity for audience participation. Many of us thought it was still a cut-and-dried deal.

My interest is mostly on housing for elderly. We have two Government agencies on housing—namely, HUD and FHA. Under HUD rental cannot exceed 25 percent of renter's income. FHA is housing at cost—namely, the apartments are built with 3 percent Government loans and rent being just enough to cover the cost of operation: taxes, utilities, sewer and water, lawn mowing, snow removal, etc.

I favor the FHA method, but find that the elderly can no longer afford housing at cost because of increasing costs. We cannot compete with HUD in rent and it seems to me that both agencies should be more equalized. We still have the urban-rural battle.

Under FHA regulations we must have so much surrounding ground area according to size of building, which is very good to a certain extent, but I think it is overdone. For instance, in St. Ansgar we could have three two-bed apartments and two one-bed on one location, and six one-bed apartments on the locations we already have if it wasn't for this ground building ratio we have to comply with. HUD builds high-rise apartments and we can't even build a two-story building—at least they frown on its suggestion.

Hoping my gripes haven't been too burdensome.

DANIEL BRUSTKERN, MASON CITY, IOWA

You sought a comment concerning accessibility. As a staff person of the Iowa Easter Seal Society and a concerned citizen, we are concerned about accessibility for all people. Handicapped people of all types have difficulty in getting around. We know that buildings built by tax dollars must now be accessible. What about all the buildings and facilities that are in existence? It should be a tax incentive to rehabilitate or remodel existing facilities. The handicapped, seniors, children, any person with ambulatory needs have difficulty in navigating steps.

HARRY G. BUNGE, OSAGE, IOWA

The building of low-cost housing for low-income elderly could be expedited, I believe, if the land cost could be included in the total cost of the FHA program, especially in those cases where low-income housing units have been built and in use for several years.

The experiance we have had in Osage with the two Hamlin Garland apartment homes or units is that the occupants are friendly neighbors, one to another, and the fellowship they find in visiting, raising small patches of flowers and vegetables, and the friendly rivalry is heartwarming and enriches their lives. But transportation is available on call, at 25¢ one way.

Transportation is very important. We found that riders were hard to get in the beginning, even though our bus was kept invitingly clean and our driver is as fine a person to take care of the riders as anyone could be. The attitude of all connected to the bus service is one of joyfully serving the total needs of the elderly. It takes time to develop a following, but we are gaining right along and the future looks much brighter. Our driver, anxious to please, took out one seat and got a board for a ramp so he could wheel a wheelchair person up the ramp without removing him from his chair. The attendant is not charged for the ride. Such concern spread, and more and more people are using the bus—a 15-passenger maxibus.

All of the programs are good and needed; however, since there is such variance in the needs of the various areas, the programs should be carefully fitted to the needs of the various areas and needs.

It is heartening to see help available, financially and otherwise, for many elderly who, because of misfortune, adversities, bad luck, etc., became elderly with few wordly goods. All of us are in accord with this thinking. I wonder if this attitude might not have been, or is being, abused by many who seem to be of the opinion that suddenly and automatically when you get to be 60 years old you become poor and not able to make your own decisions as you used to. The Government has to provide finances and programs to keep you occupied and solvent.

On the other hand I believe that there are many elderly who are asking, "Not what can I squeeze out of the Government, but what can I do to help my neighbor?" in the same spirit that President John Kennedy asked at his inaugural: "Ask not what can my country do for me, but rather, what I can do for my country?" Senior citizens should become aware of the needs of others and take care of them as they are able. In our senior citizens group we have done a lot of this; namely: Collecting and preparing items for handicapped at Handicap Village, Woodward, and Crestview; helping with three blood pressure screenings; arranging to help with the swine flue shots; providing quarters for the poppy sales; helping with cancer, Easter seal mailings, and stuffing; bus tours conducted to various places; responsible for the senior citizens Mitchell County bus; and many other needs as they come up—visiting sick, deliver meals-on-wheels, etc.

RALPH CAYLER, BANCROFT, IOWA

I hereby state that I am publisher of the Bancroft Register, a weekly newspaper published in Bancroft, Iowa.

As a public service, every week we publish an article by Adella Ulses, manager of the congregate meal site, and also an article by the activities director of the Heritage Nursing Home, as well as the visiting list at Heritage Nursing Home. All three of these columns are well received by our readers and attached is a copy of these columns from our newspaper.[1]

We feel that the community center alteration would be justified as money well spent for the senior citizens of the community. We also know that it would be used extensively by the senior citizens of the community.

PHIL DOOCY, BANCROFT, IOWA

I am president of the Bancroft Chamber of Commerce, which organization of some 50 businessmen unanimously approve the alteration project of the community center so that it can be used and benefit the senior citizens of the community. This project has unqualified support by the people of the community. It would be an example of money actually being used by the senior citizens for which it was intended.

RAY M. FAIRHOLM, DENVER, IOWA

I think it's time to separate the welfare programs from social security and from the programs for the older folks. It should not be necessary to be poor, black, or pregnant to receive aid. Also the administration of the elderly is too costly. All or most of the money meant for the older person is skimmed off by social workers. Even our State commission on aging is not above taking all they can get. I am president of the Hawkeye Valley Area on Aging (10 counties). I am 73 years old. Aside from my social security, I need no other help, but I see others who do.

WALTER A. FANGMAN, BANCROFT, IOWA

I am city clerk of the city of Bancroft and attached find copy of Minutes of the council as requested by HUD for the approval of the community center

[1] Retained in committee files.

alteration. This provides that the city would fund the operational costs of the community center up to $600 a year.

[Enclosure]

SPECIAL MEETING OF BANCROFT CITY COUNCIL, MAY 17, 1976

The special meeting of the Bancroft City Council was held at the community center at 7:30 p.m. on May 17, 1976.

The meeting was called to order by Mayor Pro Tem George W. Kockler. Councilmen present were: Stanley Lowe, Mike Schiltz, and Jim Summitt. Absent were: Joe Welp, Jr., and Roy A. Fox, mayor. Also present were the board members of Low-Rent Housing Agency.

The purpose of the meeting was to discuss plans of the new addition to the community center.

After discussion, it was moved by Summitt, seconded by Schiltz, that the city give the Low-Rent Housing Agency funds to maintain the new addition to the community center not to exceed $600 annually. Voted: Ayes: Lowe, Schiltz, and Summit. Nayes: None.

There being no further business to come before the meeting, on motion by Lowe, seconded by Schiltz, and carried, the meeting was adjourned.

GEORGE W. KOCKLER,
Mayor Pro Tem.

Attest: WALTER A. FANGMAN,
City Clerk

THOMAS W. GARRY, BANCROFT, IOWA

We have a sincere problem for our rural Bancroft elderly—lack of rooms for meals for them. Along with meals are also many social gatherings, which also lacks space. In this day and age of inflation, which is the hardest on our elderly, why could there not be something done to give them an area to meet, talk, and play with respect, instead of limited area to do these things—a place their age and hard years of service deserve?

ELIZABETH S. JOHNSON, MASON CITY, IOWA

One of the prime concerns in providing for people 60 years of age or older is to avoid the temptation to herd them, failing to remember that while they are in one age category, they remain people with specific personalities. One of the real needs of anyone is the ability to realize his personal worth and to achieve this, he must feel that he is a contributing member of the society in which he lives. He may be handicapped at an older age by limited income, by role loss, by health problems, but, above all, he must be able to retain his identity and his dignity as a human being. Having lived more than half a century with probably more than 40 years of experience in earning a livelihood for himself and others, other than the experience he has gained in simply living as long, he has too much to offer society to be shelved or placed in a position where his gifts are withheld from those who can and should benefit from them. Not to be able to give of himself lends to his frustration, depression, and finally to his defeat. To be able to do so gives him worth in his own eyes of those he serves. He is able to channel his experience and knowledge where it can benefit his community and he finds himself busy, interested, and alive.

It is to assist the older person to retain his sense of worth, to give him channels for giving of his experience and knowledge where they are of value, to help him retain his vitality and zest for living that the retired senior volunteer program exists. The person who is herded, who is patronized because of his age, loses his dignity as a person. It is true that he may need assistance to remain economically able to contribute, through transportation programs, through nutritional food programs and the like, but he also has an equal need for being satisfied with his role as a senior member of our society. As a member of society he has the same needs that anyone would have—the sense of worth, the dignity of being a unique individual with a contribution to make to the total welfare of everyone. No one remains a vital, contributing member of the total society when they are out of contact with other members of that society. Grouping people by chronological age is unnatural and deteriorating to the personality.

It is for that reason that an abject fear exists among older people of becoming dependent and being relegated to a euphemistically named "retirement" home. No matter how well they are physically cared for and no matter what is done to inspire activity, because the situation is an unnatural one, it defeats the personality of the older person and society is the loser. The problems of the older American must be met but with respect for the cultural differences which exist.

The great thing about the retired senior volunteer program is that it is the individual who is important. It is the primary concern of the professional staff of an RSVP project to see that the personality of the individual is not diminished in any way by his participation as an RSVP volunteer.

C. L. KELEHER, BANCROFT, IOWA

I am Msgr. C. L. Keleher, pastor of St. John Parish in Bancroft, Iowa. In Bancroft, we have about 20 apartments for the elderly and a small community building, all constructed about 10 years ago with HUD funds.

About 2 years ago a program of congregate meals was set up in the small community building, for it was the logical location for such a project. The congregate meals program has been very successful, for not only have most of the residents of the apartments come for meals, but many of the nearly 100 senior citizens of the community also come. As a result, the community building is extremely over-crowded at meal time.

The local HUD board approved an enlargement of the community building, but we have been unable to obtain permission from the State HUD board. The reason given by them at a joint meeting of the local board and State board recently in Des Moines was that our enlargement plans went beyond the limit of their guidelines.

Could there be some consideration given to giving more flexibility to the HUD guidelines for community buildings?

Thank you.

JAMES KENNEDY, BANCROFT, IOWA

The community center building enlargement program in Bancroft was started to assist the congregate meals program. The large number of elderly who are now enjoying hot meals three times a week in our community center building is a tribute to the staff and the planners of congregate meals.

We have tried to use the funds that are already allocated for modernization, but cannot get approval from the Des Moines HUD office. They state that building a larger community room and feeding the elderly is not their area of concern.

We would direct your attention to a report by a Special Committee on Aging of the U.S. Senate, number 94–478, page 32, last paragraph: "Added cost for footage and construction because of nutrition program funds requires serving eligible low income elderly from the neighborhood as well as occupants in a development." This seems to me to be quite clear in its meaning and intent. Why should it be so difficult to understand for a government agency such as HUD?

I am sure that your office is well aware of the problems that the local housing authority has encountered. You have been sent copies of correspondence from the HUD Des Moines office and a representative from Senator Culver's office was at a meeting of the local board with the Des Moines HUD people.

We would appreciate your help. Thank you.

WILLIAM A. KENNEDY, BANCROFT, IOWA

I state that I am president of Heritage Nursing Home, a 40-bed community nursing home directly across the street from the community center in question. living within 300 feet of the community center are 20 occupants of the HUD project, 24 occupants of the Farmers Home Administration project known as Heritage Apartments, and 40 occupants of the nursing home. We have an active arts and crafts program and other programs at the nursing home and our

ambulatory patients are able to visit back and forth with friends in the HUD program units and also in Heritage Apartments.

The community center is so small that accommodating only about 20 people is worse than no community center at all and is therefore unsatisfactory to any program dedicated to the senior citizens. Pending for over 2 years has been their application for alteration. They have started a retired seniors volunteer program to operate out of the community center since we thought the community center would be altered but this project is being held in abeyance pending the final decision on this matter. Also, the transportation van is being held up since it was to be housed in the community building garage alteration, so you see the future of the senior citizens is definitely dependent on the progress of the community center alteration.

H. J. McNERTNEY, BANCROFT, IOWA

I, H. J. McNertney, make the following statement in regard to the alteration of the community center which has been pending for more than 2 years, and I have been a board member since the Low-Rent Housing Agency was started some 5 or 6 years ago.

So as not to be duplicating the record, I am enclosing a copy of my letter[1] of June 14, 1976, to which there has been no reply. This sets forth most of the facts, minutes of the local housing authority's meetings, and other pertinent data as it pertains to the pending alteration.

I must state first that the local board has worked hard on this project for the last few years and the fact that there is on hand some remaining funds out of the modernization grant which we received has been due to their hard work and effort. This all started when we received a modernization grant of $100,000 to correct drainage problems and other problems. Two bids were received in excess of $50,000 and through the efforts of the local board the low bidder submitted a bid lower than $20,000. Despite pressure and advice to not accept the low bid, the board did accept the low bid, work has been completed, and there is a remainingg balance on hand. The board has worked hard to save this money. The board is securing a bus so that the elderly will have transportation and, according to letter dated September 17, 1975, from the Des Moines HUD office, it appears that the garage can be approved in the form of a storage building provided it is detached. This interpretation is agreeable with the board and we also feel that this interpretation applies to the alteration versus addition argument that has been ongoing for some time. In one of the attachments to my letter of June 14 appear the minutes of the local board meeting of April 19, 1976, wherein our executive director having visited with representatives of the Des Moines office reported that the only way the project would be approved would be if we would secure an agreement from the city to fund the operational costs. This also I can verify as this was the agreement which I had secured from the Des Moines office and this was the agreement under which we secured the resolution from the city to fund the operational costs of this alteration to the operation of the community center.

The statement of understanding dated April 7, 1975, between H. R. Crawford, Assistant Secretary for Housing Management, and Arthur S. Fleming, Commissioner, stated that they were to pledge their diligent efforts to foster close cooperation and continuous liaison among the various agencies and to review from time to time the product of this collaboration and new potentials that may emerge. The action steps provided that HUD will be instructed that modernization funds can be utilized to accomplish alterations necessary in community space to accommodate meal preparation and service. We feel the community center can be so altered and architects have been employed and have reworked the plans three or four different times, all with HUD approval and have come up with a final plan which has been termed an addition rather than an alteration. All of the statements and principles to help the elderly and all of the money appropriated to help the elderly is meaningless unless it is translated at the local level and gets to the local elderly in terms of help. Much money has been spent by HUD in administrative road blocks, bureaucratic redtape, and repetitious paperwork, to stop this project from helping the elderly of the community. Regardless of this, on behalf of the elderly, many people have spent money, time, and sacrifice, written letters, made trips and telephone calls, because the cause is right. These people and the elderly of the community's vision of a community

[1] Letter and attachments retained in committee files.

center alteration can be realized if HUD officials would interpret the rules and regulations in a cooperative and fair manner in accordance with the intent of Congress and the signers of the statement of understanding referred to above rather than to engage in intentional administrative delays, intergovernmental paperwork and indecision, and bureaucratic autonomy.

FRANK O'CONNOR, BANCROFT, IOWA

I am maintenance man at the HUD program, also Heritage Apartments and Shannon Apartments, being a total of 66 rental apartment units plus the community center next door, and part of this complex is the Heritage Nursing Home, a 40-bed home.

In this community of 1,100 people are approximately 380 elderly. Therefore, I am dealing with our elderly—our surplus senior citizens. Our elderly are put out to pasture with nothing to do here in Bancroft. We are wasting our human resources, our elderly; they have no place to go and socialize or do anything. We do have the small community center which holds about 20 people. They serve congregate meals in shifts but there is no room for arts, crafts, socializing, or any other senior citizen activities.

For the last 2 years I have seen the elderly and heard them plead for alteration to the community center and although local people and groups write or call, they are delayed and receive no response. They are in a desperate state of despair and I hope that the senior citizens of Bancroft can be helped by providing an adequate community center for congregate meals, the transportation program, the senior citizens volunteer programs, and the other programs that they are working on.

MARY V. O'CONNOR, BANCROFT, IOWA

All of us are aware that we are bound by rules and regulations and laws. However, we also know that rules and regulations and laws are subject to change.

An example of a situation where a regulation could be given a different interpretation and a law amended lies in the situation now faced at our public housing facility, a HUD project.

On hand are funds labeled "modernization funds" which due to watchfulness on the part of the board of directors of the site were not needed to complete the job for which the modernization fund was granted. The Board then took the position that the money remaining should be used to enlarge the community building in the HUD project which is located centrally in the elderly units and directly opposite a FHA 24-unit complex of apartment homes and tenanted by other elderly and nonelderly as well. Although the HUD units are only able to house 20 elderly singles or couples, we have been serving a much larger segment of the other elderly in this community by offering the use of the community building as a congregate meal site. We are now actually suffering because there has been a tremenous response to this program and we have literally turned over the community building to the meal program and do not have room to provide any type of activity which does not fit into the dining room atmosphere and denies the elderly tenants of the HUD a place to use as intended.

No other suitable facility exists in this small town of approximately 1,100 population and even though a report prepared for use through a Special Committee on Aging of the U.S. Senate, No. 94–478, page 32, last paragraph, which states that at Government housing sites "added cost for footage and construction because use of nutrition program funds requires serving eligible low-income elderly from the neighborhood as well as occupants in a development," use of the modernization funds have been prohibited by the HUD Des Moines insuring office.

This particular case has other ramifications, for example the extremely high cost of utilities charged by the city-owned utility company which have resulted in putting the HUD project into financial difficulties and which has been quoted by the Des Moines insuring office as further evidence as to why the project

should be denied the permission to enlarge the community building. Due to the law which insists that only 25 percent of income may be charged for housing, we are not permitted to charge a rent in keeping with the increased costs of operation. In almost every instance the cost of utilities exceeds the rent which we are permitted to charge.

To sum up, we need funds desperately to accomplish our goal; enlargement of the community building which will enable us to better serve the over 300 elderly of the community and not just the 20 persons who now reside in the project.

Other avenues of funding have been investigated, a Federal grant or use of FHA funds, but the moneys have either been allocated or cannot be used by us for our stated purpose. We do not know when any other money will come to us, and for this reason we are asking if you know of any way that we can be helped.

Thank you for any consideration that you give to this matter.

MURIEL M. PETERSON, MASON CITY, IOWA

There is continuous talk of the elderly preferring to remain in their own home, and also there are comments about the rising costs of health care and growing numbers in nursing homes—not needing that level of care. Yet home care/health care services are the most difficult to obtain! They may be the most economical, but services are scarce to nonexistent, depending upon the locality and, if available, there is a waiting list. Medicare regulations are more strict for coverage of home health care than for hospitalization.

In Iowa, all but four or five homemaker service programs are under the department of social services (DSS). The DSS provides for the person whose income is within 80 percent of the State's median income, adjusted for family size. Cuts in allowable numbers of State employees or some DSS area administrators feeling homemaker services is not beneficial means home care service is difficult to obtain and no expansion of services possible. Persons exceeding the 80 percent guidelines must pay at least $4.23 per hour for service, if and when time is available. It is ironic the persons paying taxes (probably the greatest share) are the persons virtually denied services.

Nursing home costs are enormous, but what is being done to develop alternatives? Locally, nothing. It is easier to get funds through title XIX (medicaid) for a person's care in a nursing home than it is to get funds for other types of care. An adult day care program has much merit for our community, but where do you get the start-up funds—and where does coverage come to supplement the cost that the participants are not able to bear? The State of North Dakota received approval for title XIX to be used, but Iowa says "No, that is not possible." Both States are in the same HEW region—and the regional office OK'd North Dakota using it. Residential care centers are needed desperately—not the type of independent group housing of Shalom Towers or the Manor as mentioned at the hearing, but centers where staff are available to monitor needs, do meal preparation, laundry, cleaning, but no nursing staff. State Federal programs do not really pay for that level of care.

At the hearing, comments were made about winterizing/insulating older person's homes. Many older persons have decided years earlier not to keep up their homes because they'd not live long enough to benefit from the up-dating, but the Federal Government is supposed to step in and do it! That is perpetrating a bad situation. Older persons with health problems or physical limitation living alone and no neighbors nearby are in a very precarious and self-endangering situation. That is their right, but by fixing up their homes and providing various services for them, our tax dollars are encouraging inappropriate behavior. (Homemaker services are usually not provided if the environment is endangering, and the persons are assisted in making more suitable arrangements.) We must get away from the idea to own a home and to remain in it is all there is to life. Commitments to a physical/material object is overwhelming and placed in priority over life and limb.

Thank you. I've aired my gripes at the moment. About half of the patients with whom I work at NIMC are over 65 years of age, thus, in the 4 years I have been here, I have shared with many the frustration of bureaucratic redtape.

MARIE PAULUS, ROCKFORD, IOWA

First, I think we had a wonderful meeting and crowd. Over 11 towns were represented—people I didn't know. Also, we had over 50 Rockford residents, The panels were good, but we would have found more facts if people from the floor had been able to talk and explain problems on chore service. So many silly questions were asked—for example, "How far did your husband get in school?" The service doesn't always get where it is needed the most. Also, the insulation helps people really in need. Some could do it themselves if they got the help.

Also, I think most of the money put out to help the elderly is spent on jobs for younger people at desk jobs, and that they really don't understand the problems. By the time salaries are paid, money is gone. Lots of people who could use congregate meals are too proud to come. Many enjoy just being together—going at 11 for 11:30 dinner.

DAVID SCHILTZ, BANCROFT, IOWA

We have a good clean town with a growing population. We also have a good number of elderly people who don't have a place in town to have community lunches and other activities which they need very bad.

If I may add, the people of the HUD office in Des Moines are treating us like a bunch of criminals, just because we're trying to help these elderly people of our town.

The money which we are trying to do this with came from the HUD offices to fix a water problem we had in the low-rent housing project. We solved this problem with half the money they gave us, so I see nothing wrong with the idea of using the money we saved to better our community room for lunches. We need the extra room very much for there are a lot of elderly people in this town who depend almost solely on these lunches.

ADELLA ULSES, BANCROFT, IOWA

I am site manager of the congregate meals for the elderly in Bancroft. We serve 45 to 50 a day, 3 times a week, and desperately need your help and need to expand. The facilities we have are nice, but we need more room; 98 percent of the people taking part in these meals are from one-person households. No one will ever know what these meals mean to the elderly for fellowship and nutrition.

We serve in the community room of the HUD-Bancroft low-rent housing which accommodates 20 people, and we serve many, many more. According to HUD regulations, we are refused to use modernization funds even though we have them on hand for this project.

We have met with objections all the way for enlarging this building and need your help—please.

DONALD J. WELP, BANCROFT, IOWA

I am vice president of Shannon Apartments, a 12-unit rental housing project financed by the Farmers Home Administration. We have been advised by HUD to go to Farmers Home Administration for financing a contribution to the community center. However, they advise us this is not possible. We refer to the statement of understanding between HUD and the Administration on Aging concerning the nutrition program for older Americans dated April 7, 1975, and signed by H. R. Crawford, Assistant Secretary for Housing Management, and Arthur S. Flemming, Commissioner, wherein they refer to the implementation of the nutrition program and the collaboration between HUD and the Administration on the Aging and pledged their diligent efforts to foster close cooperation and continuous liaison among the various agencies and to review from time to time the product of this collaboration and new potentials that may emerge for their mutual benefit. This statement means nothing if it is not implemented on the local level and all funds go for administration, consultants, and experts, and none is spent for the elderly. We feel the elderly deserve a proportion of the funds allocated for them.

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THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 5—SIOUX FALLS, S. DAK.

AUGUST 18, 1976

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The Nation's Rural Elderly:

Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove, Iowa, August 17, 1976.
Part 5. Sioux Falls, S. Dak., August 18, 1976.
Part 6. Rockford, Iowa, August 18, 1976.
Part 7. Denver, Colo., March 23, 1977.
(Additional hearings anticipated but not scheduled at time of this printing)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

THE NATION'S RURAL ELDERLY

WEDNESDAY, AUGUST 18, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Sioux Falls, S. Dak.

The committee met at 9:40 a.m., pursuant to notice, in the Senior Citizen Center, 132 South Dakota Avenue, Sioux Falls, S. Dak., Hon. Dick Clark presiding.

Present: Senator Clark and Representative Larry Pressler.

Also present: William E. Oriol, staff director; Philip S. Corwin, professional staff member; John Guy Miller, minority staff director; and Alison Case, assistant clerk.

OPENING STATEMENT BY SENATOR DICK CLARK

Senator CLARK. Good morning.

I have a very brief statement that I would like to open with. Senator McGovern has also sent a statement for the record that I will read and then I want to turn to Congressman Pressler, who is a member of the House Aging Committee, for a statement. Then we will begin with the panels.

I think while we are talking we are going to ask the first panel to come on up, because we do have a great number of witnesses and only about 2 hours and 10 minutes to get through about 12 or 15 witnesses. So Peter Johansen and Vada D. Thomas, come on up and have a seat here.

Then the second panel, if they will be ready, includes Phil Burke, Shirley Overland, Irene Eilts, Larry Oppold, Lillian Nace, Ray Bagley, and Gerry Eisenbraun.

I do want to welcome all of you to this hearing. We are particularly happy to be in Sioux Falls and to talk about problems of the rural elderly, which is what these hearings are really all about. We decided about a year ago in the Senate Committee on Aging that we would hold a series of hearings on how elderly people are affected, particularly in rural areas, in the smaller cities, in the towns, and across the countryside.

We have had four hearings, and this will be the fifth that we have held here in South Dakota, Nebraska, and Iowa. The last hearing will be in Rockford, Iowa, this afternoon. In the meantime, we are going to be riding on the bus out to Canton at 11:45 when we finish here.

If I might just summarize in 1 minute what we found in the hearings that we have held so far, I would say this: First and foremost, people who live in rural areas, in the small towns, and in the small cities are affected by transportation, because it really does not matter much what kind of facilities you have—health care facilities or anything else—if you can't get to them. We found an enormous need for buses—for transportation in the rural areas, first and foremost.

We found further that there are real problems, particularly in the Midwest and, I think, all across the country, in terms of health care. We simply do not have the health care facilities in the smaller towns and across the countryside that we badly need. We are going to be talking some about that in terms of extended health care. It does not mean that we can have a doctor and a hospital in every small town; what it does mean is that we ought to have some kind of basic health facilities.

We have also learned and talked with people about the problems of nutrition—the congregate meals program, the meals-on-wheels program, and what that has meant to older people. Again we are only scratching the surface, but it is an important beginning, not only in terms of diet, but in terms of the sociability that is associated with it—the fact that people have an opportunity to get together, talk, and see one another.

We have talked about problems of legal services for older people. Above all, we heard, particularly yesterday, from older people about housing.

So we have a great number of specific problems that relate to people in rural areas.

Now I have two statements here, one from Senator George McGovern, as I said, and another from Senator James Abourezk. I think, rather than reading all of the statements, let me simply read a couple of paragraphs from each. First from Senator McGovern.

DEAR MR. CHAIRMAN: It is a pleasure to welcome the members of the Senate Special Committee on Aging to South Dakota. I believe your committee can learn a great deal about the problems of the elderly from your visit here. Too often testimony is only received in the major cities, ignoring the unique problems of the rural elderly. South Dakota's 116,000 senior citizens—

That is an interesting figure, 116,000—

represent a major percentage of the State's population, yet very few have access to public transportation or the other services offered in large metropolitan areas.

Now Jim Abourezk.

First of all I would like to welcome Dick Clark and the Senate Special Committee on Aging to South Dakota. South Dakota is one of a handful of States where the majority of elderly citizens live in small towns and rural areas, and we are honored that the committee is looking into this important issue.

Now I will make both of those complete statements a part of the record at this point.

[The statements follow:]

STATEMENT BY SENATOR GEORGE McGOVERN

It is a pleasure to welcome the members of the Senate Special Committee on Aging to South Dakota. I believe your committee can learn a great deal about the problems of the elderly from your visit here.

Too often testimony is only received in the major cities, ignoring the unique problems of the rural elderly. South Dakota's 116,000 senior citizens represent a major percentage of the State's population. Yet, very few have access to public transportation or the other services offered in large metropolitan areas.

As chairman of the Select Committee on Nutrition and Human Needs, I have been particularly concerned by the problem of malnutrition which plagues millions of our Nation's senior citizens. We have made great progress in this area with the title VII elderly nutrition program, but much more can be done.

The Nutrition Committee recently held hearings, for instance, on the nutritional problems of our Nation's housebound elderly—those persons who cannot attend the title VII congregate meal sites. As you will undoubtedly discover again today, confinement to nursing homes is often not a result of physical illness, but the result of an inability to shop and prepare food.

I am extremely proud that you and 12 of the members of your committee have joined as cosponsors of the National Meals on Wheels Act of 1976 which I introduced following our recent hearings.

This bill will be a major step forward in our efforts to feed the 3 to 4 million older Americans who would like to, but cannot, attend the title VII nutrition sites. In South Dakota, as well as other rural States, this program would be a valuable addition to our services to the elderly.

Again, Mr. Chairman, I and the citizens of South Dakota extend our warmest welcome and our sincere hope that your inquiry today will lead to a better life for older Americans.

STATEMENT BY SENATOR JAMES ABOUREZK

First of all, I would like to welcome Dick Clark and the Senate Special Committee on Aging to South Dakota. South Dakota is one of a handful of States where the majority of elderly citizens live in small towns and rural areas, and we are honored that the committee is looking into this important issue.

I regret that I am not able to attend personally to hear the witnesses and participate in the discussion. Although I know that many South Dakotans already admire the good work of the Special Aging Committee and my colleague Dick Clark, I want to mention in particular the very high regard I have for the way the committee goes about its investigations and hearings under the leadership of its chairman, Frank Church, and the outstanding work that Dick Clark has done in representing the needs of older people in our part of the country on the Aging Committee.

Those of you in attendance can be sure that what you say will be taken seriously and can be used by Senator Clark and the committee staff within the framework of considerable attention they have already been directing toward problems of the rural elderly.

South Dakota was not an early frontier. Life has always been hard here, and this year's drought only reminds us of the endurance and persistance of the settlers who scratched a living out of the soil.

But in South Dakota, unlike other States, those pioneers, those first generation settlers, fathers and mothers of our State are still among

us. Every town in this State has its elders who came with their parents or as young people to settle the plains, to make a new life, and to develop South Dakota.

When we talk about South Dakota's rural elderly, we are talking about the people who not only figuratively, but literally, built our State, established our way of life, and toiled for the comforts we enjoy today.

Thus, it is a special irony that the rural elderly are, by and large, missing out on the benefits of that affluence. We have 18 counties without an active physician; 29 rural post offices have been closed in the past couple of years; passenger rail service has been gone for 20 years, and rail abandonments mean that more and more towns are without freight service altogether. Family farmers are selling out, and estate taxes make it more difficult to keep a farm or business in the family.

This is not the heritage our older citizens deserve. When we in Congress make an attempt to use their talents and enrich the lives of older South Dakotans through green thumb, foster grandparents, elderly housing, senior centers, tax credits, food stamps, and other individual programs, we face vetoes, impoundments, and impediments from an administration which seems to be long on handwriting and short on compassion.

The less an American fits the description of middle-aged, middle-class, metropolitan, and white, the more that individual must depend on public services, and the more difficult it is to provide the services needed.

Rural Elderly Deprived of Urban Services

The rural elderly—probably the most needy—are also the most difficult to serve. Consider some of the main issues before the Congress: In the health field, doctors are short in rural areas; facilities are lacking; emergency medical services are expensive; and costs of specialized care is astronomical.

In transportation, the same deregulation of railroads, trucking, and airlines, which would lower prices for urban residents, would mean no service at all to many rural areas and the biggest hardship on the elderly who depend on public transportation.

Even the postal service is trying to cut back its service—which is least profitable and most inconvenient to provide—to rural post offices, rural home delivery, postal money orders, and other special services.

We have heard a lot about big government and about government interference in people's lives, and there are changes which should be made, but I think it is important to remember that the poorer you are, the older you are, the farther you live from the city, the more government is necessary to assure equal opportunity for a decent life.

It would be nice if I could say today that if we do X first, Y second, and appropriate Z per year, the conditions of the rural elderly will be improved. It doesn't work like that. Housing, income maintenance, crime prevention, jobs, health care, transportation, consumer representation, legal and nutritional counseling—the rural elderly can use all of these services and more, yesterday. The rural Indian elderly, of whom there are many in South Dakota, have even greater needs as a group and even more difficult times trying to take advantage of what America has to offer.

Clearly, we must enable more people in more places to participate in existing programs. But what we really need is an attitude of caring on the part of government and of society as a whole. We need to realize that cuts in government, deregulation, laissez faire in reality mean that the rural elderly and others who are least able to cope are also the first to suffer. A life of dignity and a living income should be a basic right of every American, and certainly of everyone who made the State of South Dakota and the Nation the sort of country which we can all be proud of.

Senator CLARK. I would like to ask Congressman Larry Pressler who is a member of the House Committee on Aging for any comments he might have.

STATEMENT OF HON. LARRY PRESSLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Representative PRESSLER. Thank you very much, Senator Clark.

I am here mainly to listen. I see a lot of familiar faces here. I think the hearing is important and we thank you very much, Senator, for bringing this committee here to South Dakota because the vast majority of South Dakota's elderly—57 percent of our elderly—live in small towns and rural areas. I come from Humboldt out here which is one of those small towns and a lot of the Federal programs do not reach people in rural areas or small towns. As Senator Clark has pointed out so well, transportation and health care are two of the principal problems that senior citizens in my district at least are experiencing.

I have a statement which I am going to insert in the record to save time. I might say that studies have shown that nationwide 27 percent of all Americans 60 years or older live in what we describe as rural or farm country, but in South Dakota that figure is much higher. So with that I am going to insert my statement into the record so we can spend more time listening here.

It was the Education and Labor Committee, the Subcommittee on Education, which John Brademas chairs and which I am privileged to serve on the House side, through which the Older Americans Act was authorized. I was a cosponsor of that act, particularly the transportation portions of it.

Thank you very much for being with us.

[The prepared statement of Representative Pressler follows:]

PREPARED STATEMENT OF CONGRESSMAN LARRY PRESSLER

It has been said that approximately 8 million persons, or 27 percent of all Americans 60 years and older, live in what may be described as rural or farm country. I believe that we would find this a most conservative figure if compared to the rural elderly population in our State. Indeed, 83,000 of South Dakota's approximately 685,000 citizens—or over 12 percent—are 65 years of age or older. In view of the fact that, according to the U.S. Census Bureau, well over half, or at least 57 percent, of the residents of South Dakota are called "rural", and that one can hardly call a State with a land area of 77,047 square miles and a population of 685,000—9 persons per square mile—urban, I believe that it is particularly fitting that the first of the hearings on "The Nation's Rural Elderly" be held in South Dakota.

As a cosponsor of the Older Americans Act amendments, and a Representative of a State with an unusually large number of elderly citizens, I am especially concerned about the problems of these Americans who have contributed so much to

the growth and development of this great Nation. The problems faced by the rural elderly are especially perplexing. We find that providing even basic services—such as minimal medical and health care and transportation to and from town for groceries and necessities—becomes a major problem. I welcome Senator Clark and the Senate Special Committee on Aging to South Dakota, and I hope that these hearings will enable us to better serve "the Nation's rural elderly."

Senator CLARK. Thank you.

Now we are going to start with the first panel, Peter Johansen, chairman of the South Dakota Advisory Council on Aging from Yankton, and I think he is accompanied by Jim Anderson who is director of the South Dakota Office on Aging. We will hear first from Mr. Johansen.

Let me say that because we have about 15 or 20 witnesses and just exactly 2 hours, we are going to ask you to try to limit the statements to about 5 minutes and then we will have some time for discussion.

You go right ahead, sir, any way you would like to proceed.

STATEMENT OF JAMES V. ANDERSON, ACSW, ADMINISTRATOR, SOUTH DAKOTA OFFICE ON AGING, DEPARTMENT OF SOCIAL SERVICES

Mr. ANDERSON. Mr. Chairman, as a result of the staff contacts that have been made, it has been suggested that I make a brief introductory statement first and then Mr. Johansen will continue.

Senator CLARK. Very well.

Mr. ANDERSON. My name is James V. Anderson. I am the administrator of the South Dakota Office on Aging, a unit of the State Department of Social Services.

On behalf of Governor Richard F. Kneip, I welcome you to South Dakota for this hearing in your series on "The Nation's Rural Elderly."

Governor Kneip is not able to be present at this hearing today but in many ways he has shown his understanding of the concerns of older citizens of this State and has supported legislation and services for their benefit. He is pleased that you and staff of the Senate Special Committee on Aging have come here to listen to the people of this State.

To begin, I will outline some characteristics of this very rural State and then further information will be offered by a person with more personal experience on aging—its problems and successes.

In brief, this statement presented by the office on aging and the advisory council on aging cannot fully represent the concerns and resources of all public and voluntary agencies. Some subjects should have further presentation by organizations dealing with health, education, labor, economic opportunity, and other social services.

From the perspective of our specific responsibilities, we offer the following comment on the status of older persons in South Dakota and on a number of programs and services.

South Dakota has a total population of 682,900 inhabitants of all ages. Seventeen percent, or 116,000, are age 60 or older.

PREDOMINANTLY RURAL AREA

South Dakota remains predominantly rural, with 55 percent of the population remaining on farms and in smaller towns, and 45 percent located in communities of 2,500 or more inhabitants. There are only 26 towns with a population of 2,500 or more. There is no major metropolitan area.

Average county population of persons age 60 and over is 1,724 persons. Forty-four of the sixty-seven counties have older populations which fall below that small average. In those counties the average falls to 859 persons. Twenty counties have 700 or fewer persons in that age category.

American Indians comprise 2.3 percent—10 times the national average—of the State's population age 60 and over. Approximately 8,400 square miles, or 11 percent, of South Dakota is designated as Indian reservation.

Currently 30,423 persons, or 26 percent, of the State's population age 60 and over have incomes below poverty level. Lack of employment opportunity is a major cause.

"Housing remains the paramount problem of poor and elderly persons," according to a study made by the South Dakota Economic Opportunity Office. "Blighted housing conditions contribute to the physical, mental, and social instability of their occupants."

Unemployment, rising energy and food costs, and inadequate housing all pose serious problems for elderly persons, especially those with fixed incomes—and that tends to be most of them.

Age discrimination and mandatory retirement hold down the income levels of elderly persons. Social security and supplemental security income benefits do not keep pace with inflation and cost-of-living increases which confront unemployed elderly.

It was the consensus of the 1971 White House Conference on Aging that distance is a major problem in delivery of Older Americans Act programs and services in rural areas. This is true of most social services provided in South Dakota. Even in towns, lack of transportation keeps many elderly, disabled, and poor persons from getting to vital services.

The success of nutrition programs for the elderly is dependent upon efficient provision of supportive services such as transportation, outreach, escort, nutrition education, health and welfare counseling, shopping assistance, information and referral, and recreation services. Provision of these services means that problems of distance unique to each of these services must be dealt with.

Now, Senator, to discuss some aspects of the service delivery system, I wish to introduce the chairman of the South Dakota Advisory Council on Aging. He is Mr. Peter B. Johansen of Yankton. After a long career in business, he served for a time on the staff of the State office on aging where he helped in the establishment of senior citizen centers and retired senior volunteer programs. Still resisting retirement, he has taken time off from his current full-time job to be with us here.

STATEMENT OF PETER B. JOHANSEN, CHAIRMAN, SOUTH DAKOTA ADVISORY COUNCIL ON AGING, YANKTON, S. DAK.

Mr. JOHANSEN. The State's 225 senior citizen service centers and clubs, mostly located in rural communities, are the most significant focal point for delivery of social services to the elderly.

More and more senior centers are becoming multipurpose senior service centers providing a range of service beyond recreation. Such services include information, referral and outreach, nutrition and nutrition education, home-delivered meals, education and life enrichment, health services, volunteer services, counseling and assistance with social security, SSI, sales tax relief, medicaid, medicare, and other problems.

Under Older Americans Act regulations the definition of a multipurpose senior center includes being open to constituents 30 hours per week and having a full-time director. This puts rural areas at a disadvantage. In the smallest communities a center may provide important services though it may not need, nor be able to afford, a full-time director. Regulations presumably intended to encourage good use of resources should recognize sparsely settled areas as well as cities, so that rural elderly will not be ineligible for possible benefits.

In many of South Dakota's communities there is no available facility that is suitable for successful senior center services and activities. Often these small towns have acquired unused, older buildings in need of repair and with architectural barriers. These buildings were not designed for senior center purposes, most having been places of business or large old houses, and are inadequate without repair, alteration, or renovation. Thus the new availability of Older Americans Act title V funds for acquisition, alteration, or renovation of these buildings is a welcome resource.

RESPONSIBILITY FOR ADMINISTRATION

Officially, administration of title V is being carried out directly between prospective applicants and the Administration on Aging in Washington, D.C., but State units on aging have been called upon by the Administration on Aging to disseminate information and application materials. Thus, it is the State agency which is seen by the applicants as the responsible contact and from whom adequate and timely assistance is expected. However, too little time was allowed, the materials are partly new and complex to this program, and not all materials were sent out by the Administration on Aging when promised.

Some of the application materials to be used had not arrived even 2 weeks before applications were due at the Administration on Aging. There could not then be adequate preparation by the applicant, nor technical assistance and prioritization by the State agency. A 12-day extension which has now been announced will help only a little. The result has been frustration for the applicants, a poor image for the Administration on Aging and the State Office on Aging, and unnecessary difficulty in providing technical assistance, coordination, and manpower for this purpose.

Transportation poses a problem for all elderly, particularly rural elderly, and consistently ranks as a primary concern. Federal and State departments of transportation should continue their priorities for stronger emphasis on rural transportation with consideration for disadvantaged persons such as elderly, handicapped, low and middle income.

Basic needs of older citizens are not unlike those of the general population, but assessing appropriate services to meet those needs is much more difficult for them, particularly the disadvantaged, low-income, or infirm elderly. We make extensive use of the personal, one-to-one contact of outreach workers to help older persons receive services for which they are eligible.

Related to outreach is information and referral. In July 1975 a statewide service called TIE-LINE was implemented to provide toll-free access for all citizens to more than 6,500 public, private, local, State, and Federal agencies that can help them. The office on aging supports, through funding and technical assistance, the special efforts of TIE-LINE to serve more older persons.

Important to service delivery is training. Through Older Americans Act and other funding, experts in the field of aging have conducted sessions on a wide variety of topics geared to increasing the expertise of service providers and the capacity of older persons to serve themselves.

The office on aging annually develops and administers a State plan on aging and awards grants serving older persons in all counties. Efforts continue to build the capacity of comprehensive and coordinated programs for older persons throughout the statewide planning and service area. Together with the office, the advisory council on aging has helped secure legislation for senior citizens' use of school buses, school lunch facilities, county and city mill levies, and increased awareness of needed legislation benefiting elderly citizens.

The office on aging has field coordinators who promote coordinated planning and development of services and resources among senior organizations, agencies, and State and local governments. Also facilitated by the office on aging has been establishment of a statewide consortium of public and private colleges and interested organizations in the Gerontology Association for Training and Education—GATE.

Elderly Indian Needs

As already noted, the 2,600 older Indians comprise 2.3 percent of the State's population age 60 and over. The office on aging has made a major effort to develop services for older Indians, working with tribal organizations and providing technical assistance and Federal funds.

On the reservations, unemployment is high, averaging 47 percent. Transportation is scarce and distances are measured in hours of travel rather than blocks or miles.

At the Bicentennial Governor's Conference on Aging, May 1976, a task force on Indian affairs was convened to discuss needs of older Indians. Recommendations of this group reaffirmed the continuing need for transportation services and other supportive services. There is a desire for location of nursing care facilities on reservations; there are none now.

A person who cannot communicate with others may mistakenly be thought to be mentally deficient or at least uncooperative. The cause may be loss of hearing, or a speech impediment, but the resulting frustration, misunderstandings, and rejection can lead to withdrawal and inability to function adequately even for self-care.

In South Dakota, mobile equipment and traveling educational and therapy teams have proved the feasibility of communication disorder screening and education in rural areas. The results of such screening and education have significant impact upon the lives of older persons. Hearing and speech often mean the difference between independence and dependence.

With advanced age may come some changes in a person's lifestyle that are desirable and freely chosen and other changes that are unwelcome. Nearly all South Dakotans live in private homes or apartments where they have convenience, comfort, and security. In time, with changes in family composition, reduced income, and loss of some physical abilities, the older couple or single person often finds the familiar surroundings becoming less convenient and secure.

All have an economic concern; a balance between income and the costs of utilities, maintenance, taxes, and insurance. Other needs from time to time may be home health care or homemaker service, chore service, transportation, hot meals, telephone reassurance, friendly visits, spiritual ministry, counseling, or legal service. If the supportive service can be supplied, the older person continues to function well at a relatively low cost.

When a person needs additional or more concentrated assistance, a foster home, group home, long-term care facility, or hospital may be needed. Some older or handicapped persons have moved to these facilities when they could have continued at home if support services were available. Surveys indicate that this occurs in South Dakota at a rate higher than the national average. For both humanitarian and fiscal reasons the State is working to increase its home support resources.

Isolation, physical problems, death of loved ones, family problems, economic worries, psychosomatic illnesses, and other problems confront the older person. Ways in which mental health services can be provided to older persons are greatly needed.

Despite efforts, little progress has been made to link mental health clinic services to the needs of older citizens, especially rural South Dakotans. Nursing homes, for the most part, are not yet equipped to deal with older people with emotional problems.

These are some aspects of the needs of older persons and resources serving them in South Dakota. It is all too briefly and incompletely described, but the office on aging will submit a written statement which will add detail and will include some other materials of concern or interest.

Thank you for your interest and for this opportunity to contribute to your studies.

Senator CLARK. Thank you very much for a very comprehensive statement.

We will hear next from Vada Thomas, advocate of the poor, Catholic Social Services, Sioux Falls, S. Dak.

STATEMENT OF VADA D. THOMAS, ADVOCATE OF THE POOR, CATHOLIC SOCIAL SERVICES, SIOUX FALLS, S. DAK.

Mrs. THOMAS. Good morning, Senator Clark and Representative Pressler.

I want to thank you for the opportunity to appear here this morning to speak on behalf of the 23,000-plus elderly in South Dakota who live below the poverty level. I want to direct particular attention to those 5,500 who must rely on SSI to supplement their income.

It seems unjust to me that a nation which has established a poverty level of $2,800 a year as being the minimum needed to provide the basics of life to a single adult, $3,700 for a couple, can then proceed to assure them income of $2,013 to meet these needs. Now $2,013 is only 73 percent of the poverty level.

South Dakota did not accept the responsibility of supplementing SSI. Of the 5,547 aged people in South Dakota receiving SSI benefits in April 1976, only 266 persons were being supplemented by South Dakota to their own payment level in December of 1973, which was a maximum payment of $193 per month.

Recent increases in social security and SSI payments has decreased this number to 169 persons as of August 1, 1976.

At the last legislative session, Senator Michael O'Connor introduced a bill for State supplement to SSI to bring all individual recipients in South Dakota up to the State level of $193 per month with a pass-through for future SSI increases at the request of the State advisory council. But as often happens to legislation that benefits the poor, it got caught in the game of political football and went down to defeat in the closing hours of the session by partisan political maneuvering.

My recommendation to this committee is that the Federal Government assume the responsibility they accepted with the passage of SSI and raise the Federal SSI payment to at least the official poverty level. If this level is not appropriate for all areas of the United States, which I am sure that it is not, a regional approach could be used.

TRANSPORTATION FIRST PRIORITY

I would strongly oppose the urban rural system of payments for several reasons. First, the increased cost of transportation in extreme rural settings such as we have in South Dakota would more than equal the added cost of housing in an urban area. Transportation is a must for South Dakota's rural elderly, as many of them have to travel long distances to obtain medical services to purchase food stamps and even to purchase food. In small communities the food prices are much higher than they are in the supermarket in a larger city. Rural homes rely on fuel oil or bottled propane for their heat, which costs much more than natural gas.

Another area of concern to South Dakota's older population is housing. South Dakota has a severe shortage of low-cost rental units. South Dakota relies on property taxes for the support of their school districts. Many older people are finding this tax burden too much for their limited income and are being forced out of their own homes into rental units.

In the Sioux Falls area it is almost impossible to rent a one-bedroom apartment for less than $125 on the open market that would meet housing code standards. I have included a list with a sample of various rents. As a matter of fact, I understand that the situation is worse in Rapid City, Pierre, Brookings, Yankton, and Vermillion.

[The list follows:]

[From Argus Leader, Aug. 4, 1976]

ONE-BEDROOM PRICE QUOTATION

1. $230.
2. $150.
3. $95.
4. $175.
5. Rented—no price given. Electricity extra.
6. $175 plus electricity.
7. $130 plus electricity.
8. $175.
9. $85, basement efficiency apartment.
10. $140.
11. $170.
12. $95, efficiency only.
13. $125 plus electricity.
14. Rented—no price given.
15. $125, 6-month lease. $130, $50 deposit required. Electricity extra.
16. $100, includes utilities.

Mrs. THOMAS. South Dakota has 3,952 units available for the elderly and handicapped in subsidized housing. I must correct this a little bit because I have not included the figures from the Farmers Home Administration, so that could change this.

Now, 2,109 units are public housing while 1,843 are funded under other subsidy rent programs. Only 387 of these are on the Indian reservations. For the 32 percent of the elderly population having incomes below the poverty level, or more than 23,000 people, more low-income housing is needed to neutralize the effect of inadequate income.

If I could divert from my prepared statement just a moment, I was doing some back reading yesterday and I discovered that there was a bill introduced last year in the House of Representatives which would have provided an automatic grant subsidy for anyone on SSI. That bill I think was by Congressman Brademas—I am not sure. If that bill is still around, I would like to see it rejuvenated; it would solve this particular problem we are talking about.

MEDICARE, MEDICAID INADEQUACIES

In a recent study on the problems of social adjustments of the low-income elderly living in subsidized housing, I found that even though this minimized many of the problems of inadequate income, most of the persons interviewed said that they needed more money. One of the greatest needs of the elderly is dental care, including dentures. Neither medicare nor medicaid include dental care for adults. Dental care is important to the elderly—it is necessary for proper nutrition, good health, and personal dignity. I believe that we are really putting down our older citizens when we say to them that dentures or dental care is a luxury that is nice to have if you can afford it yourself.

Since July 1, 1976, optical and other medical services to adults have been seriously curtailed under the State medicaid program. Let me just remind you that money and services given to the poor help the economy of everyone as this money is put back into immediate circulation and, with the multiplier effect of four, it increases the economy of the entire community.

Thank you again for the opportunity.

[A letter from Representative Ottinger was submitted for the record.]

CONGRESS OF THE UNITED STATES,
Washington, D.C., August 9, 1975.

DEAR FRIEND: I am writing to enlist your support in the effort which I and other Members of Congress have undertaken to effect badly needed reforms in the supplemental security income program.

As you will see from the enclosed reprint from the Congressional Record, I have introduced legislation which would provide a supplemental allowance to SSI recipients such that they would not have to pay more than 25 percent of their income for housing. The allowance is limited to a maximum of $1,200 per year.

I firmly believe that such rent supplementation is one way of getting around the basic inflexibility of a program that has failed to take regional cost of living differences into consideration in the awarding of benefits. In the higher cost-of-living areas of the country, rising rent and utilities, coupled with a lack of adequate alternate housing at reasonable prices, has made it increasingly difficult for those on SSI to survive.

Although other housing allowance proposals have been introduced, I believe that my bill—H.R. 7138—more adequately addresses itself to the problem. The 25 percent allowance is in line with the standards set by other Federal housing programs, such as the section 8 housing assistance payments program.

We must demonstrate highly visible public support for the bill if it is to have a chance of passing. I urge you to encourage the members of your organization to write to their congressmen and, particularly, to the Members of the House Committee on Ways and Means, who are named on the enclosed list.

I would also be grateful if you would disseminate this information as widely as possible to any groups or individuals who might have an interest in supporting this legislation.

Thank you for your interest, and I hope that I can count on your support.

Sincerely,

RICHARD L. OTTINGER,
Member of Congress.

Senator CLARK. Thank you.

Just a couple of questions of each of you.

First, Mr. Johansen. You are obviously in a position to have thought a good deal about the problems of the elderly in South Dakota. You are Chairman of the Advisory Council on Aging. Obviously the purpose of this hearing is in no small part to try to see what is most important—not what is important, but what is most important—in the rural areas. As you look at the situation in South Dakota, if you could increase the funding—either create one new program or increase the funding significantly—which program would you put at the top: transportation, nutrition, unemployment, or housing? As you look at it, what is the greatest problem in South Dakota?

Mr. JOHANSEN. I would say, offhand, that transportation would be the most pressing problem.

POVERTY LEVEL MINIMUM

Senator CLARK. Now I want to ask Vada Thomas a question. I must say I agreed with a great deal of what you said—in fact, I can't think of anything you said that I didn't agree with—but particularly the point that medicare has a long way to go. As you say, you don't get dentures, eyeglasses, prescription drugs, and one could go on and on. I refer particularly, though, to the statement that it would seem that in a country as strong and as wealthy as this one, the first priority ought to be to bring people up to the level of poverty so that no one

lived below this level. I cannot remember the exact dollar figure, but it is amazingly small.

We introduced legislation to raise social security and SSI for every American to the level of poverty so that no one would live below the level of poverty. I cannot remember the exact dollar figure—it was much, much smaller than I thought. My recollection is that it is about the cost of three Trident submarines. It would be a remarkable thing to be able to say that we don't have anyone in this country that lives below the level of poverty. So I congratulate you on the statement.

The one question I wanted to ask you was which program do you see from your experience that we need most? I know we need a lot of different things, but do we need housing? Do we need transportation? Do we need health care? Which of those would you select as being the greatest need?

Mrs. THOMAS. In speaking of South Dakota as a total, I would have to again restate transportation. Looking more specifically to Sioux Falls, I see housing as the greatest need.

Senator CLARK. Thank you.

Congressman Pressler.

Representative PRESSLER. I have just a short question which I might address to both Peter and Vada, and that concerns the points that Vada made concerning optical care and other health care. I find I get a lot of mail from senior citizens who actually can't buy glasses, for example. I am the cosponsor of legislation to expand that coverage and I must say that I agree with the things that you have advocated here this morning, but what can we do in the Congress to jar loose thinking? Certainly I suppose by coming here and taking this testimony, but we get a great deal of mail, some of which I will insert into the record at some point.

Do you have any specific figures in your groups as to senior citizens in rural areas who are going without dental care or without optical care? It is very difficult to have specific figures on something like that because a lot of it is hidden poverty.

Mrs. THOMAS. I don't have a total figure. I can say in the last month I have had five requests for dental care and three for eyeglasses—calls from people who have called me and asked where they could get these.

Representative PRESSLER. I find a lot of senior citizens buy these glasses from a drugstore which may be helpful, in some instances, to save the cost of going to an optometrist. Have you found that to be true? There are very low-cost glasses available.

Mrs. THOMAS. I have not checked into that.

Representative PRESSLER. We don't have any figures available on that?

Mrs. THOMAS. No; I don't think there are any available at this time. Dental care—we are trying to document those in a more complex way for the people needing dentures.

POVERTY OFTEN HIDDEN

Representative PRESSLER. I think in our small town, Senator—and I hope the committee takes this thought back with them—there is a lot of hidden poverty that is very quiet. People in South Dakota and in your State are very proud—they have been very proud—and they are

ashamed to admit this need, but it becomes evident through routine things like eyeglasses and care of the teeth. The people just try to get along. We have a great deal of hidden poverty among the aged.

Senator CLARK. Thank you very much.

The next panel is on older service users and providers. Phil Burke is going to be accompanied by Shirley Overland; Irene Eilts is accompanied by Larry Oppold; and Lillian Nace and Ray Bagley are accompanied by Gerry Eisenbraun.

We are going to hear from this panel about older service users and providers, those people who provide the services and those people who use the services that are available to older people.

Now, again, because we do have so many witnesses today, let me remind those of you who are going to speak that we would like to have you try to limit your comments to about 4 or 5 minutes so that we might be able to ask some questions afterward; otherwise, we will just have to dispose of the questions.

Phil Burke, you are president of the Huron Area Senior Center, Inc., South Dakota. You may proceed at this time.

Mrs. OVERLAND. I am going to introduce Mr. Burke.

Senator CLARK. That will be fine.

STATEMENT OF SHIRLEY M. OVERLAND, DIRECTOR, HURON AREA SENIOR CENTER, INC., HURON, S. DAK.

Mrs. OVERLAND. Senator Clark and Representative Pressler, I am Shirley Overland, director of the Huron Area Senior Center, Inc., here in South Dakota. I am submitting a written statement on the development of our rural multipurpose center, along with comments on title V, our DARE program—developing adult resources in education—and our plans to remodel the Huron College dormitory for low-income elderly housing and a senior citizen center. At this time I will present my testimony to you in written form, but I am very proud to introduce to you Phil Burke, president of the Huron Area Senior Center, Inc.

[The prepared statement follows:]

PREPARED STATEMENT OF SHIRLEY M. OVERLAND

The Huron Area Senior Center, Inc., developed from its meager beginnings because of the interest and perseverance of several retired Federal employees. Some said it could not be done but they continued on in spite of numerous obstacles. The group met in various community buildings and churches before moving into an old rented hatchery about 4 years ago. Much of the remodeling was done by the seniors. Those attending numbered from 35 to 50. The present director was hired with the assurance that this was a part-time job and she could come and go pretty much as she pleased. Her salary was $3,000. She was expected to coordinate a few craft and recreational activities. The director, as an enabler type person, had an abundance of volunteer experiences in developing programs and working with people of all ages. Her study of other Older Americans' Act programs and attendance at workshops plus the enthusiasm and dedication of the board of directors led to increased program activities and involvement of other older volunteers.

The center membership mushroomed because of superb news coverage and excellent community involvement but mostly because "each one brought one." The senior center was the place where things were happening. Persons who had been living in isolation and loneliness were brought by other caring senior citizens and soon they too were involved. A wide variety of activities (often more than

the old hatchery could contain) enticed others to come just to see what was going on and soon they too joined the ever-increasing membership. The incubators were moved out of the back room to make more space. A new floor and ceiling, and a coat of paint made additional activity areas.

The Huron center was chosen as a title VII nutrition site largely because of the existing services, outreach, and concern of its members. The philosophy of service to all rural older Americans and community has built a firm foundation. Three new people joined the staff with title VII funds: a site manager, outreach worker, and bus driver. Two minibuses were provided, one with title VII funds and the other with one-third county, one-third city, and one-third center funds.

The center had and continues to have special events that generate some income. Examples: "Country Christmas at the senior center," "Around the world with the senior center," bake sales, gift shop open daily that sells articles made by senior Americans, quilt raffles, "Pioneer Cookery for Modern Cooks" (a cookbook), "Gambles Senior sellabration" (senior center takes over Gambles store for 3 days and handles all sales and countless demonstrations), gift shop at the South Dakota State Fair in Senior Citizens Building (manned by senior citizens serving coffee and cookies to thousands of pioneer South Dakotans during 6 days of fair), etc.

The center director is aware the senior center is not for everyone and yet there are many proud rural elderly that have tragic unmet needs. They continue to try and work things out alone because they'd made it through the dirty thirties and depression years. How could these folks be helped? A home care program could provide the answers but how with limited funding?

At the same time several members of the board were aware that the other small communities (200 to 500 population) in Beadle County (with large percentage of elderly) had no services provided. Each community was contacted and if interest was indicated, the Huron Center director and several board members met with key community leaders (elderly included). A title III grant provided for a home care director, funding for five satellite centers and money to develop a rural transportation program. The buses go weekly to each small town bringing the people into the county seat (Huron) for services, nutrition, recreation, and visitation.

The home care program has been most beneficial. Calls and visits come from families in other parts of the United States. They are concerned for an elderly parent. Grandma could come and live with them but she chooses to remain in her home. A home visit is made and the necessary help provided through information and referral with other agencies. Calls come from the elderly themselves asking for chore and homemaker services. If they cannot pay, they are assisted in working out the details with title XX. Doctors refer hospital dismissal patients on special diets to the home care director. She coordinates meals-on-wheels for these individuals. She visits daily in homes of elderly. She assists with tax refunds, SSI and other programs. She operates in a loving, caring, nonthreatening way. She accepts each individual as a fellow human being in need of love and a sense of worth. Each staff member at the Huron center functions in this way. This accounts for a membership that has crossed all economic barriers with an age span of over 40 years.

Each satellite center has developed its own program. However in this third year of funding (ordinarily the last) the Huron director is spending time monthly with each group. She is "planting seeds" to assist them in developing to their fullest potential. The philosophy that we look selfishly to our own needs so that we can have a good time is rapidly disappearing. Instead we will reach out to those on the fringe today and then leave something behind tomorrow when we are gone. In this way others can continue to build on our programs, thereby serving more people.

If through our services throughout the county we can help elderly rural South Dakotans to remain in their own homes or community and stay out of nursing homes, we will know we have served our fellowmen. A superb example of change of attitude is one couple in particular from one of the satellites. When we first visited their community to discuss a senior center, the committee was receptive. However, a great deal of the conversation that first day concerned an elderly man who had recently married a nearly blind, somewhat retarded young woman. They lived in a tarpaper shack with dirt floor and no conveniences. His prime goal was to have enough wood chopped to keep them warm the next winter. The community laughed about the ridiculous marriage. Several units of subsidized

housing were built and Jake and Erna moved in. I saw them 2 weeks ago at their senior center. They were accepted and loved. They were neat and clean. As we embraced, Erna told me proudly how she had gotten up at 5 a.m. to bake bread for the potluck dinner. She calls him "Daddy" and he calls her "Honey." If Erna is left alone because of his death, she will have loving friends to support her because now she belongs. This community realizes they must serve others, young and old. This is our mission.

TITLE XX FUNDS UTILIZED

Recently funds were made available through UMTA to purchase a van to transport elderly and disabled. With the approval of the county and city commissioners, we purchased the vehicle—80 percent UMTA and 20 percent local matching funds. The vehicle has been operating for 6 months. All three buses operate with title XX funds. The new program started slowly but is growing very rapidly. Elderly nursing home residents have gotten out of the home for the first time in years. They can now make visits to the doctor or hospital (for tests) without lying down in an ambulance. Some are able to come to the senior center. Elderly wheelchair individuals, still able to remain in their own homes, have built outside ramps so they, too can take advantage of the van. The joy in their faces when they can again be with old friends is heart warming. One lady in a wheelchair bought a piano. Getting out seemed to give her new hope. Title XX makes it possible to transport handicapped of all ages. A new adjustment training center is taking advantage of the bus to transport their workers. Crippled school children will be using the vehicle in the fall.

The Huron Area Senior Center, Inc., is the grantee for RSVP. They are using a second-hand bus purchased with senior center funds. ACTION has promised them a new van as funds are now available. As director of the senior center, I am grateful that we are the grantee for RSVP. We can coordinate our programs instead of competing as I see in many communities. Their work with the elderly has grown and will increase considerably when we are in the same building. RSVP has searched out individuals and provided meaningful volunteer opportunities. Grandmas and grandpas are tutoring slow learners in the schools. One elderly gentleman is teaching German to a high-IQ kindergarten youngster. Another lady, with tears in her eyes, speaks of "life" that was given back to her (after her husband's death) because she was again needed. Another (Nell, her poem is enclosed) [1] has been under psychiatric care all of her life. Now, she is off of tranquilizers and for the first time free and happy. "Continue whatever you are doing!" the doctor orders.

TITLE VII NUTRITION PROGRAM

The title VII nutrition program has changed many lives. Children visiting their elderly parents say mom and dad don't even look the same. The oldsters' eyes sparkle, they are healthier and life has taken on new dimensions. Oftentimes a person will come for a meal and after a few visits to the center, will become involved in a musical group, crafts, or some other activity. The nutrition program, senior center, and RSVP work together complementing one another. The services provided through title VII are most beneficial. Subsidized housing built in Huron apart from shopping facilities makes it impossible to get to a store. Weekly shopping trips, escort service, trips to doctors, and daily trips to the senior center for dinner and other activities make the difference between happiness and almost total withdrawal. The outreach worker assists and encourages (through home visits) the shy and reticent. She provides home-delivered meals for the ill. She gives love and support as needed as well as assisting with information and referral. The site manager plans menus and supportive programs that teach proper nutrition habits, fun times, etc.

Why is a senior center important in rural communities? A large percentage of rural elderly have come from the farm. They are work oriented as are most midwesterners. Their unspoken philosophy is "If you can no longer work, you are no longer useful." When eyesight goes dim, when the heartbeat weakens, or a number of serious operations cause the human being to slow down, uselessness takes over.

[1] See appendix 1, item 2, p. 312.

Dr. Peter Goldmark at the 1975 NCOA convention spoke in great detail of the movement of city people back to the rural areas. He spoke of the importance of planning for this time. In 1976, 1 out of 10 are 65 and older. By the year 2,000, 1 out of 5 will be 65-plus. This has tremendous implications for rural America. Multipurpose senior centers can provide the necessary services in a nonthreatening way. Multipurpose senior centers can provide services with less dollars than the government utilizes subsidizing nursing home residents.

How important is a senior center in a rural area? In 1974, the Huron Center can document keeping 44 persons out of nursing homes. In 1975, 46 would have had to be placed in a home if our services would not have been available. The example of the Huron Multipurpose Senior Center "rubs off" on other centers. We can see the influence within Beadle County and throughout the State. Visitors from other States stop to inquire about our service programs. The city and county commissioners say the few dollars we get are the best dollars they spend. If we weren't here, who would provide the loving support, the rides, the assistance for shopping and trips to the doctor? Who would say "I've missed you" when someone has been gone? Who would provide incentive for an 88-year-old lady to have hip surgery and be back on her feet in a couple of weeks? Or who would provide the importance of living to our 90-year-old, top quilt raffle saleslady when she broke her hip (on her birthday) and "breezed in" 3 weeks later under her own power?

Is a multipurpose senior center important in rural America? You bet it is! It may not be as visible as the large city complexes, but the same needs exist and they are being carried out in condemned buildings, old Legion halls, makeshift do-it-yourself deserted stores, old unsafe hotels that no one else wants, and even converted creameries and hatcheries.

COMMENTS ON TITLE V

It pleases me that some money is finally being made available for renovation and alteration of facilities to be used as multipurpose senior centers. The dollars that will be available to rural States such as South Dakota will be inadequate. However, the stress upon multipurpose senior centers is excellent. As in my previous testimony, you are aware of the importance I place on a service-oriented center.

Maching funds will place a responsibility upon the community, which is good. I am aware of all the projects that have been completed in our area for youth through BOR where half of the funds are Federal. It would be most beneficial if this same type funding was provided for older Americans.

If title V provides a quality building instead of a makeshift structure it will prove to be a good program.

A problem I foresee is small rural communities where renovation or alteration would be more costly than a new building.

DESCRIPTION OF "DARE"—DEVELOPING ADULT RESOURCES THROUGH EDUCATION

The DARE program is a joint effort of Huron College (Dr. David Nichols, community learning center) and the Huron Area Senior Center, Inc. It is unique in that (1) the college has adapted the traditional liberal arts disciplines to the particular needs of older persons: (2) the college staff has also used the teaching situation as a laboratory for their own learning and growth: (3) the college and center have worked jointly (young and old together) to develop a lifelong learning program: and (4) all additional available community learning resources are utilized. A copy of the DARE proposal[1] is included.

Previous to the development of the DARE program, the senior center director held a series of sharing sessions first with the elderly and then with all other agencies in the community that were providing learning opportunities. Many were dubious and said they'd never go back to school. However, when in serious consultation a goal was set "to get the cobwebs out of the brain," those in attendance were in agreement to move ahead into unchartered waters.

Enclosed are copies of the first two sessions of DARE.[2] Notice the utilization of various community resources. Several activities have become very popular

[1] See appendix 1, item 3, p. 314.
[2] Retained in committee files.

and have continued. Senior surfers, senior sharing group, and defensive driving will be repeated for the third time this fall. Approximately 300 senior citizens have taken part in these sessions. Other elderly have enrolled in regular college courses.

DARE is important because we are learning together—seniors, college staff, and community instructors of all ages. There is an openness and sharing that has brought about mutual respect.

The excitement that this program has motivated among the elderly has become contagious. "DARE kick-off breakfasts" before each new session are well attended and give the program the extra impetus needed.

The learning experiences of the college and senior center in the DARE could serve as a model for other communities.

PURCHASE OF M'DOUGALL HALL

McDougall Hall is a dormitory on Huron College campus to be utilized for low-income housing and senior center services.

For some time the senior center has been at a stand-still in further program development because of over-crowding. A larger building is needed. All available funding resources were explored, but no solutions were found. Land was purchased with center money and a plan drawn, but before moving any further, the board was in agreement that the unbuilt building was already inadequate.

The possibility of purchasing McDougall Hall was studied, but again funds were not available. When money was appropriated for section 202, a proposal was submitted to HUD in Washington, D.C. To be eligible for this loan you had to provide services along with subsidized housing. We were already providing the services, but needed more center space and knew many senior citizens were living in substandard housing. This appeared to be the answer; however, we were rejected for a loan. Inadequate money in section 202 plus the fact that we were Rural, were reasons given. In the meantime, the city had received a $150,000 community development grant to be utilized in remodeling the second and third floors of the dormitory for low-income senior housing. Architectural drawings are being studied by the State Housing Authority as to feasibility. The first floor and basement would provide senior center space. The rental from 23 apartments will, of necessity, pay the cost of remodeling and purchase price. A lease has been signed with an option to purchase included in the agreement. During the interim time while waiting for the money to become available we will rent the dormitory. This will make it possible to put the KARE (Kinship of the Ages through Reconciling Education) program into action. (A copy is enclosed including diagrams and program ideas.) [1]

The senior center members and Huron College students have experienced a glimpse into what the future holds. In January 1976 an interim class spent a month with the senior citizens. The students did research in the field of gerontology but most of their time was spent with the elderly. They delivered meals, they made home visits, they danced and played cards, they quilted and learned to crochet, they served meals and washed dishes, they took part in the musical groups, and visited the nursing homes. They took the oldsters to ball games and even attended a State gerontology conference together. Most of all, they learned to love one another and accept each other as fellow human beings. There was no generation gap. At the close of the month-long experiment the senior center building was filled to capacity as experiences were shared in a group meeting. Eyes were damp when students presented a plaque saying "You have touched us, we have grown." What more can be said?

Does this senior center on campus have implications for other communities? To Dr. Howard McClusky's (from the University of Michigan) knowledge there is no other project such as this in the United States. We expect that Huron will become a laboratory for other programs and colleges to study and copy. Students working on advanced degrees could find no finer situation in which to work and study. Where else could you work and live with the elderly being human together and have academic facilities so near at hand?

We know it is a brave venture into unchartered waters, but we have the confidence and enthusiasm to be pioneers. As Victor Frankl says "Love is wanting to uncover the potential in people." The elderly of the United States are our greatest untapped resource. Please help us "get it together" to help people to help themselves.

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[1] See appendix 1, item 4, p. 320.

ADDITIONAL COMMENTS

The severe drought in South Dakota, particularly in our area, is of grave concern. Budgets are being cut by the city and county. They are aware of our programs and services but tax dollars will be less. Our salary scale is meager. The director hopes for $8,500 in 1977, but other salaries are in the $3,000 to $6,000 range. Green Thumb (a valuable resource for us) and CETA workers are utilized. If there is a budget cut some service will have to be curtailed. Which one will it be? The government has emergency funding for other disaster areas. Is it possible that during these difficult years some subsidy arrangements could be made to keep a program from discontinuing its assistance to elderly? We ascertain that the drought will bring more people to our doors.

The question remains to be answered: Will we be able to assist them?

STATEMENT OF PHIL BURKE, PRESIDENT, HURON AREA SENIOR CENTER, INC., HURON, S. DAK.

Mr. BURKE. Senator Clark, Congressman Pressler, I might add that we were happy to have Mr. Oriol visit our center a couple of weeks ago. We appreciate very much his being there.

I am going to present to you sort of a run down on the birth and growth of what we think is a pretty good senior center. Ordinarily I don't like to read testimony, but I will.

As a result of the concern of a small group of retired Federal employees who are members of NARFE and the cooperation of several other groups such as the Huron Branch of American Association of University Women, Farmers Union, churches, and encouragement from the Governors Council on Aging, a meeting was held at the Farmers Union Building on March 23, 1971, at which time an advisory council of 11 members was named. One week later officers were elected officially setting up the Huron Senior Center. Les Wilcox was selected as president and served up until last January when I assumed the duty as president, because of his absence from the group. He is still a member of our cast, however.

GROWTH OF ORGANIZATION

This action started one of the fastest growing senior centers in South Dakota, from a humble beginning with about 35 members in March 1971 which met one afternoon a week in the youth activity center, to its present status with over 700 members and coordinating five different satellite centers in Beadle County with a membership of over 400.

The group met in various facilities in Huron for the first year—churches, Y.W.C.A., et cetera—until a year later the West Hatchery Building was rented and put in shape for center activities with volunteer labor by members of the senior center. I might add that you never saw a bunch of old characters like myself and several other people work and bleed and hurt and ache and everything else. A short time later a director was hired, Mrs. Shirley Overland, who is still serving in that capacity.

I might also add that Shirley Overland has been a great power in our organization. She is warm, she is feeling, and she is a real person.

We were funded in part by a grant from the Older Americans program, and since then we have been funded by Older Americans grants for some of our satellites. The county and city have been quite coopera-

tive and we have taken advantage of various title grants from other special programs.

From that point on we have upgraded our center to the extent possible considering our crowded space, and we are very, very crowded in our present location. We have added or sponsored the retired volunteer service program which needs to be located in another building because of the lack of space in ours; the nutrition meal program which provides meals for an average of 80 people per noon meal 5 days a week; a home care director who assists people in caring for themselves in their homes and directs meals-on-wheels which serves an average of 20 meals per day 5 days per week.

Through the help of the transportation program—title XX—we transport older Americans and handicapped persons in Huron and Beadle County, making regular weekly trips to the smaller towns and transporting eligible people to Huron which enables them to see their doctor, dentist, to participate in center activities, et cetera. We will be transporting several handicapped children to special schools and some adults to the job adjustment center.

Our members are active in many, many things. We are not just simply a charity group. We do all of the things that need to be done. One of the big activities of the center is the craft center which enables us to raise some money to supplement our limited budget.

We will shortly be moving into a dormitory on the Huron College campus, which is a new thing for South Dakota and probably one of the newest in the Nation, which will provide additional space and enable us to provide more programs, better social services, provide space for all our related programs and, hopefully, in the near future to provide low-rent housing for eligible persons.

One of the other big programs in our activities is the learning program. We have a program set up with the Huron College. You would be surprised the number of seniors that are waiting eagerly for new classes to start this fall. We have had several classes—not hardcore learning, I would guess—but learning the new math, defensive driving, and what have you. We feel that our center is a center that is fully aware of the needs of senior citizens. We recognize that senior centers are not for all people. Many people are not comfortable in that surrounding but with our percentage of people that do belong and do participate, we feel when we get to larger quarters we will have much greater participation.

Now just for a moment I would like to direct my comments to another subject, and that is the impact of the present drought conditions on future senior center activities. We are confronted with a serious drought in Beadle County which also affects a large portion of South Dakota. This situation will have a marked effect on both the county of Beadle and city of Huron's ability to properly fund, not only senior citizens' centers and other meaningful projects, such as roads and streets, in fact all of the functions of both governing bodies will be curtailed.

Tax Base Threatened

At the county level, about 23 percent of the tax base is derived from personal property. With the sale of whole herds of cattle in many instances, the partial reduction of herds in nearly every instance, the

inability of farmers to purchase new equipment, and the lack of sales on the retail level thereby reducing taxable inventories, these will be serious threats to the overall tax base which, along with a sharp increase in the delinquency rate, will put both the county and the city in a bad financial bind, especially in 1978 when the real crunch will be felt and which will also be felt in 1977 when the current taxes become due and the inability of people to pay.

I submit that consideration should be given to supplemental Federal funding to help finance centers to at least permit them to operate at present levels until local governments can regain sufficient taxes to pick up the load. We do take advantage of the various title programs at this point, but these programs are limited and not available for many of the basic operational costs which we have.

Thank you for the opportunity to speak.

Senator CLARK. Thank you very much.

Mr. Bill Oriol, who is the staff director, was telling me that he visited your center and it is located in an old hatchery. Our first hearing was in Winterset, Iowa, the day before yesterday, and we met in a senior center which was formerly a creamery, so it looks like we are really taking advantage of the agricultural buildings.

Mr. BURKE. And they both smelled about the same when we moved in.

Senator CLARK. They probably did.

We are going to hear next from Irene Eilts of Spencer, S. Dak.

STATEMENT OF LARRY OPPOLD, DIRECTOR, AGING SERVICES CENTER, SIOUX FALLS, S. DAK.

Mr. OPPOLD. I am to introduce Irene.

I am Larry Oppold and I am director of the aging services center located in Sioux Falls, S. Dak., serving a six-county rural area. My main function is to train and supervise 10 workers who live and work with the elderly in their own communities. I am here today to introduce one of these workers to you and, as I do, I want to state that I feel one of the most effective ways to meet the total needs of the rural elderly is by funding salaries and training for these wonderful people called outreach workers. The presence of an outreach worker in a community means not only skilled individual attention for needy elderly but their presence causes a process of community awareness and response to the elderly that is very effective.

At this point I would like to introduce Irene Eilts and let her explain some of the things that have happened in her community and in other communities in the six counties where our program operates.

STATEMENT OF IRENE EILTS, SPENCER, S. DAK.

Mrs. EILTS. Thank you.

Congressman Pressler and Senator Clark, I am Mrs. Irene Eilts, an outreach worker from McCook County. My home community is Spencer, S. Dak. I appreciate the introduction given me by the director. I feel the role of an outreach worker is very important to serving the needs of the individual elderly, their families, and their communities. I have been trained and involved as an outreach worker in my

community for the past 2 years. I have seen the confusion, isolation, poverty, hunger, and pain of social withdrawal of so many elderly in my work.

I have also been richly rewarded in seeing so many elderly brought back to health through my efforts and those of the community volunteers that have helped me serve their needs. I want to emphasize the concept of volunteer help because part of my role as an outreach worker has been to educate and organize concerned individuals in communities to respond to their elderly neighbors' needs.

I must say the response has been terrific. In rural areas we have much desire to serve the needs of the elderly. All that is needed is someone to show the way. Outreach workers like myself in this area have been the catalyst for meals-on-wheels programs, transportation projects, visitation, and telephone reassurance.

There are some problem areas, however, that outreach and community resources have not been able to solve. Aside from income problems, the No. 1 problem among them is the need for homemaker service. Although the department of social service has continued to increase its homemaker service potential with local adult personnel, yet they cannot keep up with the growing demand for trained homemakers. In addition, the present homemaker program is not designed to meet the needs of those persons who require around-the-clock supervision.

As it presently exists, homemaker service is beginning to address the problem of alternatives to introduce visitation but this is only the beginning. Along with homemaker services, rural areas need financial support to supply home health aides and handiman service. In addition, funds are needed for physical and occupational therapy, for experimenting with day adult care and alternative living situations in the rural areas.

A ready resource is available in rural areas waiting to be developed to meet the above needs. This resource is still active older people themselves, especially the older women. Older women greatly outnumber the men because many are widowed. They are also poor—living on social security alone. Most desire to be active and useful to society and earn their own way. These women have been caring, feeling homemakers all their lives. Their talents and their contributions are still needed by society, especially the homebound elderly. These people, men and women, should have the opportunity for training in a paid service to their peers.

Volunteerism is great and should be encouraged in the area of service also, but persons living on poverty income should not be expected to volunteer their time and travel when others are paid professional salaries. Three thousand elderly in this immediate area are living on less than $3,000 a year. The senior companion program which addresses this need should be expanded to provide the opportunity for the elderly to be in service to other elderly. At the present time, there is no senior companion program in this State, and a very limited number in other States. I would strongly recommend an increase in Federal funding for this elderly employment service program.

In closing I would like to relate to you an experience of mine as an outreach worker. I have visited this lady very often as I realized she

had many problems. Being a very lonely person, she didn't communicate with people very easily. After visiting with her several times she realized that I was very concerned and was really there because I cared and wanted to help. By this time she had gained confidence and felt that she could trust me with her problem—and at this time it was a very serious one.

She had been informed that she would have to reimburse $1,800 to social security; also, she would not be receiving her check or be eligible for food stamps. She didn't have any money and didn't know where to go for help. I immediately went through the proper channels and things began to happen. Within 6 hours the problem was clarified. This $1,800 was an error, plus they also found out that she had been underpaid. Therefore, she received a bonus check for $400 and would receive more each month—and also be issued her food stamps. Needless to say, this lady was very grateful and happy, especially for the service of the outreach worker.

This is only one of the many cases that we experience. While much has been done, much still remains to be done. All of us that are involved with the older American program feel that we have only scratched the surface. There is not one of us who can say for sure that he may not end up as an elderly person living alone without transportation, without relatives and friends near—to feel very lonely, useless, and unwanted. We ask consideration in helping us to keep trained personnel at the grassroots level.

I thank you.

Representative PRESSLER [presiding]. Thank you very much for that fine testimony.

In the absence of Senator Clark who is being interviewed, I might call on Gerry Eisenbraun who will make two introductions, and then we will have some questions.

STATEMENT OF GERRY EISENBRAUN, STATE DIRECTOR, GREEN THUMB PROGRAM, NATIONAL FARMERS UNION, SIOUX FALLS, S. DAK.

Mr. EISENBRAUN. I would like to make a statement for the record and that is that Ben Radcliffe, the president of the South Dakota Farm Union and also chairman of the executive board of the National Farmers Union, who is the administrator of the national green thumb programs, sends his regrets due to other commitments. He would have liked to have been at the meeting today, so you will have to do with second best.

Also for the record I would say that I am Gerry Eisenbraun and that I am the State director of the National Farmers Union Green Thumb program in South Dakota. I am not here to testify, but I would be happy to answer questions pertaining to the green thumb program in South Dakota. We appreciate your calling this meeting on what we feel are the needs of the rural and the minority elderly and in having the opportunity to have several of our green thumb workers testify.

I have with me three green thumb workers that I would like to introduce at this time. First of all, Mrs. Lillian Nace of Flandreau in

Moody County, S. Dak. Mrs. Nace is a widow, 70 years young, has been with the green thumb program since 1969, and has done a tremendous job as the hostess of the senior citizens center there, but I will let her tell you about her work later on.

I have another. Mr. Ray Bagley of Madison in Lake County, S. Dak. Mr. Bagley is 61, a little bit younger than the average Green Thumber in South Dakota. He has been with the green thumb program since 1964. He started as a green thumb worker at the Lake Herman State Park and has been promoted, first to crew foreman, and then later on to the area 4 person. He, too, will tell you his part in the green thumb program.

Now I have another person with me that is not listed on the program. A little bit ago we were talking about some of the needs in South Dakota. We were trying to reach this lady for about the last week and we could not get through because she does not have a telephone. We found out this morning that in order to get a telephone to her it would take 2 miles of wire and posts, and about a $400 deposit. I thought I would just enter that in the record. She will tell you about that. Beatrice LaFromboise of the Sisseton-Wahpeton Sioux Tribe, Wilmot, S. Dak., in Roberts County. Mrs. LaFromboise is a widow, and started with green thumb during February of this year, is the safety monitor of the crew she works with, and is also a member of the South Dakota Green Thumb advisory board. This would be on the State level.

Mrs. LaFromboise would like to testify. However, we realize that you are under a strict time schedule, so she will testify only if time permits. She will be available, however, to answer questions and as a resource person if you would like to direct any questions after the presentation.

The South Dakota Farmers Union Green Thumb started in March 1968 in five eastern South Dakota counties. Since then we have grown from 5 counties and 72 workers to 29 counties with an authorized strength of 216 workers. I don't want to throw out a lot of statistics, but I do have some here that you might find interesting. The average age of the green thumbers in South Dakota would be 70 for a gentleman and 66 for the ladies. Out of the 116,000 people that are older workers in South Dakota, 31,000 are eligible for green thumb, and the Green Thumb program reaches only 6 percent of the people that are eligible. We have, at the present time, three applicants for every job that is available in South Dakota. We have requests for the green thumb program from 48 of the 68 counties in South Dakota.

Senator CLARK [resuming chair]. Forty-eight of the 68?

Mr. EISENBRAUN. Right. Senator, we are presently operating in 29.

To give you an idea of the breakdown in ages, out of the 216 people that we have on board, presently we have 24 that are under age 60, 32 that are between the age 60 to 64, 56 between 65 and 69. We have 60 people that are between the ages of 70 and 75 and, not to be outdone, we have 44 that work every day and who are over age 75.

Senator CLARK. Forty-four over the age of 75?

Mr. EISENBRAUN. Right. Our oldest workers are 85 years old, and I think we have two ladies and one man that are 85. So let's not shortchange the aged. I mean they are here and it isn't necessary that they

retire at age 65. They are active and there is a wealth of talent that goes to waste.

At this time I would like to introduce Mrs. Nace. She will make her statement and answer questions if you have any. Then Ray Bagley can go after that.

STATEMENT OF LILLIAN NACE, FLANDREAU, S. DAK.

Mrs. NACE. Senator Clark and Congressman Pressler, I certainly welcome you here. I am the hostess at the senior citizens center. I started September 15, 1969, and we have a lot of things in common. A lot of elderly people come to me with their problems. I am so happy. I have just moved into a brand new building. The county commissioners have fixed a gorgeous building for us and the people at the bank gave us the equipment, and it is beautiful. I mean, people are very generous to me in Flandreau—very good to me. Whenever I ask for anything, they are really helpful.

I think the green thumb program is really one of the most wonderful things for elderly people in Flandreau. We have 5 Indian women that work at the Indian school and they do the mending for 580 students. They fix the sheets, pillowcases, and the curtains for their dormitories there. I think, as Gerry said, one of them is 85 years old.

I have had five older people come to me with their problems: "Can you help me, Lil?" I will say, "Well, come and tell me what you want." We talk things over and I try to get help for them. They have been very good.

All in all, I think green thumb is really a good program because there are so many elderly people who think when they are 65 years old that they cannot work. As a matter of fact, I have a lady that is 94-years-old that comes to my center every Thursday for pot luck, and she helps clear the table. She helps, and I think this is really remarkable. If you see her walk on the street you would think she was about 40. As a matter of fact, she was a dressmaker, and she still makes her own clothes.

That is all I have to say.

Senator CLARK. Thank you.

We are going to hear now from Ray Bagley from Madison.

STATEMENT OF RAY BAGLEY, MADISON, S. DAK.

Mr. BAGLEY. Good morning.

GREEN THUMB PROVIDES NEW HOPE

Distinguished guests, Senator Clark, and Congressman Pressler, I am an area 4 person for green thumb and I will explain what the green thumb program has meant to me. Before working for green thumb, I was working for an independent mail contractor at Sioux Falls and I was cut down to 1 day a week driving 100 miles a day. Since I got hired for green thumb, it means keeping a home together. I have a disabled brother and an 80-year-old mother, which means that we can be together with my working for green thumb and watching over them.

My work on the road brings me in contact with many people. I have run into incomes as low as $88 a month, some a little over $100, trying to keep a home and pay taxes and live, which is next to impossible. I have met many people. Many live in cramped housing taking medicine, complaining, and still able to work. After we were able to put some of them on green thumb working a few days a week, you would not believe the change in appearance and all.

There are many intelligent people that have retired that could do most anything, and they do. I feel that green thumb is a wonderful program. I have always gotten along with the director and the staff, and I also enjoy working with older people and the staff sponsors.

That is about all I have to say. Thank you.

Senator CLARK. Thank you very much.

Before we go to the questions, I know that Congressman Pressler has another commitment, and I would like to give him the microphone if he has anything he would like to say before he leaves.

Representative PRESSLER. I just wanted again to thank the various witnesses. The reason I have to leave is because I am going to give a speech on vocational education in Watertown at 1 o'clock, and one of the sections of that speech is continuing education which will include senior citizens. I think one concept that we have overlooked in our country is the fact that continuing education, retraining, or even the training for crafts and skills in vocational areas is very important to senior citizens. This is something I hope we develop more.

I am going to stay for just a few of the questions here and then I am going to have to head towards Watertown for that 1 o'clock speech. I want to explain why I am leaving and thank everyone for being here.

Senator CLARK. Thank you.

Now time is short, but I would like to ask just a couple of questions.

First, Phil Burke, I wonder if you could summarize very briefly. You talked about the center at Huron and, although I have to admit I have not been in Huron since 1946—I guess that is 30 years—I remember the town and I remember the State fair there, and so forth. How would you summarize the value of a multipurpose center for senior citizens? Why should we continue to fund it? You know we put more money in that program this year and, although I don't have the figures in front of me, I remember Iowa is getting $75,000. I think we have about 3 million people. You have, I think, about 700,000 in South Dakota. So assuming it is evenly divided, I assume that there is going to be about $50,000 available or a little less than that, perhaps, in South Dakota.

Why are they important? Why should the Congress continue to fund these? How would you summarize the importance of them?

VALUE OF MULTI-PURPOSE SENIOR CENTERS

Mr. BURKE. Senator Clark, I think I could summarize it in this way. A multiple-purpose senior center is just good economics. First of all, a senior center is a meeting place for people who have retired or are no longer able to work and reached an age when they felt that they had to retire because they were 65, because of health, or what have you.

First of all, they have got to have a meeting place. Well, a meeting place in itself is rather meaningless unless there is some substance there. Now you take a multiple-purpose senior center. As I stated first in my testimony, some do one thing and some do another, but you have got to have a wide variety of things. Some people want to learn more, they want to hit the books a little bit. Some people want to learn some craft. Some people just want to do busy work. Some people want to work with wood, some people want to work with rocks, and some people want to do various other things.

I think the crux of the whole thing is this—and I say it is a matter of economics. We have made quite a study of this thing in Huron, S. Dak. We feel that we have kept a lot of senior citizens out of nursing homes—kept them in their own home where they want to be and where they are satisfied to be. We help look after their nutritional needs if they need that, or give them a place that they can come to, to do the things that they want to do and, at the same time, get loved and appreciated. I think it is strongly a matter of economics.

Now I had the girls run this off. They did a very good job in our senior center. They feel they can document it quite well. We have 50 to 60 people coming to our senior center that are well and healthy that would otherwise be in nursing homes, because we caught them just in time. You know what it costs to keep a person in a nursing home, whether the individual pays it or the public.

Senator CLARK. It is convincing testimony. You are a good witness.

Let me ask Gerry a question. As I understand, Gerry, you have got a program up in Sisseton. I have been in Sisseton, too, but I guess that has been about 30 years ago. I know that there is a large reservation there and, as I understand it, you have a green thumb program there. I think you indicated when I stepped out for a moment that there was someone here who might be able to answer questions about that program. I wonder—could I ask that person a question? Is that person in the audience?

Mr. EISENBRAUN. Bea, would you just step up here for a moment.

Senator CLARK. Gerry, for the record, would you introduce the lady?

Mr. EISENBRAUN. Yes. Bea LaFromboise, and she is from the Sisseton-Wahpeton Sioux Tribe. She is one of our green thumb workers there. She is also a member of the South Dakota Green Thumb Advisory Board.

Senator CLARK. What I want to ask you really is, we offered an amendment—in fact I was a cosponsor of an amendment—to introduce funding for the green thumb program. That is going to be coming up again in another year and I would just like to get your judgment in terms of what you have seen of that program and whether we should continue funding it at a higher level. Is it valuable?

Mrs. LAFROMBOISE. It is.

Senator CLARK. What do you thing of it?

Mrs. LAFROMBOISE. Yes, it is very, very valuable.

Senator CLARK. Why so? Why is it valuable?

GREEN THUMB PROJECTS

Mrs. LAFROMBOISE. We have been going around repairing and painting the homes of the people in Sisseton and then, with their help, they

are putting an addition to my house because I am raising seven grandchildren and the youngest is 3.

Senator CLARK. You are raising seven grandchildren and the youngest is 3?

Mrs. LAFROMBOISE. Yes.

Senator CLARK. How old is the oldest?

Mrs. LAFROMBOISE. Sixteen.

Senator CLARK. From 3 to 16?

Mrs. LAFROMBOISE. Yes.

Senator CLARK. What are they doing to your house? How are they helping?

Mrs. LAFROMBOISE. They are building a bedroom addition and a porch to my place, and they are still working. I didn't know I was going to come here. The crew is at my house.

Senator CLARK. I see. It is a good time to be gone.

Mrs. LAFROMBOISE. I had to leave them today, so my kids are cooking dinner for them.

Senator CLARK. Good enough.

Mrs. LAFROMBOISE. I got up at 4 o'clock to prepare the meal this morning.

Senator CLARK. Well, tell me this. If you didn't have that project——

Mrs. LAFROMBOISE. I would not get anything.

Senator CLARK. What would you do with all the children?

Mrs. LAFROMBOISE. Just get along, I suppose. I had to have that extra addition.

Senator CLARK. You would not have been able to do that without Green Thumb?

Mrs. LAFROMBOISE. No.

Senator CLARK. You think it has helped other people?

Mrs. LAFROMBOISE. Yes; it really helped other people, too.

Now a few other things. There are six Indian men working on the title X and six non-Indians. We all work together, and then I go 27 miles to work.

Senator CLARK. How do you do that?

Mrs. LAFROMBOISE. I leave at 7 in the morning.

Senator CLARK. What kind of work do you do?

Mrs. LAFROMBOISE. Well, I go over there and help the green thumb. I am a timekeeper there.

Senator CLARK. Good.

Mrs. LAFROMBOISE. I go help them. However, if I could paint, I would paint. Then I help with the senior citizens. They are making quilts and sofa pillows so they can sell them. Also, the senior citizens have one meal a week there on Thursdays.

Senator CLARK. I see. What do you think of that program where they have one hot meal a day or in this case, one a week?

Mrs. LAFROMBOISE. They really enjoy that.

Senator CLARK. How many people come to that program there?

Mrs. LAFROMBOISE. Through the meals?

Senator CLARK. Yes.

Mrs. LAFROMBOISE. Oh, from 15 to 20, and they really enjoy those meals.

Senator CLARK. I want to thank you very, very much for coming down and testifying.

Effect on Alcoholics

Mr. Eisenbraun. Senator Clark, we tried something a little bit different with our program there. There were a number of gentlemen that were eligible for green thumb that we have, since then, enrolled in the alcoholics program. One of the jobs that Bea had, to begin with, was to see that everybody got to work, and when they didn't show up in the morning, Bea would get into her car and go get them. She saw to it that they kicked a little money into the kitty so at least they had one hot meal a day—on those days that they worked. Since then, two of those gentlemen have enrolled to take further treatment. The working pattern is almost perfect and it has to do with Bea, because she watches those fellows and she takes care of them. She goes out and gets them if they don't come to work.

Senator Clark. We thank you very, very much.

One other question of the panel. Larry Pressler wanted this question asked and I am interested in the answer as well, Lillian, and then I want to ask Mr. Ray Bagley as well.

Specifically, what additional green thumb projects could be performed in your communities if you had the money to have it done? What would you like to see done?

Mrs. Nace. We have five men that work there. I think Gerry Eisenbraun should be very, very proud of his green thumb operation. They have an enormous 4–H building and they built it. I just don't have any special thing for them to do. They helped me move, and the building I was in—they cleaned it up so magnificently that you would think a women had been in there; they scrubbed the floors and everything.

Senator Clark. They are good for something once in a while.

Mrs. Nace. This is my third time and I hope it is my last time, but the first time I moved I had a little tiny place. The next time we moved, it was kind of a funny little story. I know you will all laugh at it, but the man that owned the building was really harsh to us. A community action man helped us but we just could not get any place with Mr. Fuller. We had some old toilets and some old sinks in the basement and we told him we had to get a hot water heater. We didn't have any money.

We started to paint the walls and we used 2 gallons of paint on a little space. A lady that works at the school came over when she got off—and I don't want you to all laugh about this—we had this darn old black toilet that was so black you could not even see it. I said to the man, "Buy me a new toilet," and he said, "No, I won't." One of the green thumbers got on one side and I got on the other and we got down on our knees and we prayed that we would get it clean. We finally got it cleaned. This is kind of an odd story, but nobody knows how hard the green thumb men work. They had scrubbed those sinks.

This man would absolutely not give us any new sinks and so they scrubbed them. We had an old stove in there and one of the green thumbers said, "Lil, I will scrub that." Afterwards I said, "You will have to scrub that again." He said, "We have to do that many times over; you are too particular." One guy had to wash the stove five times and we had to heat the water. We had a little two-hole electric plate. We finally got it done.

I tell you, I have a lot of respect for the green thumb men and women. I tell you, these men really have done wonders. If you ever see the building that they built, it is really nice. They helped with the courthouse and the park. They just do anything anybody asks them to do.

Senator CLARK. Thank you very much.

I want to ask Ray now, if you had any more money in green thumb and if you had any more jobs, what would you do?

FUTURE POSSIBILITIES

Mr. BAGLEY. In Madison it would set a standard with us, with the city, and the senior center. Schools are always needing more help. For instance, some schools with a custodian start at a quarter to 6 in the morning and go until 6 at night. Then there are the extra activities like at night watching the school. In Madison there are more and more parks and a lot of buildings to clean. I feel that there is lots of room for expansion.

Senator CLARK. Thank you very much for appearing as a panel. We appreciate it. You have been excellent witnesses and it has been good testimony for us to have.

Thank you.

Mr. EISENBRAUN. Senator Clark, could I impose for just a couple more minutes? We realize that you are going back to Iowa and we hear that green thumb will be starting their program in Iowa shortly, or maybe they have already.

Senator CLARK. That is right. We had a witness the day before yesterday talking about it.

Mr. EISENBRAUN. The green thumbers in South Dakota, I think, understand what you are trying to do and we, of course, like to give credit where credit is due so we are going to present to you the official green thumb hat.

Senator CLARK. Oh, really. [Applause.]

I don't know. Do you think that is pretty fancy?

Mr. EISENBRAUN. It says on there, "Senator Dick Clark, Honorary Green Thumber," so take it back with you.

Senator CLARK. Thank you very, very much.

You see, I don't have too big a head for it. [Laughter.]

Mr. EISENBRAUN. I purposefully made it that way because I wanted to tell you not to get the big head. You have to earn these, and there are not very many people who have them. You will join the ranks of people like Pat Nixon, George McGovern, and some of these people. So when you go to Iowa and visit the Green Thumb crews, take it along with you.

Senator CLARK. I will wear it.

Mr. EISENBRAUN. Take it along as identification.

Senator CLARK. Thank you very much.

We have three more panels and we have got about 45 minutes remaining. The next panel is one person, Jack Claymore, who is project director of the Cheyenne River Reservation in Eagle Butte, S. Dak.

Jack, if you would take about 4 or 5 minutes for your statement we would appreciate it. We are very pleased to have you here and we are anxious to hear your testimony.

STATEMENT OF JACK CLAYMORE, PROJECT DIRECTOR, CHEYENNE RIVER RESERVATION, EAGLE BUTTE, S. DAK.

Mr. CLAYMORE. I am Jack Claymore, Senator. I am glad to be here. I am testifying for the Cheyenne River Sioux Tribe.

I have some written testimony here, but what I would like to say—you want to know what the most important things are on the reservation. The most important thing right now is transportation, and a nursing home on the reservation. Right now the nursing homes that we are utilizing are off the reservation and it is a handicap to the elderly Indians because they like to speak their own language and they like to be closer to their own people so they can have visitation. They don't have that now and that is one of the most important things on the reservation.

Transportation—we cover a two-county area in Dewey and Ziebach Counties. Right on main Highway 212 are the only grocery stores that there are in the town, so outlying communities on the reservation do not have many grocery stores available. For these people to get to town, to get groceries and stuff, they have to hire somebody out of their pocket to get to town. Sometimes they cannot afford to hire anybody to come to town and buy groceries, but they will pay them in part for their groceries to bring them to town, and I don't think that is right at all. I think that transportation in order to procure groceries on the reservation is one of the biggest things that we need.

I also have some written testimony here on nursing homes[1] that I will just leave with you.

Senator CLARK. Good. We will make that a part of the record, too.

[Background material submitted by Mr. Claymore follows:]

BACKGROUND MATERIAL SUBMITTED BY JACK CLAYMORE

History: The Cheyenne River Sioux Tribe was originally a part of the Great Sioux Reservation which was set aside under the Fort Laramie Treaty of 1868. The first agency established for the Cheyenne River Sioux Tribe was in 1869, 10 miles south of the mouth of the Cheyenne River, along the Missouri River. It was named Fort Bennett. As a result of the division of the Great Sioux Reservation by the act of March 2, 1889, the Cheyenne River Sioux Reservation was set aside as a separate reservation. The agency was moved from Fort Bennett to Swiftbird Camp. The name of the camp was later changed to Cheyenne Agency. In late 1950's, the Oahe Reservoir was constructed for the purpose of generating electricity, irrigation projects, and flood control from the Missouri River Valley Basin. The Cheyenne Agency was moved again to its present location at Eagle Butte, S. Dak.

Tribal government: The Cheyenne River Sioux Tribe is a constituted authority under an act dated June 18, 1934, and is unincorporated. There are 13 districts established under the constitution and by-laws of the Cheyenne River Sioux Tribe. The governing body is composed of one tribal chairman, one tribal secretary, and one tribal treasurer; also, 15 councilmen from 13 districts to conduct tribal business in duly convened tribal councils.

In 1972, several members of the Cheyenne River Sioux Tribe appealed to the Federal court of the U.S. Governments to redistrict the Cheyenne River Sioux Reservation. The Honorable Judge Joseph Bottom, Federal judge for the State of South Dakota, issued a court order to redistrict the Cheyenne River Sioux Reservation to six Districts. Despite the court orders, the governing body of the Cheyenne River Sioux Tribe did not change.

Location: The Cheyenne River Sioux Reservation is located in the north central part of South Dakota, about equidistant from Rapid City and Aberdeen.

[1] See appendix 1, item 5, p. 330.

Pierre is approximately 90 miles southeast of Eagle Butte. The agency for the Cheyenne River Sioux Reservation is about 100 miles long and 50 miles wide. The Cheyenne River Sioux Reservation is bounded on the east by the Oahe Reservoir and on the south by the Cheyenne River and the Oahe Reservoir. All of Dewey and Ziebach Counties of South Dakota are contained within the Cheyenne River Sioux Reservation. The reservation is 4,392 square miles and has 300 miles of BIA roads.

Transporation: The transportation problem has been with the Cheyenne River Sioux Tribe ever since the establishment of this reservation. There is a hardship among the single and multifamily units because the per capita income is below the national level and the cost of living is much higher than the national figures on the reservation. There are approximately 1,050 families living on the reservation and from that figure about 325 families have no transportation, about 475 families owned one or two vehicles, and 250 families owned two or more vehicles in running condition. There are no commercial bus lines, airlines, and passenger trains that served the Cheyenne River Sioux Reservation, except Eagle Butte has a 2,500-foot runway for small planes. The Bureau of Indian Affairs has buses for their schools and will not allow nonstudent passengers on their buses due to no insurance coverage for the nonstudent.

Mr. CLAYMORE. I have some other things on the nutrition program.[1] You talked about hot meals. We serve 155 a day at this time and that program is doing very well.

Senator CLARK. How many people would you have eligible if everyone came? I am just trying to get some picture of how many people are involved.

Mr. CLAYMORE. We are probably leaving out about 150 that we are not reaching because of the lack of transportation or not enough funds for the program.

Senator CLARK. So you are reaching about half the people.

Mr. CLAYMORE. We are leaving out over half the people right now.

The biggest share is on the reservation, and that helps us. We have nursing homes there, but the outlying communities—we are going out to different areas by bus twice a week to bring them in, which is 20 miles away. We bring in transportation, but we are not reaching several communities on the reservation, and that is due to lack of funds.

I have other things. The weatherization program we have going there is now funded for $39,000, but it is only $350 per home. We are doing what we can with that at the present time.

Senator CLARK. Does it get pretty cold there?

Mr. CLAYMORE. Yes, it does.

Senator CLARK. So the winterization is a valuable one.

Mr. CLAYMORE. Yes. It goes below zero.

Senator CLARK. That is not a very costly program either.

Mr. CLAYMORE. No.

Senator CLARK. It seems to me with a little bit of money you can do a great deal by way of winterizing homes.

Mr. CLAYMORE. We have what we call a supporting service program up there that is funded through the State. I will just read it as it was started.

The Cheyenne River Sioux Indian Reservation is composed of the two-county area of Dewey and Ziebach Counties. The 1970 U.S. Bureau of Census printout sheets showed a total of 535 people in the age group of 55 to 64, and 567 in the age group of 65 and over, thus show-

[1] See appendix 1, item 6, p. 331.

ing that approximately 900 people of ages 60 and over live in our two-county area. Since 1970 this figure has increased considerably. In 1970 many of these elderly were living with their families in crowded living quarters, especially in our smaller communities and out in the country.

Housing Shortage Alleviated

To help alleviate this problem, the Cheyenne River Housing Authority has built, with funds from the Housing and Urban Development program, four manor-type homes for the elderly. These manor homes provide individual apartments for the tenants where they can live by themselves. As there was a need for ample water supply for these manor homes, they were built at the larger communities of Eagle Butte, Isabel, Dupree, and Timber Lake.

The first home was built in Eagle Butte in 1966 and consisted of 14 apartments. Some of the original tenants still reside in these homes. Then, in 1974, an addition was added to the manor home increasing it to twice the original size, and a 20-unit manor home with central kitchen is ready for residency. Also in 1974 other manor homes were built. At Isabel there are 18 apartments, at Dupree there are 12 apartments, and at Timber Lake there are 12 apartments. These apartments, which consist of a living room, efficiency kitchen, bedroom, and bathroom, are occupied by individuals 62 and older with a few exceptions made for the physically disabled who are below the age minimum. Some of the apartments are occupied by couples and some by singles.

These manor homes have fulfilled the need to provide housing for the elderly that were previously living in the overcrowded housing with their families, but they did present another problem. For awhile they provided housing for the elderly, but there were no funds to provide service to the elderly with their daily domestic duties and/or health care needs which their families had previously seen while they resided in the same household. The economical level of the elderly is so low that the 25 percent of their income for rent is not even sufficient to cover the cost of the maintenance of the buildings. There are no funds available to provide the service to the residents that is needed from the rent income.

These homes are not nursing homes but, because we do not have a nursing home on or near our reservation and our elderly do not want to move into a foreign environment where they are unable to speak their native language, we have elderly occupying these apartments who require daily care. Many of our elderly need to be in a facility where they can reach help if needed due to heart conditions, possible diabetic coma or insulin reaction, chronic illnesses, and limitations of movement. Some of the individuals have poor eyesight and need assistance in taking their medication, such as insulin. The majority of the residents at the Eagle Butte Manors need 24-hour surveillance. They also require assistance with their personal care.

Obtaining Funds Difficult

In 1974 the eight manor aides on the Cheyenne River Reservation were funded for $42,250 from the model projects of the office on aging

out of Pierre, S. Dak. This was 1-year funding only and we were instructed to try to seek other funding for this essential program. We submitted requests to Indian health service, CHR program, Aberdeen area, and to the rural health delivery system, region XIII, Denver, Colo. We also approached local programs such as manpower program, tribal work experience program, and HUD. We were unsuccessful in obtaining funding for the program from any of these sources.

The program was picked up under the title III portion of the Office of Aging in 1975, and at the same budget level. We again made a concentrated effort at trying to obtain funding from other sources, but again were unsuccessful. We were recently refunded for another year by title III of the Office of Aging at the same budget level. Because of the structure of the title III regulations, we should be self-supporting in this 3-year period but, because of the economical problems of the Cheyenne River Reservation, this is not feasible and we will have to continue to search for funding to provide this needed service in the coming years.

The majority of the tenants living in the manor homes had previously lived out in the country or in the smaller communities where they lived in crowded housing conditions with their families. Any care they required was provided by their families in the best way they could in their crowded living conditions. Because of the transportation problems in our two-county area the families were unable to continue to see to their elderly's needs after they resided in the manor.

Supportive service manor aides provide a service to our elderly, both in the manors and the ones who live alone out in the community, with their daily needs. They identify the needs and take steps to take care of them. New problems develop daily and need to be dealt with accordingly. The types of immediate or emergency needs they deal with are: treatment for medical needs, psychological problems, family problems, housing changes, transportation, and pressing economic problems. The types of less urgent problems dealt with are: social problems, household domestic duties, personal care, nutrition education, assistance with meals, and some of the transportation.

Routinely they use the team approach of utilizing the existing resources of all available agencies to initiate an assistance action plan for the elderly. They realize that each elderly person is different and no two are exactly alike, and they deal with them accordingly. The assistance they are providing allows our elderly people the chance to be independent in their own homes and not placed in an off-reservation nursing home where it is a proven fact that the average person lives only approximately 6 months after placement. The supportive service manor aides provide an information service.

The manor aides receive continual training from the PHS Indian Health Service staff, community health representative program, State extension service, and State health department.

There are no transportation costs written into the program.

There is no personnel to place in the new Eagle Butte Manor.

Manor aides should be allowed a cost-of-living raise.

Because of the increased need for nursing home care for some of our elderly, there is a great need for one to be established here on the reservation.

We are talking here about the manor aides that are taking care of the elderly. They have not had an increase. They have not asked for it, but they have not had an increase in 2 years.

Senator CLARK. Would it be safe to summarize your testimony, then, primarily as saying that, as you see it, the greatest need on the reservation there now is the nursing homes? You need people who would be able to stay there with them who speak their own language, with their own friends, and who would come to visit them.

Mr. CLAYMORE. Yes.

Senator CLARK. Second, and very importantly, transportation. You have already got a hot meals program, but it is serving a little more than half the people. And, of course, housing needs.

Mr. CLAYMORE. Yes.

Senator CLARK. Thank you very much, Jack, for your testimony. We appreciate it.

Mr. CLAYMORE. If I could have another moment here, this is Irene Gronau, the chairwoman of the Tribal Community Services Board.

Senator CLARK. Would you stand up, please? We are very pleased to have you here.

Mr. CLAYMORE. She has testimony here.

Senator CLARK. Yes. I wish you would give that to the reporter so it can be made a part of the record as if given.

Thank you, Jack.

[The statement follows:]

PREPARED STATEMENT OF IRENE GRONAU, CHAIRWOMAN, TRIBAL HUMAN SERVICES BOARD, SISSETON, S. DAK.

Tribal senior citizens of the Lake Traverse Reservation have been retarded in developing a comprehensive and progressive tribal senior citizen organization because of several factors which exist in our community and State. Through the efforts of the northeast South Dakota community action program and other local agencies, we do have an integrated senior citizen program in Sisseton and in Waubay. But incidences have occurred in these programs that have made some of your tribal participants feel unwelcome. It takes only a minor incident to inflame latent feelings and to destroy all the hard work and the efforts that people in both the Indian and non-Indian communities have made. As a result, most of our tribal senior citizens remain unorganized into any program, while non-Indian senior citizens groups have sprung up all around us and are now flourishing.

Hence, the first need that we have identified is the need to develop a tribal senior citizen program that is staffed by tribal people, is responsive to the special needs and problems of Dakota senior citizens, and is well coordinated with other programs and priorities of the Sisseton-Wahpeton Sioux Tribe. We have inquired about developing a separate title 7 program for Dakota people but have learned that the State of South Dakota already has "too many" Title 7 programs. There has been some discussion of expanding the title 7 program that already exists in this community to cover five proposed tribal subsites among the seven tribal districts. Such a program could hire tribal members as staff to implement the program. However, tribal members are wary of a tribal program that would be under the supervision of an agency other than the Sisseton-Wahpeton Sioux Tribe.

In addition, we have applied for title 3 moneys for community services, but even if these are granted they could not provide the comprehensive senior citizen program we envision for our Dakota elderly people. At any rate, it would not provide for a meal a day, which is what our elderly people want.

A second major problem that our tribal senior citizen program is experiencing is a lack of continuity of staff to coordinate efforts to develop a comprehensive tribal senior citizen program. The Tribal Human Services Board is currently involved with trying to help the tribal senior citizens to get organized, but we can see the real need for there to be a full-time tribal senior citizens coordinator to

stay on top of all the title programs that are being developed and to develop proposals to tap into these programs. As a result of the lack of continuity we have had during this past year, we are very concerned about whether we are even going to have a senior citizens program during fiscal year 1977.

We are in agreement with the need identified at the Phoenix National Indian Conference on Aging that funding for all programs to serve native American elders through the Administration on Aging be granted for a minimum period of not less than 5 years. Those programs which have then demonstrated their effectiveness in serving native American elders should be continued to be funded on an ongoing basis.

A fourth major need of our Dakota elderly is adequate transportation. Our elderly people are geographically dispersed throughout the seven rural tribal districts on the Lake Traverse Reservation. There is a need for a transportation system to be developed that would facilitate senior citizens being able to shop, visit the doctor, go to church, and participate in senior citizen and recreational programs. We have written a proposal for an additional senior citizens van; but unless we have money to operate the vehicle, we will not even receive the grant to purchase it with.

Another obstacle that we have encountered in our efforts to tap into State Older Americans Act funds (and others) is our lack of matching capital. Our lack of capital is a real handicap when dealing with State programs.

INDIAN LIFE EXPECTANCY SHORT

Another problem that we have identified is with the regulation in title 7 and some of the other programs under the Older Americans Act which defines a "senior citizen" as a person who is 60 years of age or older. It is well known that the life expectancy of Indian people is shorter than that of the average American population. The National Indian Conference on Aging held in Phoenix in June 1976, went on record to lower the age requirement for Indian participants to 45 years of age. On the Lake Traverse Reservation we are envisioning a program that would include persons who are 50 years and older.

We have two HUD units in our community that are designed specifically for elderly people. We identify the need for other such units in our community—perhaps in some of the other tribal districts. Such units make it possible for tribal senior citizens to remain in their communities and near their families while at the same time providing for their comfort and special needs.

We have identified a need for a congregate meals program on the Lake Traverse Reservation. We think the Indian participants will benefit socially as well as nutritionally from such a program. We hope that we can receive funding for such a program.

We identify a need for an in-service orientation to be provided for staff persons working with tribal senior citizens to inform them about all the benefits that are available for senior citizens and to explain to them how to tap into these programs. These staff persons should be given an opportunity to develop and practice organizing skills (through role-playing sessions and group discussions) so that they will have a better idea of how to go about getting the senior citizens organized and operating efficiently.

There is a need to mobilize existing community resources to benefit tribal senior citizens. We need to make resource people aware of the needs of our tribal elderly and to make our tribal elderly aware of the existence of these services so they will make use of them. We further identify a need for expansion of existing homemaker aide services, nursing services, legal services, and other outreach services.

Please note that all of our testimony relates back to our need to have a tribal senior citizen program. At the National Indian Conference on Aging, held in Phoenix in June 1976, it was recommended that the Congress of the United States be petitioned to amend the Older Americans Act to provide for direct funding of programs to Indian tribes. We think that there is a definite need for such a legislative change. But in the meantime, we want to see our tribal senior citizens benefitting from existing programs.

The welfare of our tribal senior citizens has been a primary concern to the tribal human services board and to the Sisseton-Wahpeton Sioux Tribe in general. We have appreciated the opportunity to have the Sisseton-Wahpeton Sioux Tribe give testimony at this hearing about the needs of our Dakota elderly.

The Sisseton-Wahpeton Sioux Department of Vital Statistics has furnished the following data concerning Sisseton-Wahpeton Sioux Tribal members who are 60 years old or older:

Date of birth:	Number	Date of birth—Cont.	Number
1916	21	1906	8
1915	20	1905	10
1914	26	1904	12
1913	16	1903	10
1912	16	1902	18
1911	19	1901	14
1910	28	1900	9
1909	9	Before 1900	113
1908	17		
1907	16	Total	382

Senator CLARK. The next panel is on senior organizations and it is made up of Pete Gregor, president of the South Dakota Congress of Senior Organizations and South Dakota Association of Senior Citizen Centers, Winner, S. Dak.; Eunice Anderson, vice president of Mountain Plains Congress of Senior Organizations, Sioux Falls, S. Dak.; and Don Daughetee, State coordinator, South Dakota Congress of Senior Organizations, Pierre, S. Dak. It seems to me that there was to be one other person as well. Dr. Robert Hayes is also accompanying the panel.

Now this panel is going to speak, as I said, on senior organizations. Each of them have a prepared statement—some of them may not. Please try to limit your statements to about 4 or 5 minutes and then we will have some questions.

Let's start with Pete Gregor.

STATEMENT OF PETER GREGOR, PRESIDENT, SOUTH DAKOTA CONGRESS OF SENIOR ORGANIZATIONS AND SOUTH DAKOTA ASSOCIATION OF SENIOR CITIZEN CENTERS, WINNER, S. DAK.

Mr. GREGOR. Senator Clark, ladies and gentlemen, my name is Pete Gregor. I am the president of the South Dakota Congress of Senior Organizations. I am honored to have the privilege of offering testimony to your distinguished committee.

Senator Clark, you are to be commended for your concern for our elderly. The topic I would like to discuss is difficulties in the delivery of health services in rural South Dakota as it affects both Indian and non-Indian people. The foremost hardship for the elderly is the serious shortage of physicians and professional health personnel in rural areas. It is especially difficult or impossible for the Indian and non-Indian elderly who are no longer able to drive or cannot afford a vehicle because they live on fixed social security incomes. In many instances, living in a rural area means driving 50 to 70 miles one way to get medical attention.

We have proposed some solutions. About 2 years ago Dr. Robert Hayes, who was then secretary of the South Dakota Department of Health, recognized the serious shortage of physicians. He organized a physicians extender program and was successful in getting the State legislature to appropriate funds for a pilot program. To date, Dr. Hayes has placed and oversees four physician extenders in four of South Dakota's more isolated communities. The program is work-

ing very well, but it falls far short of covering the many more rural areas in need. We desperately need Federal assistance to expand this type of program and to provide more widespread health care coverage.

In my area near Winner, Mission, and White River, 12 to 13 percent of the population are Indians. Under Dr. Hayes' program, both Indian and non-Indians get health care indiscriminately. Mr. Oriol has asked me to invite Dr. Hayes to this meeting to tell us more about this program and now I yield to Dr. Hayes.

Thank you, Senator Clark.

Senator CLARK. Thank you.

We are particularly pleased to have Dr. Hayes here. You may proceed in any way you think appropriate.

STATEMENT OF ROBERT H. HAYES, M.D., UNIVERSITY OF SOUTH DAKOTA MEDICAL SCHOOL, WALL, S. DAK.

Dr. HAYES. Thank you, Senator Clark, and staff.

I came from Iowa and was educated there and migrated to South Dakota back in the fifties and have been here ever since.

I am sure our problems in South Dakota and Iowa are somewhat similar. Iowa certainly has made great strides in terms of what it is doing in terms of health care for its populations. Most of you folks here know the University of South Dakota School of Medicine has just gotten started. We now have our first class of senior medical students in a 4-year program and we are certain that that will at least ease this burden. Certainly in Iowa you have done a great deal about serving the needs of the people in rural areas.

The lack of health services is acute, as Mr. Gregor has mentioned. I am pleased to say that we didn't really have much trouble with our legislature in asking for funds and getting them. I have a great many friends there who are very interested in the program. Our administration, our Governor and his staff, and our legislature provided the means, and we are now doing that. I won't go into that in great detail.

I might say that what it amounts to is that we did pass the physicians' extender law. I should explain that term because most people don't know what that means. We have young people in the health field now who are nurse-practitioners and physician assistants. These folks help the doctors, they do certain amounts of work the doctors once did and they do it quite well. They have been trained very thoroughly to do it. It requires a physician like myself to work with those folks, to visit them each week, and to work with them each week.

For example, I have a little circuit and I guess I am called a circuit-rider now because I go from the little town in which I now live, Wall, S. Dak., to Murdo, S. Dak., to White River, and over to Martin, and back up. It makes kind of a circle. Most of you know it covers about four different counties. We do take care of a lot of people. I will have a detailed report for our State legislature as we meet with them later on in the year.

I quickly tried to get some figures to show you, however, of what can be done and how it can work, for example, in the little town of Wall which is less than 1,000 people. This is just one of our sites in our project.

Senator CLARK. I believe we have all been to Wall.

Dr. HAYES. I am now from Wall. So far, for exampple, this year—and we have been in operation there in our clinic since November—we have had 3,010 patient visits. We have done pretty well. In other words, those visits run somewhere in the neighborhood of 10 to 20 a day. A person can get into our office and get the basic things done. If, for example, we cannot do what that patient needs, we refer him to a physician in the nearest town and that is 52 miles one way, 45 miles another, and 36 another, so the distances that other people have alluded to are about the same everywhere. It is a "fur piece."

Really, I think we have something to offer. We don't have the final outcome of it yet; we don't know which, exactly, will be the best way to use these folks. The model we have is one of the models. Certainly our medical school took on a big task when it did try to do this because it had enough troubles getting a medical school started without this. Our dean, Dr. Karl Wegner, I think made a very lonesome decision and a very important one—he decided to do it. I am certainly pleased to work for the school and for him and to try to do this for our folks in South Dakota.

I don't have anything else to say at this time.

[The prepared statement of Dr. Hayes follows:]

PHYSICIAN EXTENDER PROGRAM

The State of South Dakota has the lowest physician-to-population ratio in the United States. Medical care and health facilities are located, for the most part, in the larger cities of the State with little emphasis on the rural areas.

In attempting to provide the rural areas of the State of South Dakota with primary health care, the 1974 South Dakota State Legislature, by legislative mandate, charged the University of South Dakota School of Medicine with the task of developing and implementing a 4-year degree granting medical school that would place emphasis on family practice.

The first third-year class began training May 12, 1975, and will be the program's first graduates in the spring of 1977.

Further concern for providing health care to the rural areas of the State of South Dakota prompted the 1975 legislators, upon recommendation of the joint committee on appropriations to appropriate $60,000 for the development and the implementation of a program for physician extenders.

The legislative mandate or charge was given to the University of South Dakota School of Medicine to develop such a program. The initial budget appropriation is to be used to initiate a service program using physician extenders in a health service shortage area and to attract additional physician extenders to locate in South Dakota. These additional physician extenders would be placed with cooperating physicians in service shortage areas throughout the State.

Since funding became available on July 1, 1975, the school of medicine was unable to pursue financial commitments prior to that date.

Dr. Robert Hayes, former Secretary of Health, was employed as the program director. Meetings and conferences followed with the faculty as well as with the president of the university. From these studies, meetings, and deliberations, the following program proposal has evolved for your consideration. Original proposals have been modified because of budget limits, problems concerning possible duplication of physician extender educational programs, malpractice insurance requirements and concerns regarding physician acceptance of these people.

A rural site near one of the potential modules of the medical school is suggested as the base of operation for the physician extender program. This has the potential of bringing the school of medicine into a community without a physician and also has the potential of being near the communities which are likely to have no doctors and would, therefore, be an appropriate site for physician extender use. The obvious support of the community is needed as well, but in most cases this would be anticipated.

ESTABLISH SCHOOL

It is proposed that Dr. Hayes, the program director, move to the selected doctorless community and establish the school of medicine physician extender office there. It is felt that the program should eventually consist of five or more physician extenders in rural communities in the western part of the State. This would require up to four communities/counties to employ physician extenders (either nurse practitioners or physician's assistants) who would then be assigned by written agreement to Dr. Hayes, and other physicians, if necessary, for direction and technical supervision, in compliance with existing State statutes which limit assignment of physician assistants to two per physician. Dr. Hayes would work with the physician extenders and assist them with their patients in a teaching-service model. The project could consider such communities as Wall, Murdo, White River, and Edgemont. This selection of communities for the project would be on the basis of established health service shortage area designation criteria. These criteria include the geographic area to be served, population, demonstration of need, relationship to other health services in the area, anticipated cost and benefit, attitudes of community, county, and area residents as well as nearest physician(s) availability and manner of financing, demonstrated commitment for immediate and continuing support by the community, and management and professional capability of the organization or governmental unit sponsoring the proposed service (physician extender.)

Dr. Hayes would be available to area solo physicians for locum tenens relief if desired. These physicians would be those who are alone in communities with hospitals and nursing homes. This would allow the medical school to accomplish the all important function of extending itself to help the local doctor "hold the line" until new doctors graduate from our medical school and complete the several additional years of training necessary before they can begin practicing medicine.

Dr. Hayes, living in the selected community, would be on call by telephone and/or radio to back-up physician extenders in the selected sites. He would visit and work with the extenders in these sites on a rotating basis of 2 to 3 weeks. If he is relieving one of the area physicians, he could carry out the same functions of telephonic and/or radio back-up from that community.

In addition to the above, the volunteer ambulance services of the selected local communities could be assisted by Dr. Hayes. This would provide support for the developing emergency medical services program and should be of benefit to those communities in the creation of a medical evacuation system.

Fees which are collected for patient services would be collected by the sponsoring governmental unit and would be turned over to a community health fund and its board or to the county health fund and the county commissioners. These moneys would help defray the cost to the local communities/counties for the physician extender and her/his office.

Several possibilities exist for the provision of physician back-up of the program director during vacations, sick leave, etc. These include support by a physician from the State department of health, participation by faculty from the school of medicine or assistance by area physicians in private practice. The best of these alternatives, and perhaps others, will be explored and implemented to the fullest extent of available resources.

An important function of the program director will be to provide a liaison function between the demand for and supply of physician extenders. The possibility of availability of physician extenders will be explored with existing educational programs. The responsibility of the project director will be to establish communication between those schools and possible user-communities and physicians. Time has been allocated for the project director to carry out this additional other major function of the physician extender office.

Malpractice insurance has been a problem as indicated in the July 18, 1975 report. However, it has been resolved, and Dr. Hayes will be covered by the St. Paul Insurance Co. The individual physician extenders are to be covered through their own employers (the counties or communities) by a company of the sponsoring communities' choice.

In summary, the medical school proposes a teaching service model for its physician extender program. The model will have a rural ambulatory care center (RACC) as well as physician extenders to deliver service to rural communities, to educate physician extenders, and to assist local volunteer ambu-

lance services. An important aspect of this program will be the development of a rural center through which it may become possible to rotate medical students for some portion of their training. This would have the dual advantages of exposure to a rural setting and the opportunity for medical students to work with physician extenders, thus facilitating their understanding of and confidence in this new type of health manpower.

Senator CLARK. I have some questions, but I will now call on Eunice Anderson.

STATEMENT OF EUNICE ANDERSON, MOUNTAIN PLAINS CONGRESS OF SENIOR ORGANIZATIONS, INC., SIOUX FALLS, S. DAK.

Mrs. ANDERSON. Thank you, Senator.

Senator CLARK. Eunice is vice president of the Mountain Plains Congress of Senior Organizations here in Sioux Falls, I think.

Mrs. ANDERSON. No, that is not right. The Mountain Plains Congress of Senior Organizations have two representatives from each of the 6 States in region 8: South Dakota, North Dakota, Wyoming, Colorado, Utah, and Montana.

Senator CLARK. Where are you from?

Mrs. ANDERSON. I am from Sioux Falls. I am one of the two representatives. We are an advocacy group, the Mountain Plains. This is a very new concept. I don't think there is anything like it in the United States. We all have common problems. We are mostly rural. I am very happy to have been at this hearing and I am going to make good use of this because the material that we have gathered here we will use and bring forth in all of our States. We have found that it is useful to find out what they do in other States. I am going to skip some of my remarks because it has been covered.

We had discussions at our annual conference in South Dakota of the White House Conference on Aging. By the way, we had the largest number of people at our White House conference forums by population of the whole United States. So our people are very interested in each other, thank goodness, and also meetings of the South Dakota Association of Senior Citizens. We all agreed that social, recreational, and educational opportunities are absolutely necessary for the well-being of the aged.

So I am coming to the conclusion that everybody else does, the fact that we need transportation; the lack of mobility is so tremendously important. Actually the infirmities of age, if there were a certain amount of mobility, would not be so important whether they live in nursing homes, foster homes, or with relatives. So transportation is related to everything—nutrition, health care, religious and social activities.

Senator McGovern recently has proposed a national Meals-on-Wheels Act—and I am not sure whether this has been changed since I read it—which includes information referral services and a demonstration project which would mail a week's supply of food to the homebound elderly. The proposal also contains a training cost for those who would implement the problem.

I have been considering the problems of the rural aged, especially their lack of transportation and resulting difficulties in obtaining the bare essentials for existence. Jack, over here, and I have often talked

about this on the Indian reservations. I would like to propose an alternate to Senator McGovern's Meals-on-Wheels Act which, I would think, would serve far better for the needy elderly and could be administered under the existing title III program.

Mobile Grocery Service

I have spent some time in rural Sweden, and I have observed how they have solved some problems relating to the lack of mobility. I propose using mobile vans or units which carry groceries, staples like bread, milk, eggs, frozen meals on wheels, aspirin, mineral oil, stamps, thread, a rotating library of books, magazines, and in addition to the driver, an outreach worker.

Senator Clark. Rather than hot meals?

Mrs. Anderson. Well, if you realize as I do—I have been on the Governor's Council on Aging for 12 years. The difficulties in small towns right now is with the cost of gasoline. Several of the little towns have had to give up meals-on-wheels because of the cost of gas. We have trouble with the insurance with the drivers; we have not been able to clarify that.

Senator Clark. In other words, you think the availability of groceries is a greater problem than the hot meals?

Mrs. Anderson. Yes. You can have both. I could see the possibility in some concentrated little town—I am thinking about Crooks, S. Dak.—a little town out here.

Senator Clark. How big is Crooks?

Mr. Anderson. Oh, 100 or 150.

Senator Clark. I see.

Mrs. Anderson. They are getting bigger when they get close to Sioux Falls because they have built more houses. There is no place too big. Those people no longer can drive; they cannot get driver's licenses. The cost, even of a short distance—we have many of these little towns in this area, and when I speak of rural, I am talking about this mobile unit. I can see them going from that which they did in Sweden, although they did serve others besides. In Sweden, it is still more difficult with cars, automobiles, and transportation, although they have mass tranportation buses, but then they go into outreach.

For instance, the outreach worker could contact these people by telephone. I think this is one of the tremendously necessary things. Every old person, of course, should have a phone so that they have a little idea of what they are going to have. The outreach worker and the personal contact is a necessary part except nowadays we have in our neighborhood a lot of others. We have milk-vans going around the country, but these older people need that personal contact—somebody coming in. They don't have to stay 3 minutes, at least, to see that they are all right or bring them what they need. There are problems.

Senator Clark. That is an interesting idea of what you say they are doing in Sweden. I don't know whether they did this around here, but in Iowa we had grocery routes like for everything. As a matter of fact, I remember that my father, in the thirties, owned a small general grocery store and he would go out in a different direction every day with that panel truck and it would be filled with everything imaginable. He

would go to every farm, come back, and go out in a different direction the next day. He would cover an area of about 20 miles. Now those were farmers and the elderly.

You are talking about going to small towns. Why is it that nobody does that any more? Isn't it profitable?

Outreach Workers "On a Circuit"

Mrs. Anderson. Every so often you have to get an idea. In the old days I could see why it would not cost so much. I am a florist; I know what it costs to deliver a bunch of flowers. These are expensive things to deliver. However, we have to look for some funding from the Federal Government. We are using a lot of these outreach workers who are very necessary and I can just see them riding a circuit. I think that there are some problems which I wrote down here, and you would understand, that would have to be discovered—the use of food stamps. You would have to evaluate the rural grocery store—medicaid, volunteers. I think this can be worked out in the community. Possibly we could not do it under title III.

Senator Clark. So your whole point is really that the problem is mobility—transportation—to get services to people in rural areas.

Mrs. Anderson. That is right. I can see on the Indian reservation—I have never talked to Jack about that but I can see the possibility of Cherry Creek. I don't know how far that is from Eagle Butte, but they have been carrying meals-on-wheels out there—hot. Well, this is really not very practical. Cherry Creek now, I think, has a grocery store. I think it is a tremendous difference, but they didn't have it. With a mobile unit they could suggest what they need. It could be used on the reservations.

Senator Clark. There are a lot of people. I don't want to keep your testimony going on, but——

Mrs. Anderson. That is not where I would start it. I would start it in an area like this where you don't have the great distances.

Senator Clark. I was just thinking, the people who are beneficiaries of meals-on-wheels, they probably can't fix the meal if you provided the groceries.

Mrs. Anderson. See, the meals-on-wheels are not in our area. We have, I think, 60, 70—maybe more than that—meals-on-wheels a day. They are from Wyoming and would never have been interfered with. Neither would it be wherever you could make it preferable, but I can see that some of these frozen meals could be adjusted to other people that really are not now. If you look at the cost of them, they are not so particularly expensive. I can see some old person having a bunch of these just like TV dinners coming out on this truck, especially even made for diabetics. The fact of the matter is the diabetic diet or older person's diet is similar.

Senator Clark. We appreciate your testimony.

Mrs. Anderson. I have one more thing to say.

Senator Clark. I am sorry.

Mrs. Anderson. About 7 years ago, the aged of Wyoming—I was, at the time, the administrator, and we started through title III. It lasted until they demolished that part of the building. I think this is

one of the most important things that we could do, the establishment of day-care centers for the elderly. They should be in the health-care facilities like this nursing home or the small hospitals, and these people are not served ordinarily as senior citizens.

They have handicaps, they are in wheelchairs, and so forth. They need their medication supervised. That is one of them. Then there is another thing that I would like to say, and that is that we need a nutritional thrust outside of title VII. The rules are wrong for title VII for a small town that maybe could have two hot meals a day that cannot afford the whole setup of the administration.

Another thing is the law that exists in many States which specifies that not more than two unrelated persons can live together in a home. I know Colorado has tried to change the law. Here is a woman who has a home and she cannot afford to heat it; it is too big. She might have three or four friends that would like to move in with her but it is against the law—they cannot do it. They could team up. They could eat better, they could have one car, have each other's company. If they did a little fighting, what of it? They would at least have some human contact. There are many ways we can help decrease the isolation of the rural elderly and make their lives more meaningful.

That is the end of my testimony.

Senator CLARK. Thank you very much.

Now we are going to hear from Don Daughetee.

STATEMENT OF DON DAUGHETEE, STATE COORDINATOR, SOUTH DAKOTA CONGRESS OF SENIOR ORGANIZATIONS, PIERRE, S. DAK.

Mr. DAUGHETEE. Thank you, Senator.

Senator CLARK. I notice that you have a rather long statement. The whole statement will be put in the record as if read, but we would like to have you summarize your views from it.

Mr. DAUGHETEE. Senator Clark, I will make my remarks brief.

I direct your attention to the program operating in the State of Washington which is called the Senior Citizens Services Act which provides a very innovative approach to the delivery of services. I think this is an area that deserves our attention in rural areas.

Housing is a very, very important problem which needs more attention from the Department of Housing and Urban Development, as is the problem of an alternative to nursing home care in our State. The availability of units is of prime importance to people who would like to stay in the rural areas but cannot find housing.

Similarly, I think one of the summary issues of this whole hearing is the fact that one of the greatest problems that the rural elderly face is from their designation of "rural." Many Federal programs define "urban" as a central city population of 50,000, the standard metropolitan area. There is only one town in South Dakota that big and we are here in Sioux Falls today. Everything else is either suburban or rural.

URBAN REGULATIONS INAPPLICABLE

At least population figures define categories into rural/farm and rural/nonfarm. It is rather difficult to implement a Federal program

in a town of 500 in South Dakota using the same regulations and guidelines required of a city in California of 35,000. One example of this is the Administration on Aging rules which requires multipurpose senior centers to have a paid director and operate 30 hours a week to qualify, yet the majority of the 230 centers within South Dakota cannot afford to have a full-time director, or even a part-time director—let alone operate those 30 hours a week.

Another example would be with the Housing and Community Development Act of 1974, essentially an urban program which allocates 80 percent of the available funding to metropolitan areas. The remaining 20 percent of the funding is available to units of local government for community development to improve housing, environment, and essential services. Of the acceptable eligibility criteria for projects under the law, a fortunate elderly applicant group might be able to secure some funding for acquisition of a facility or to remove restrictive architectural barriers for elderly and handicapped individuals.

In actuality, the decay and deterioration affecting urban centers which this law attempts to remedy are exactly the same problems that rural small towns and communities suffer. Yet, the latter are to attempt solutions with less funding. Somehow, in trying to achieve economies of scale in our Federal programs, we have cut out a substantial portion of the population—and if economies of scale are valid, then no one has told our small family farmers who represent some of the most productive farming units in the world.

Examples of Federal regulations and rules that discriminate against rural areas exist in many Federal agencies and bodies. Recently a local rural project was turned down because it "lacked sufficient visibility" for the Department of Housing and Urban Development.

Senator CLARK. You mean turned that down simply because it did not have enough visibility?

Mr. DAUGHETEE. Yes; that was the case with one local project. I think Shirley Overland can elaborate on that more fully.

Senator CLARK. We would be happy to have her elaborate on it in writing for the record.[1] That seems sort of ridiculous.

Mr. DAUGHETEE. Finally, energy policy has been getting increased attention with continued inflation, rising costs of labor, and construction of generating plants. Electric utility rates have increased like everything else; in some areas of South Dakota they have gone up by from 60 to 80 percent. This would not be so bad if individuals were consuming the same amount of electricity, but in many instances consumption is below preoil-embargo days, yet the costs have more than doubled. There is an upper limit as to what older persons on fixed incomes, pensions, or retirement benefits can continue to pay.

The phrase "The more you use, the cheaper rate you pay" is no longer a wise policy, rational practice, or justifiable means to deal with our dwindling resources. Persons who use more should pay more. Electricity is no longer a luxury but, rather, a necessity and all consumers should be provided with a basic amount of electric energy for a minimum rate and service charge. This is called a "lifeline" rate.

I think, in terms of lifeline, that no longer can residential consumers afford to subsidize commercial and industrial users by paying a higher rate for less consumption.

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[1] See appendix 1, item 1, p. 311.

Thank you very much.

Senator CLARK. Thank you very much for an excellent statement. I wish that we had more time, but I know that this room has to be vacated and we have another witness. I am going to just thank you very much for your testimony and anything additionally that you would like to supply we would be happy to have.

[The prepared statement follows:]

PREPARED STATEMENT OF DON DAUGHETEE

Senator Clark and members of the committee, as State coordinator for the South Dakota Congress of Senior Organizations, I am honored to be able to submit testimony on "The Nations Rural Elderly."

Significant changes are affecting the rural elderly in South Dakota. With approximately 115,000 persons 60 years of age and older out of a total of 665,000, our State ranks seventh in the Nation in the proportion of our older population. They live in small towns and cities throughout this State—many of which have populations under 1,000. As our percentage of older persons increases, it becomes increasingly important to have alternative living opportunities and options available to individuals if they are to live with any degree of self-reliance, dignity, and independence.

The State of Washington provided an innovative approach to alternative service delivery. They have recently implemented a far-reaching program called the Senior Citizens Services Act which will provide a wide range of services and the freedom to select from a variety of services. The services include:

(1) Access services, including transportation, information and referral, outreach, and counseling.

(2) Day care with nursing, rehabilitation, nutritional, and other services.

(3) Night services with therapeutic programs.

(4) In-home care, including basic health care, performance of household tasks, other necessary chores.

(5) Death counseling for the terminally ill.

(6) Health services designed to avoid institutionalization and including geriatric screening.

(7) Nutritious meals either in social settings or delivered to homes.

(8) Minor home repairs.

(9) Certain legal services.

Those with sufficient resources will pay fees according to their income while other elderly persons without resources will receive the services free. These achievements deserve to be studied further to assess the feasibility and costs of implementation of similar services in areas which are complicated by rural distances, availability of and transportation to commercial and professional services, and sufficient dollars.

A paramount alternative to nursing home care is in housing: single-family homes, units in quality rooming houses, and retirement communities and villages, in addition to publicly financed apartment complexes. Our zoning laws preclude more than two unrelated individuals living in the same house, yet widowed friends could use the companionship, shared living expenses, and security of a shared facility for those not requiring institutionalization nor needing a supervised living environment. For a person to be able to continue to live in their own home as they grow older, assistance is needed to cope with the chores and problems of maintaining a house. Surveys show that many of the older homes that were built in the twenties, thirties, and forties are substandard—lacking conveniences which today are classified as necessities such as indoor plumbing, electricity, and running water. As well, many of these homes are not adequately insulated or winterized. Program efforts thus far, although commendable, have barely scratched the surface of older homes in need of better insulation. Likewise, low-rent elderly housing units are available in far too few communities. Where they are available, there is usually a waiting list for accommodations. In July 1975, there were only 363 low-rent public housing units for the elderly on reservations and 1,558 units located in other communities throughout the State out of a total of 5,362 units statewide. Similarly, less than 7 percent of all insured housing projects in the State were for elderly persons. Of the 5,985 units of insured housing in July 1975, only 409 were designated as elderly units. Clearly, providing housing is a more desirable and viable alternative to institutionalizing individuals that do not need or require supervised care.

FEDERAL REGULATIONS DISCRIMINATORY

The rural elderly's greatest problem stems from the designation of "rural." Most Federal programs define "urban" as a central city population of 50,000, the standard metropolitan area. Anything below that number is either suburban or rural. Population figures at least break down the categories to "rural farm" and "rural nonfarm." It is rather difficult to implement a program in a town of 500 in South Dakota following the same rules and regulations required of a city in California with a population of 35,000, yet both can be called rural. Administration on Aging regulations require that a multipurpose senior center have a paid director and operate 30 hours per week to qualify as a center, yet a majority of the 230 senior citizen centers and clubs in South Dakota cannot afford to pay a full-time or even part-time center director, let alone operate 30 hours a week.

Another example could be drawn from the Housing and Community Development Act of 1974, essentially an urban program which allocates 80 percent of the available funding to metropolitan areas. The remaining 20 percent of the funding is available to units of local government for community development to improve housing, environment, and essential services. Of the acceptable eligibility criteria for projects under the law, a fortunate elderly applicant group might be able to secure some funding for acquisition of a facility or to remove restrictive architectural barriers for elderly and handicapped individuals. In actuality, the decay and deterioration affecting urban centers which this law attempts to remedy are exactly the same problems that rural small towns and communities suffer. Yet, the latter are to attempt solutions with less funding. Somehow, in trying to achieve economies of scale in our Federal programs, we have cut out a substantial portion of the population—and if economies of scale are valid, then no one has told our small family farmers who represent some of the most productive farming units in the world.

Examples of Federal regulations and rules that discriminate against rural areas exist in many Federal agencies and bodies. Recently a local rural project was turned down because it "lacked sufficient visibility" for the Department of Housing and Urban Development.

Finally, energy policy has been getting increased attention with continued inflation, rising costs of labor, and construction of generating plants. Electric utility rates have increased like everything else, in some areas of South Dakota they have gone up by from 60 to 80 percent. This would not be so bad if individuals were consuming the same amount of electricity but, in many instances, consumption is below pre-oil-embargo days, yet the costs have more than doubled. There is an upper limit as to what older persons on fixed incomes, pensions, or retirement benefits can continue to pay. The phrase, "The more you use, the cheaper rate you pay," is no longer a wise policy, rational practice, or a justifiable means to deal with our dwindling resources. Persons who use more should pay more. Electricity is no longer a luxury but, rather, a necessity, and all consumers should be provided with a basic amount of electric energy for a minimum rate and service charge. This is called a "lifeline" rate. Furthermore, there no longer is a rationale for residential consumers to subsidize industrial and commercial users by paying a higher rate when they consume less.

Senator Clark and members of the committee, thank you.

Senator CLARK. Our last witness is Dr. Edward Hogan, head of the geography department at South Dakota State University at Brookings.

STATEMENT OF EDWARD P. HOGAN, PH. D., HEAD, GEOGRAPHY DEPARTMENT, SOUTH DAKOTA STATE UNIVERSITY AT BROOKINGS, S. DAK.

Mr. HOGAN. Thank you, Senator.

Senator CLARK. Dr. Hogan, I have seen your statement and it is very comprehensive and complete. We are particularly happy to have it and it will be made a part of the record.

If you will give us about a 4- or 5-minute summary of that, we would appreciate it.

Mr. HOGAN. It is a pleasure to be here today, Senator Clark.

My statement deals basically with some of the characteristics, needs, and future trends of South Dakota as related to the older citizens. As we start out with the statement, we indicate that in 1970 we had a population in South Dakota of 84,000 individuals over the age of 65 and that, by 1990, this figure is projected to increase to about 97,000 people. We could go through some other demographic characteristics, but I would like to highlight some of the things I feel are important to mention.

One is that the number of older people could increase dramatically in the future because there could be changes in the future in the life-span or in the life expectancy of the older population. This could be brought about through medical change, through technology, or combinations of the two. If this occurs and the birth rate stays as low as it is now, the older population will become an even more important part of the State of South Dakota.

HEALTH CARE COSTS INCREASE

The majority of older people right now tend to be between 65 and 73 years of age. Some of the things that concern me the most in dealing with the older people are, first, the health cost. The older you get, the more subject you are to illness and disability. The problem with the older persons in this country is that as they get older and usually end up going to the hospital, they stay there longer. The average stay for a hospital visit is 12.2 days, and one of the things that concerns me about that is that from 1970 to 1973 the health care costs to the older person in the United States increased from $791 in 1970 to $1,052 in 1973. This is a pretty dramatic increase in a 3-year period of time.

Particularly important in the case of South Dakota, I think, is the elderly's income. In our State, over half the elderly population in 1970 had an income of under $3,000 a year. In fact, 30 percent of the elderly had incomes under $2,000 a year. Nationally, only 25 percent of the elderly had incomes of under $3,000 a year. I think it is rather amazing in modern industrial America that one out of every five poor people in this country is over 65 years of age and many of these people could not continue working after they reached the age of 65 and were forced to retire as their health changed.

I think we have to realize that when a person becomes 65 years of age he does not automatically desire to become a hermit. Older individuals have relationships, as do the rest of the population, but society still tends to isolate these people or allow isolation to occur. I think we need to be concerned also with cultural and recreational activities of the elderly, just as we are concerned about these needs for the younger population.

I think the older citizens need good health, both physical and mental health. They also need nutritional programs to assure them of adequate diets. The older people need adequate housing in which to live. They need areas in which to walk, play, or just sit. They need

transportation to go places. They also need access to religion, because the younger people often forget this is a very vital part of the elderly's life and it is something we tend to overlook in terms of their activities and needs.

The older citizens need an adequate income and they need an advocacy system. I think the greatest need of the older citizen is the need to be needed. Fortunately in many families the older member stays a vital part of the family. In the case of South Dakota, we have a large amount of outmigration of younger people. In our situation, a lot of older people end up isolated or in homes. If the outmigration changes in the future, then this situation would change.

Future Trends

I think we can look at some of the future trends as regards the elderly. If the low birth rate in the last 15 years continues for any significant period of time, South Dakota will continue to experience the significant increase in the older population. Second, new health techniques may reduce the aging process which could have an interesting effect, because now they are talking about the potential of having a lifespan of 180, where today 80 is normal. This would be a big change. We would not need any children for a long time.

Senator Clark. We better do away with mandatory retirement.

Mr. Hogan. Yes; we would have to do away with a lot of things. We also see dramatic changes, I think, in the sex ratio of the State. We are going to have a situation by the year 2000 where there are a lot more older women than older men. Even now this is a serious situation, but it is going to become even more critical. In the case of South Dakota I think it is important to mention the nursing homes, too, because the nursing home has become the main reason for the continued existence of some communities in this State.

As they lost the schools to reorganization, the schools were replaced by nursing homes. At the present time 7 percent of our population is in nursing homes. I believe the goal of the Government is to reduce this to 2.5 percent. As long as young people keep leaving South Dakota and the older population stays in the State, we are going to have a large number in nursing homes. Even if the situation changes somewhat in the future, we can probably expect this level to be maintained.

We also have to be aware that the educational level of the older people is going to change as time goes on. More and more of these people are going to be high school graduates and they are going to be making more demands and not willing to give up work. They are not going to be as content to sit back as they are doing now, as regards some things. We are already seeing more demands by some of the groups that are active in more militant aspects of the situation today.

I think we can say that we are going to see some future attempts that are going to have to be made to break down the barriers of isolation and to keep people in the community. We must keep them as an active part of the community. I think this could be done in communities in small rural areas like we have in South Dakota and might

well serve as a model for programs which would provide residential services and companionship protection for older citizens within a community and, at the same time, offer them access to medical services when needed.

I think there is one other thing we can say, in conclusion here, and that is basically that the greatest need of the older person, whether South Dakota or anywhere else in this Nation, is the need to be needed. Too many of the things that have been done in the past and so much of the direction our society is taking tends to take this need away from the person, and they tend to become isolated and alone.

Senator CLARK. Thank you very much.

Just a couple of brief questions. Did you give the percentage of people in South Dakota who were over 60 or 65?

Mr. HOGAN. Over 65—one out of every eight South Dakotans.

Senator CLARK. One out of every eight.

Mr. HOGAN. Yes. Nationally it is 1 out of 10.

Senator CLARK. I see. So there is a higher concentration in South Dakota than in the Nation as a whole.

Mr. HOGAN. Yes, sir.

Senator CLARK. Second, do you know what percentage live in nonmetropolitan areas, or in rural areas?

Mr. HOGAN. I don't have that right offhand, but I would imagine probably about 60 percent if you took the small towns and the rural areas combined.

Senator CLARK. I know it would be high. I would have guessed something around 50 percent.

You have given us some very valuable testimony. In looking at your testimony, there is a good deal more that we didn't have time to cover. We are very appreciative. We are glad to have you here. Thank you.

Mr. HOGAN. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF DR. EDWARD HOGAN, GEOGRAPHY DEPARTMENT, AND DR. ROBERT WAGNER, RURAL SOCIOLOGY DEPARTMENT, SOUTH DAKOTA STATE UNIVERSITY

THE CHARACTERISTICS, NEEDS, AND FUTURE TRENDS OF SOUTH DAKOTA'S OLDER CITIZENS

Characteristics

One out of every eight South Dakotans is 65 years of age or older. The older South Dakotans numbered over 84,000 individuals in 1975. Projections for the future estimate the 1980 and 1990 older populations of the State to be 89,000 people and 97,000 people, respectively.

Half of the older citizens are between 65 and 73 years of age. The other half are over 73 years and include an estimated 310 people over 100 years of age. Future trends in regard to the age of the older population are difficult to project. The age composition could change drastically in the future with a reduction in aging processes, an increase in the lifespan and/or technological changes.

In South Dakota, like the rest of the world, the majority of older people are women. In 1970, there were 83 males 65 years of age and older for every 100 females. While this is presently more favorable than the sex ratio of the elderly in the Nation. substantial change is expected in the future. By 1990 the sex ratio estimates indicate that South Dakota will have 68 men over 65 years of age for every 100 women in that same age group.

The health of the older South Dakotan is generally good. Over 91 percent of them rate their health as varying from average to very good. Only 6 percent of the older South Dakotans are bedridden. It should be noted that about three-

fourths of the elderly in the State believe that their health is superior to that of other people their age.

The problem, of course, for the elderly is that they are more subject to illness and disability than younger age groups. Older citizens average 6.5 physician visits per person per year. One out of six of them will be hospitalized during the year and once in, they will average a 12.2-day stay. Estimated annual health care costs for the elderly have increased from $791 in 1970 to $1,052 in 1973. This is a 24.8 percent increase in 3 years. At the same time, the older citizens share of health costs increased from 32.5 percent in 1970 to 35.1 percent in 1973. Present trends indicated continued increases in health care costs and unless major changes occur in government coverage, one can anticipate that the older citizens share of health costs will also continue to increase.

SHRINKING INCOME

In South Dakota, the older citizens have less than 50 percent of the income of the younger population. About half the older South Dakotans in 1970 had incomes of under $3,000 a year. In fact, almost 30 percent of the old South Dakotans had incomes of less than $2,000 a year. Unfortunately, over 1 percent exist on incomes of less than $500 per year.

It is amazing to think that in modern, industrial America, one out of every five poor people is 65 years of age or older. Unfortunately, many of these individuals became poor upon reaching age 65 through forced retirement, or as a result of health problems.

The income of the elderly population will become increasingly important. Should price increases continue, their purchasing power will become increasingly less. Also should earlier retirement ages come about, we will experience a substantial increase in the number of elderly poor.

The older citizens spend a greater percentage of their income on food, shelter, and medical services and care than younger individuals. They often have a great deal of difficulty finding basic needs, such as clothing in shopping areas. In other cases, the older citizen does not buy other items or luxuries because they simply cannot afford to purchase them or is unaware of available aid. In fact, in 1970 only 6 percent of the older South Dakotans were using food stamps. Fortunately through the use of the State Tie-Line and other services, the State has done an excellent job of attempting to extend this service to the people.

In 1974, about 14 percent of the older Americans were still in the labor force. Some 19.3 percent of the older male workers are employed in agricultural jobs which tend to be lower paying. This is an important factor to be aware of in South Dakota, for the older citizens in this State have some additional employment opportunities available to them in agriculture which are not available to older urban citizens.

About 61 percent of the old South Dakotans never completed elementary school. Some 14.5 percent attended less than 4 years of high school. It is interesting to note that over 10 percent attended college and that over 4 percent were college graduates or more.

While older South Dakotans had a median formal education of almost 9 years in 1970 future estimates indicate a significant increase in median school years completed in the future. By 1990 the older citizens will have a median formal education of almost 12.4 years. In other words, over half the elderly in the State will have completed high school. The effect of this change can be very significant since better educated citizens will place different and additional demands on government, business, and society.

Some 53 percent of the older South Dakotans are married, according to the 1970 census. It is important to note, however, that while almost 70 percent of the older males in the State are married, only about 40 percent of the females in that age category are married. Men are more favored in terms of living with a spouse in later years, particularly because society allows them to reach down and have second marriages with senior sweethearts who are younger than they. This disparity will have implications for housing needs, the incidence of personal isolation, family relationships and income among the elderly in the next 15 years. Most older men will be married and over 80 percent of the older women will be widowed and/or unmarried.

Over 63 percent of the older South Dakotans live as families. Nearly 30 percent live alone or with nonrelatives, and over 7 percent are in institutions. Over three times as many older women than men live alone or with nonrelatives.

In South Dakota over one-fourth of the older citizens live alone. Most of these individuals are active and able to take part in community life, but thousands do live in isolation. Almost 16 percent of the aged in the State do not receive one telephone call a week. Over 10 percent of the older citizens are not visited by another person at least once a week.

Fortunately, the State, the Federal Government, and citizens groups are working to end isolation through programs providing: transportation, senior centers, nutrition programs, telephone reassurance, friendly visiting, and other services.

In the period from 1960 to 1970, a significant shift took place among older South Dakotans. They tended to move into small towns and especially the urban areas of over 10,000 population. Among the reasons for this movement are: a greater concentration of medical services, increasing availability of low-income housing, the opportunity to be closer to others, better transportation, and more recreational activities.

In South Dakota today, 18.9 percent of all registered voters in the State are 65 years of age or over. Presently there is no significant evidence to indicate that older citizens vote as a block. They tend to either follow their own traditional party lines or vote independently, as they have for so many years of their lives.

Needs

At age 65 years and over, one does not automatically desire to become a hermit. Older South Dakotans have the same needs for familial and social relationships as the rest of the population. Unfortunately, society tends to isolate or allow the isolation of a large number of aged individuals.

The older citizen needs cultural and recreational activities, just as members of the younger generation do. Some of these needs can be met through senior centers. Other recreational needs can be met through community recreation programs, clubs and organizations, and family participation.

Like all people, the older citizen needs good health, both physical and mental. They need access to good medical care. They also need nutritional programs to assure an adequate diet.

They need to be able to afford the food necessary for health, as well as the clothing necessary for warmth and protection. One would think that with a market of about 22 million older Americans, some clothing company would be able to provide them with fashionable, protective clothing at a reasonable price.

Older South Dakotans also need adequate housing if they are to live as they should. It should provide adequate space, necessities, comfort, and be attractive. They need good access to utilities and repair services at reasonable costs. Their residential areas should be safe and adequately protected by police and fire departments.

The older citizen needs areas to walk in, play in, or to just sit. They need transportation from their residence to areas of activity within the community, for example to stores, doctors' offices, parks, and senior centers. They also need means of getting to church when they desire to attend. Too often younger individuals fail to recognize the importance of religion in the daily life of the older person.

The older citizens need an adequate income on which to live. As mentioned previously, most of the elderly poor in this Nation were not poor until they had to retire and their income was cut off. If they must live on a substandard income, they must not be expected to carry the same tax burdens as those individuals still employed. They also need tax reform on real estate taxes and estate taxes, since they should not be taxed out of their home or estate.

For those 7 percent of the older South Dakotans who receive institutional care, there is the need to be visited, the need to be treated as individuals, and the need for help. Just placing an older person in a nursing home or extended care facility does not end one's responsibility to a mother or father or aunt or uncle. Those people living in institutions still have wants, needs, and desires. Try as they may, the institutions cannot meet all of them, for family love and involvement are essential needs of the older citizens, whether at home or in an institution.

The older South Dakotan also needs an advocacy system. In many cases they need someone to help them and do not know where to go. They need: legal advice, help getting better housing, better health care, work, recreation, housekeeping services, rehabilitation services, and other people. They need advocates in these areas and information on how to get help with these needs.

The greatest need of the older citizen is the need to be needed. Fortunately in many families the older members are needed and actively involved as long as they live. In other cases, individuals are healthy or involved enough that they are always needed. But for some older citizens, the need to be needed was lost with the arrival of retirement or illness.

For these people, the State and Federal Governments, senior centers, care facilities, schools, groups, and individuals, are becoming increasingly active and creatively involved in developing and implementing ways in which the older citizen can realize their need to be needed. The South Dakota Office on Aging develops, sponsors, and assists communities in the implementation of programs such as: meals-on-wheels, senior centers, telephone reassurance, retired senior volunteer program, foster grandparents, in-house services, and many others. These programs and others have been developed in communities across the State and Nation. The State of South Dakota has introduced the Tie-Line (1–800–592–1865) to put the older South Dakotan and others in contact with individuals and agencies who can answer their questions and assist in solving their problems. Organizations such as the congress of senior organizations, the South Dakota Association of Health Care Facilities, and others are working for the interests of older South Dakotans in relation to their service areas. Gerontology Association for Training and Education (GATE) is a statewide consortium of education, statewide older American organizations, and others working together to inform and assist the older citizen.

The State and Federal Governments, each of these organizations, and interested individuals have as their purpose to provide the older citizen opportunities to utilize their ideas, knowledge, and talents for benefit of others—to fulfill—the need to be needed.

Future trends and implications

(1) If the low birth rate of the last 15 years continues for an extended period of time, South Dakota will experience a significant increase in the number of older citizens. This increase could be even more spectacular by an increase in the life expectancy and lifespan of the population.

(2) New health technology may reduce or slow the aging process and therefore increase the median age, the life expectancy, and the number of older citizens. This would require substantial increases in demands for services to that segment of the population.

(3) New health technology may expand life expectancy so that societal substitutes for dying may have to be found that operate in the same way retirement serves to substitute for death in industrialized societies, creating opportunities for younger cohorts advancing in age.

(4) The increase in the absolute number of elderly residents in South Dakota will generate need for additional services from both public and private sectors. Although proportional pressures on the active working population to support the elderly in the State will not increase, elderly residents may seek a greater allocation of State resources and demand more expensive programs in their behalf.

(5) The dramatic changes in the sex ratio and the decline in the proportion of elderly married women will increase feelings of isolation and cause further "anomia," especially for those women who locate their personal status in the status of a husband. New forms of polygynous marriage, or formalized living arrangement may become socially legitimated among and for the elderly.

(6) Health care for the elderly will become more centralized in larger South Dakota communities where a variety of medical services and specialties are available.

(7) The nursing home will continue to be the main reason for the existence of several small South Dakota communities. One cannot anticipate a significant decline in the number of older citizens in these facilities until out-migration of the young is reduced significantly.

(8) The rising costs of health care will bring about increased pressures on government to pick up a larger share of medical costs for the aged. This pressure will come not only for the elderly but also the children of the aged.

(9) Technological change is progressing at such a rapid rate that increased numbers of individuals will be forced to leave the labor market at younger ages. This would result in a change in the senior population since retirement could begin at 55 or 60 years of age. To accomplish this would likely require a guaranteed annual income.

(10) At the same time, one must also be aware of the fact that future senior South Dakotans share environmental histories that provided more educational opportunities, associated higher occupational and income statuses and exposure to an era of expanding public welfarism may mean that they will be less inclined to accept reduced status positions within the larger society than are the elderly today. A number of factors will help contribute to this:

(a) During periods when larger numbers of children enter adulthood, the availability of surplus but recently trained young adults tends to make the labors of older citizens obsolete and unvalued. The fact that the number of children now born who are advancing toward young adulthood is lower than for previous decades will mollify this obsolescence and devaluing.

(b) Higher completed education levels among the elderly may fortify their legitimate feelings that they have "wisdom" strengthened by experience which ought not be disregarded. From the knowledge and skill perspective, old age and status may become positively related.

(c) Nostalgia may replace scientism and technology as a fundamental American value. If so, the elderly will have an advantage.

(d) Previously, two aspects of retirement explain in part the perceived loss of status by the elderly. At retirement a person not only severs his connection with an organization, but he also relinquishes his occupational location in society. Without these two affiliations, the retiree usually becomes a person of unknown and uncertain achievement. Elderly in the next decades may not be so willing to relinquish their status locations, especially when they share higher educational levels within a leisure oriented society where work opportunities for all age groups are few.

(11) Due to changes in environmental histories, the elderly of tomorow will insist even more persuasively that relative poverty and lack of access to employment are not necessary concomitants of aging, but are the consequence of educational shortcomings and insufficient retraining. Demands for continuing education for the elderly and developmentally oriented learning opportunities will increase.

(12) Continued attempts will be made by government and concerned groups to break down the barriers of isolation. One such attempt could well be the development of service careers which cater to the total needs of the isolated or confined individual.

(13) Programs will be called for and developed to provide residential services, companionship protection, etc., for older citizens within a community environment. The emphasis will be to keep the individual out of the extended core center and in the community as long as possible. Small rural South Dakota communities might well serve as the test models for such programs.

(14) The changes in the magnitude of out-migration from South Dakota will reduce isolation and feelings of relative deprivation among the elderly as younger kinfolk remain in their locality. More sophisticated technology in communication and transportation services will further inter- and intragenerational interaction, as the machine substitutes for interfacial contact. The advent of new childbearing patterns, whereby the having and rearing of children is not conditional upon female fecundity, may delay parenthood until later years. In this event, a societal norm may assign child bearing and rearing responsibilities to the aged.

(15) Future voting impact of the older citizen will not become especially significant unless their number increases dramatically or they begin to vote as a block. As of yet there is little indication that either will occur. However, serious economic or health problems could bring about a change in these habits.

CONCLUSION

Today, one out of every eight people in South Dakota is 65 years of age and over. The people of South Dakota and the Nation must understand that most of the older Americans are individuals who have worked hard during their lifetimes, only to be retired by society when they reach 65 years of age. The elderly will play more significant roles in South Dakota and the Nation in the future. A consequence will be the expansion of human services for senior citizens and possible modifications in governmental and social policy and programs. We must remember through all this that the greatest need of the older citizen is the need to be needed.

Senator CLARK. Now I do want to say that we have some forms back on the table which are provided for any of you who would like to make

further comments or anyone who would like to submit any information for the record. It will be put in the printed record as if presented here. It simply says: "Dear Senator Clark: If there had been time for everyone to speak at the hearing in Sioux Falls, S. Dak., on August 18, 1976, on 'The Nation's Rural Elderly,' I would have said," and then you write your remarks, sign your name, and so forth. You may take these home if you like and mail them to me. Our record will be open for about 30 days. We have to receive it within 30 days in order to have it printed.

Incidentally, anyone that would like a printed copy of these hearings, or the others that we are holding around the Midwest, please just give us your name and address and we would be happy to provide that for you, too, or give it to the center here and I am sure they will pass it on.

We have about 2 minutes. I would like to try to take any questions or comments from the floor. I wish we had more time, but I know that this room has to be used.

Let me just say that it has been very valuable to us; it has been very useful to us. I think we have had a great number of witnesses today and I think what we have seen, if I can just summarize it in 20 seconds, is that the unique problems, really of rural areas, have a great deal to do with mobility—with transportation. It does not make much difference if you have a hospital, a doctor, or some kind of health facility if you cannot possibly get to it. So transportation seems to emerge, at least out of this hearing, as being enormously important.

Also, the problems of health care. As we heard from one of the last panels, the problem is really one of getting some kind of extender—some kind of health care. It may not be a doctor, but some kind of health care must be made available in the smallest of communities, and we must have some kind of satellites around, at any rate, from the larger communities so that people could at least have the basics of health care. We have heard a good bit about nutrition programs, about how valuable they are, and the fact that they need to be extended. We have heard something about the problem of employment, particularly the Green Thumb program and how important that is—how valuable it is on reservations and in other parts of the State.

So I think we have had some good testimony, some testimony, in fact, that we really had not received before in either Iowa or Nebraska. So we are very pleased that you came and very pleased that you gave this testimony.

The hearing is recessed. We are going to Canton.

[Whereupon, at 11:45 p.m., the hearing was recessed.]

BUS TRIP TO CANTON, S. DAK.

[The following comments took place on the bus ride to Canton, S. Dak., in RSVP vehicle.]

Senator CLARK. How big is Canton?

ANSWER. 2,600. It has been 2,600 for a good many years.

Senator CLARK. How far are you from Iowa?

ANSWER. Half a mile.

Senator CLARK. How many of the people are over, say 60 or 65 in Canton?

ANSWER. 600.

Senator CLARK. What kind of program do you think you ought to have that you don't have?

ANSWER. I think we should have just about everything except I will tell you——

Senator CLARK. What most do you think you should have?

ANSWER. What most? I will tell you one thing that we do not have that I think is quite essential. We have many, many people who might have $5,000 in a savings account. They cannot live on their social security and yet they are not eligible for SSI or food stamps because of that $5,000 in the savings account.

Senator CLARK. I see.

ANSWER. What is $5,000 today?

Senator CLARK. It is nothing.

ANSWER. You can be in the hospital 10 days and it is gone. We all need just a little security like $5,000 in a savings account which is very little, but it is security for a lot of people. They cannot live on social security or the interest off that, and they are not eligible for SSI as long as they have $5,000. Why can't they have $20,000 or $50,000? Why can't we work and make all the money we possibly can to build our own social security? We pay into that.

Senator CLARK. Yes.

ANSWER. There is a group of people in between SSI and the people that have more money and that is the people that are just over the edge, they have a little bit too much to get SSI and they are the ones that are hurting because they have to pay for all their own medications and all that. If they are on SSI, this is worth $1 million because they have all their doctor bills paid and all their hospital bills paid. Up until just now they could get glasses. They really have it made. But the people that have just a little bit over what they need to get on SSI are the ones that are really hurting, they are the ones I feel sorry for right now.

Senator CLARK. Tell me the reasons that a person would be on SSI rather than social security.

ANSWER. Well, there are a lot of them that never paid into social security, or probably very little. I was on the SSI alert and I ran out. Many people were living on a $78 social security check.

Senator CLARK. So the only reason you would be on SSI is that you either paid nothing or too little into social security, and therefore can't qualify.

ANSWER. That is right. A lot of these people are 85 or 90 years old, and their husbands were farmers. The farmers were not allowed to pay into social security, so they never paid anything.

Senator CLARK. Will the day come when there will be no SSI—everybody will be covered by social security?

ANSWER. I don't know. SSI is the supplement, and I don't know. Do you know what the maximum is if you have not paid in?

Senator CLARK. It is about $100.

ANSWER. Seventy-seven dollars.

Senator CLARK. If you have not paid in.

Housing Shortage

What about housing for older people in Canton? How is that? Is it good or bad?

Answer. We need more. What we have is excellent. I live in Government supplemental housing.

Senator Clark. How many units are there?

Answer. Twenty-four.

Senator Clark. Is that all there is in the whole town?

Answer. We have another one with 20 units.

Senator Clark. Twenty.

Answer. So that is 44.

Senator Clark. I notice there was the Lincoln County border. Notice the air—you can tell it when we came across that county line.

Answer. Everybody take a deep breath. That was a barnyard you smelled.

Senator Clark. I will tell you, that corn does not look too bad. It is not too tall though, is it?

Answer. The ears don't have any kernels on them.

Senator Clark. I see. Then you do need some additional housing units? There is a demand for more?

Answer. Yes.

Senator Clark. One of the big problems, of course, is just having adequate income to be able to afford the things you need.

Answer. That is right. I have social security and I have a very small bank account. On my social security it is pretty hard to feed myself and keep my car. I live 10 or 12 blocks—close to town.

Government supplement—I pay $135 a month.

Senator Clark. Those of you who live in housing that has been built in part by Government funds, would they have a rent supplement program so that you don't have to pay more than a quarter of your income in rent?

Answer. Yes.

Senator Clark. I think that would be helpful.

Answer. Low-income housing. I live in low-rent housing.

Senator Clark. If we had any more money to distribute or we could increase the appropriations, what would you like to see occur in the kinds of programs you have? Nutrition, health care, transportation, green thumb employment, some other employment—what would you like to see? What do you think the need will be next year?

Effect of Mandatory Retirement

Answer. I wonder if employment would not be the best help. Our administrator is a man—how old, 72? How old is Bob? He was sick and almost disabled until he got a job with the green thumb program for 3 days a week. He has to get up in the morning 3 days a week, get dressed, and go to work. He is a different man.

Senator Clark. Isn't that something!

Answer. Otherwise, he was sick in bed every day. At least 3 days a week. It is not only the money, but having to get up and be somewhere at a certain time.

Answer. I think that is the answer.

Senator CLARK. In my judgment, and I know there are a lot of people who disagree with me—we got into an argument yesterday at the hearing, but I think the worst thing we have ever done in this country for older people is to have mandatory retirement.

ANSWER. That is right.

Senator CLARK. That, to me, does not make any sense. If at age 65 I am an excellent Senator, I don't see why I should not continue. If I am an excellent doctor, I don't see why I should not continue. If I am an excellent laborer or farmer or whatever—I think anybody ought to be able to retire at 60 or 62 or 65, but it ought to be their choice.

ANSWER. That is right.

Senator CLARK. I don't see why you have to force them.

ANSWER. That is a different thing if you are working for yourself. This Bob owned his own business and he got sick. Now because he has a boss, he has to be at work at a certain time and he is there. When he was on his own, he was tired. We have farmers like that who retire because, probably, they are not able to farm so they retire at an early age and are absolutely not much good. But if they do get a job and have to be there, they are in better shape healthwise.

Senator CLARK. I know, of course, the other problem that is tough is the problem of inflation. I had a great uncle who retired on the farm in about 1938 and is still living. He retired probably at 60, something like that, and sold his farm for $10,000. Well, he thought he had all the money in the world he would ever need in 1938 with $10,000. He didn't see any reason in the world not to retire. Now, of course, he has lived on far beyond what anybody ever assumed, but he was broke at the end of the war and that money was gone. That was all there was to it.

It is just hard to understand how much inflation you can have in a very brief period of time. You retire, and 10 years later you have got what may not be worth half as much, and 13 or 14 years later it is not worth that much.

ANSWER. I don't think that our elderly should have to live below the poverty level. There are many, many of them who are able to work, and they should be able to.

The reason for social security was to create more jobs. If you still work after that, at the same time you are not allowed to create any more jobs. That was the main idea—for more employment.

Senator CLARK. Yes.

Has the drought out here been pretty serious in your area?

ANSWER. It has been bad. See the corn—now there is not much there.

Senator CLARK. It is pretty small, isn't it?

ANSWER. No ears, just the stalk.

Senator CLARK. What about small grain—oats?

ANSWER. If we have a fair crop, I will be surprised.

Senator CLARK. Is there much wheat grown in this area?

ANSWER. Not much. Very little wheat.

Senator CLARK. Are beans standard, a little bit more than corn?

ANSWER. Yes; here is a 1,100-acre farm right here.

Senator CLARK. Land now is selling at $2,400 an acre.

Well, did you enjoy the hearing?

ANSWER. Very much.

What do you think about this van situation?

Senator CLARK. It is kind of interesting. I never thought about it before, but it is kind of interesting.

ANSWER. You think that is a pretty good idea?

Senator CLARK. Might be.

ANSWER. You would think they could make money out of it where they could go out to a town and sell the thing out, and then go on to another town.

ANSWER. The price of gas is high.

Senator CLARK. My Dad used to do that—go out to the country. He had an old panel truck. This was in the 1930's. He did it until the war, I suppose—in 1940, 1941, 1942.

ANSWER. It sounds interesting.

Senator CLARK. You had a small town that had no grocery store.

ANSWER. I would think it would be almost a necessity in the western part of the State.

Our transportation is a problem.

Senator CLARK. You have smaller towns between towns.

ANSWER. Yes.

Senator CLARK. How big is Fairview?

ANSWER. I am sure they have neighbors to drive them in, but it is not too good.

Senator CLARK. I think I would be that way, too. I mean you would not mind doing it sometimes, but you would hate to do it all the time.

How many of you here no longer drive?

ANSWER. Everybody drives.

Senator CLARK. Everybody drives.

When did you get this bus?

ANSWER. Three years ago.

Senator CLARK. It is quite a bus.

ANSWER. Yes, we think it is pretty nice. This helps us. We can visit relatives in town.

Miss Mae had to take the bus today. You cannot trust the senior citizens. They say they will go to a meeting and they will not show up. Mae takes them and makes sure they go.

Senator CLARK. She knows she has a load. Is she kind of a slave driver?

ANSWER. Mae, are you a slave driver?

Senator CLARK. I know she is the busdriver.

ANSWER. She is not a slave driver, but she is an inspirer. You understand that word.

Senator CLARK. I do.

ANSWER. She makes us all feel guilty if we don't do something good every day.

Senator CLARK. Good enough. Would it be all right if we take her where she is badly needed?

ANSWER. You don't take her.

Senator CLARK. We need a little inspiration in Washington, you know.

ANSWER. No, don't take Mae to Washington. She could do us a lot of good there, too. The town she lives in is not the size of Canton.

Senator CLARK. That is why she is so darn good. It is not by accident that you are praising somebody who lives in Iowa. [Laughter.]

ANSWER. I was born in Iowa.
Senator CLARK. Where?
ANSWER. Marcus.
Senator CLARK. I know where Marcus is. I have been in Marcus. I went to a centennial in Marcus.
ANSWER. Did you go to it?
Senator CLARK. Yes. I walked in the parade.
Mr. STENGLE. My wife was born in North Dakota in a sod house.
Senator CLARK. In a sod house?
Mrs. STENGLE. Yes.
Senator CLARK. How long ago was this?
Mrs. STENGLE. My parents went there.
Senator CLARK. Do you know what year they went to North Dakota?
Mrs. STENGLE. 1906—well, 1905.
Senator CLARK. They lived in a sod house. Did you ever read this book by Willa Cather called Oh Pioneers? You ought to get it. Do you have a library in Canton? I tell you, it is a great book because she lived in about that same time. She is dead now. She lived in a sod house out in Frisco, and it is either in Nebraska or Kansas—I think Nebraska—and wrote all about life at that time. It is a novel, but it is based on her own life when she was a young girl living in a sod house. You would like it.
Mrs. STENGLE. The sod house that my father built for my mother—they homesteaded on 72 quarters. They were married and they built a two-room sod house with an attic. The roof of our house and the walls were plastered with gumbo.
Senator CLARK. Gumbo.
Mrs. STENGLE. Yes.
Aung Aggie, the pastor, and the traders that came along made it their home. They would sleep in our attic.
Senator CLARK. How long did you live there?
Mrs. STENGLE. I was 9 years old when they moved.
Senator CLARK. So you remember it.
Mrs. STENGLE. Yes. My father was responsible for one of the first consolidation schools. I went 4 miles.
Senator CLARK. You walked 4 miles?
Mrs. STENGLE. No, no.
Senator CLARK. You rode 4 miles.
Mrs. STENGLE. We would have high school students.
Mr. STENGLE. Transportation was not a problem then, they walked.
Mrs. STENGLE. We rode horse and buggy.
Senator CLARK. You drove the horse and buggy to school. Now what years would that have been?
Mrs. STENGLE. Well, I was born in 1908.
Senator CLARK. So it was during the First World War.
Mrs. STENGLE. Yes, because we moved down here in 1917.
Senator CLARK. It was a sod house. Was most of it below the ground, or was it all above?
Mrs. STENGLE. This was all above. They had dugouts, but the house was above ground.
Senator CLARK. What was the dugout for?
Mrs. STENGLE. To store our crops and our potatoes.
Senator CLARK. Kind of a cellar.

Mrs. STENGLE. Cellar, yes.
Senator CLARK. Did you do a lot of canning in those days?
Mrs. STENGLE. Yes.
Senator CLARK. Would you can meat?
Mrs. STENGLE. Oh, yes, and I remember jackrabbits.
Senator CLARK. Shoot jackrabbits and can them?
Mr. STENGLE. Yes.
Mrs. STENGLE. We didn't always have that. Of course, that was fresh meat.
Senator CLARK. Canned jackrabbit. I have never eaten that. Are there still a lot of jackrabbits out around here?
Mr. STENGLE. No.
Senator CLARK. What happened to them?
Mr. STENGLE. Too many hunting them.
Senator CLARK. Is hunting good out here any more?
Mr. STENGLE. More deer.
Senator CLARK. What is the closest town in Iowa to Canton?
Mr. STENGLE. Inwood.
Senator CLARK. I am going over and start a hearing at 2 o'clock this afternoon near Mason City about 180 miles from here.
Mr. STENGLE. Where is the plane?
Senator CLARK. The plane is in Sioux Falls.
Mr. STENGLE. Mr. Oriol is following us.
Senator CLARK. Bill does all the work.
I have never ridden on one of these buses.
Mrs. STENGLE. This is one of the old type roads.
Mr. STENGLE. This is about the first paved road they put in.
Senator CLARK. When was that?
Mr. STENGLE. 1927.
Senator CLARK. 1927. It has held up pretty well. That is 50 years next year.
Mr. STENGLE. It was put in before I was married and that was 49 years.
Senator CLARK. Mr. Stengle says it was put in 49 years ago, in 1927.
Mr. STENGLE. We would go to town sometimes and get stuck along here.
Senator CLARK. Really.
Mr. STENGLE. Yes.
Senator CLARK. Where did you teach?
Mrs. STENGLE. Around the corner back there.
Senator CLARK. How did you learn to be a teacher?
Mrs. STENGLE. Normal.
Senator CLARK. Normal school.
Mrs. STENGLE. Yes.
Senator CLARK. Did you do that in your last 2 years of high school?
Mrs. STENGLE. Part of it the last 2 years of high school.
Senator CLARK. How old were you when you started teaching school?
Mrs. STENGLE. Nineteen.
Senator CLARK. Country school.
Mrs. STENGLE. Yes.
Senator CLARK. How many years did you teach?
Mrs. STENGLE. Five.
Senator CLARK. Five years.

Mr. STENGLE. She is still teaching.
Senator CLARK. Teaching you and others?
Mr. STENGLE. That is what I mean.
Senator CLARK. Is she a good lecturer?
Mr. STENGLE. Certainly is.
Senator CLARK. How long have you been married?
Mrs. STENGLE. Forty-three years.
Senator CLARK. I say "Kant-n," I notice several of you say "Kan-ton."
ANSWER. This area was settled by Norwegians. There were other nationalities.
Do you want to go to the Senior Citizens Center?
Senator CLARK. Yes. Can we do that?
ANSWER. Yes.
Senator CLARK. I think that is where they were going to meet us.
ANSWER. I think they are following us.
You will see our little housing unit on the right as we go by.
Senator CLARK. You point it out to me.
Who built this, the Farmers Home Administration?
ANSWER. I don't know.
There they are, and they are beautiful.
Senator CLARK. Very nice.
ANSWER. That is the community building where they have parties and washers and dryers.
Senator CLARK. I think this would be great.
ANSWER. It is a beautiful center.
Senator CLARK. That is about as nice as I have ever seen.
ANSWER. You will get to see the other one, too, the Elms. That is the other elderly housing unit.
I think the next time, Mae, we better all drive our cars and meet you.
Now isn't this a beautiful town?
Senator CLARK. It certainly is. There's the courthouse.
[Whereupon, at 12:45 p.m., the bus ride concluded.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. LETTER FROM SHIRLEY OVERLAND[1] TO SENATOR DICK CLARK, DATED AUGUST 20, 1976

DEAR SENATOR CLARK: Transportation was expressed as the No. 1 need for South Dakota. I agree. However, I am firmly convinced that our ministry needs to be to the total person. This includes meals, shopping trips, volunteer opportunities, lifelong learning, recreation, opportunity for spiritual growth, to mention only a few. I have been in communities where a meal was provided, a nutrition movie viewed, and people moved silently to their bus for a ride home. Multipurpose senior centers can exist with volunteers. Seniors and others even in the smallest communities can be motivated to serve their fellow human beings. I've seen it happen and know it can be done in a nonthreatening way.

Title XX Means Test for Transportation: I request that group eligibility be declared for elderly transportation. After going through the means test twice since February (because of social security raise) we find 85 percent of our riders are eligible to ride without making a copayment. There is also a segment that will not fill in the forms. They are back home, isolated. They are too proud to reveal their income. The time of administering the means test (because we cannot afford to hire two extra employees) has taken away from our home care and outreach calls.

Senator McGovern's meals-on-wheels: I feel a grave concern for this approach unless it can be administered with some human caring and person-to-person involvement. It should be incorporated into a title VII or title III program. If this is not possible, then some caring group must, of necessity, be responsible. People eat because they desire to live and care about themselves as persons. Without human contact the costly program will be unsuccessful in accomplishing the intended goal.

In response to a statement made at Sioux Falls, S. Dak. Hearing: Our Huron Area Senior Center was declared "not visible" for a $450,000 section 202 HUD loan. The statement was made from Washington HUD that it was a lot of money to go into a rural area that wasn't visible. If the Denver office (John Otto) would have had input, they would have realized the total situation. HUD loans have been made to Huron College and no payments made for several years. The Denver Office looked upon this proposal as a life saver for the college and a chance for HUD to recoup some of their funds. The decision however, was a political one and was made in Washington.

Senior center facilities: Senior centers exist in old creameries, hatcheries, and condemned buildings, yet we continue to build fine schools, library facilities, parks, etc. "Senior citizens take the hand-me-downs of their communities," according to William Pothier, speaker at the 1975 NCOA convention.

Joseph Jordon, also at the 1975 NCOA convention, stated "The quality of the senior center building equates what the community thinks of its older population." Jordon also stated that "Someday every community will have an adequate service providing center as natural as a school for the kids."

Nursing homes in South Dakota: 7 percent are in nursing homes in South Dakota. This could be reduced to 3 percent if adequate rural multipurpose senior

[1] See statement, p. 292.

centers were provided. Hon. Morris Udall at the 1975 NCOA convention asked, "Is it proper for the Federal Government to allow elderly folks to be placed in nursing homes for profit and reduce the services that could keep them in their own home or apartment?" He continued by saying that the cost is $7 billion a year to give nursing homes a profit. That's a lot of money, isn't it?

Alcoholism in the elderly: There is a marked increase in this disease among the elder American. NCOA is presently studying the problem and will be reporting at the 1976 convention. Dr. Johnson of the Johnson Institute (a nonprofit foundation in Minneapolis that deals with this problem) states that the increased numbers, particularly in the Minneapolis high-rise apartments, is most alarming. This is also true in other communities. I personally know one practicing alcoholic that remains sober because he has a daily title VII meal. If he misses this meal he is in trouble and back in the hospital. For him the meal and the fellowship really pays off. What about those that no one ever sees or cares about? They die. The Alcoholics Anonymous program assists many, but a knowledgeable outreach worker could help to "bring up the bottom."

SHIRLEY OVERLAND.

ITEM 2. POETRY SUBMITTED BY SHIRLEY OVERLAND

MY VIEWS AS A SENIOR CITIZEN

(*By Nell Kuestermeyer, 1976*)

We are senior citizens
Of which we are very proud.
We have so much fun
Being with the crowd.
A simple greeting
When we meet
Makes us feel good.
A pleasant smile
For you and me
And all will know
We are doing what's worthwhile.

We enjoy everything we do
Because we are together.
When things seem dull and blue,
We think of senior center.
We don't have
To sit and fret
And worry all the time,
There are so many things to do
Some are work,
Some are play,
Yet all are doing what's worthwhile.

One of the things I like the most
Is to dance—which is just grand.
Then comes Thursday with Shirley,
The leader of our band.
She points that stick
And we all know
We'd better pay attention.
Cause she's working very hard
To relieve our hypertension.

Come on out and join us!
You'll be glad you did.
You will meet old friends
And make new ones,
Of this there is no end.

Yes, we are senior citizens,
Taking one step at a time.
Live for today, not tomorrow!
Because with God's help
You will know
Each one of us,
Because our faces really shine.

"BELONGING"

(By Shirley Overland, December 1972)

Strolling down the sidewalk can be lonely,
Walking along as I reach
The grocer,
The coffee shop,
The dime store,
Where people I can see.

They chat and laugh in little groups
And seem to have such fun,
And I feel
Lonely.

Many times I walked along the sidewalk
Past a place called "Huron Senior Center."
I sneaked a glance
Through the windows
And saw
People.

They chat and laugh in little groups
And seem to have such fun,
And I feel
Lonely.

I thought about that place many times
And walked along the street,
And peered into those
Big, friendly rooms.

I thought, "I'll know no one."
"I'll not know what to say."
And then one day
I opened wide the door
And someone said, "Hello,
Come on in."

My heart leaped
As I made that step—
To be greeted by
A friendly voice,
A great big smile.

Now, I no longer walk the streets.
I've found new friends.
I keep busy with games and visiting,
And I've learned a thing or two.
I've gone on some trips
And found that someone cares
For me and you.

Now I chat and laugh in little groups
And have such fun.
And I no longer
Feel
Lonely.

ITEM 3. "DARE" PROGRAM PROPOSAL, SUBMITTED BY SHIRLEY OVERLAND

DEVELOPING ADULT RESOURCES THROUGH EDUCATION (DARE)

A unified delivery system for educational services to older Americans in the city of Huron

Name of primary agencies: Huron College Community Learning Center, and the Huron Area Senior Center.

Name of cooperating organizations and institutions: Retired Teachers Association; National Association of Retired Federal Employees; Community Counseling; CMA colleges; Briar Cliff, Buena Vista, Dakota Wesleyan University, Dordt, Mount Marty, Northwestern, Sioux Falls, Westmar, Yankton.

Project director: Shirley M. Overland, director, Huron Area Senior Center, Inc.

THE COMMUNITY PROBLEM

Older persons and continuing education.—There is a great national concern about "lifelong learning" and providing educational services to older Americans. Colleges and universities, partly due to declining enrollments of younger students, have identified retired persons as a new potential clientele. These institutions have generally taken two steps to recruit older persons as students. The first has been to lower fees for traditional courses. The second has been to create a curriculum of activities that younger educators have decided older Americans want: arts, crafts, estate planning, knitting, etc. Both these approaches tend to force the older American into a younger framework and stereotype their educational activities.

Many of these programs have failed in three respects: (1) Colleges have not acted to adapt the traditional liberal arts disciplines to the particular needs of older persons or trained their facilities to do so; (2) They have failed to adequately consult with the older persons themselves as to their educational needs and desires; (3) Finally, they have ended up as just one more agency competing for the attentions, time and dollars of older persons. They have failed to provide a comprehensive educational program utilizing all the resources of the communities in which older persons reside.

The Need—A unified delivery system.—The way to solve the above problems is to devise mechanisms whereby older persons are carefully consulted in planning educational programs and the resources of the entire community are utilized to serve them. In many communities, the senior center is the best catalyst for this unified system, although few centers perform the function. In communities where there is an institution of higher education, the opportunity exists to utilize the senior center as a focal point for the continuing education program with the assistance of the professional educators. That dual sponsorship furnishes an ideal foundation for a unified system.

Huron—An ideal laboratory for a unified system.—Huron and vicinity has a very high population of older persons. While one in eight in South Dakota is a senior citizen, in the Huron area one-fourth of the population is 55 years of age and older. The Huron Area Senior Center has over 700 members and is one of the most successful centers in the State. Huron College, Presbyterian related, has 356 students and a new community learning center office concerned with adult education.

(1) The senior center educational program: In late 1974, Shirley Overland, director of the Huron Area Senior Center, called together representatives of various community organizations and agencies, including Huron College. She later held a series of sharing meetings with senior center representatives. As a result, the center launched its first educational programs, which included first aid, defensive driving, tips for shoppers, and modified home nursing.

(2) The liberal arts for older Americans program:[1] In fall of 1974, Huron College proposed (and was funded under title I) a liberal arts for older Ameri-

[1] Please note that the new proposal herein is not a request to continue the LAOA program. The original LAOA program was narrow in scope and, while the DARE proposal contains components of LAOA and builds on its findings, the new proposal attacks a larger and different problem—the construction of an integrated delivery system for educational services.

cans program. This program was designed to identify the particular learning needs of older persons and attempt to adapt traditional liberal arts disciplines to those needs. This process of planning and conducting nine courses was designed to train faculty members and produce guidelines for planning future learning experiences. This program was instituted in summer, 1975, and 45 older persons participated in the first four courses. Three more courses were begun on October 7 (with 55 participants) and three more are planned for the coming calendar year.

(3) The Huron College "live-n-learn" senior center proposal: Discussions have been proceeding for approximately 6 months between Huron College and the Huron Area Senior Center as to the possibility of converting a large college residence hall, McDougall Hall, into a senior center and living quarters for older persons. The importance of this proposal to future educational programs is obvious. A senior "live-n-learn" center would have potential for educational activities unique to the State of South Dakota and found in few locations in the Nation.

(4) Interaction thus far: Huron College personnel participated in the center's initial planning of its educational program, and its members and director serve on the steering committee for LAOA. There has been a trend toward more unified direction of all the learning experiences available within the community with the focus at the senior center and with the college furnishing staff and administrative assistance for the liberal arts portion of the program. However, to this point, these efforts have continued to have fragmented and overlapping administration.

The establishment of the community learning center at Huron College this fall completes the authority structure that would make possible a workable unified system. The time has come to merge programs in a community that has demonstrated the leadership to develop a unified educational system for older persons.

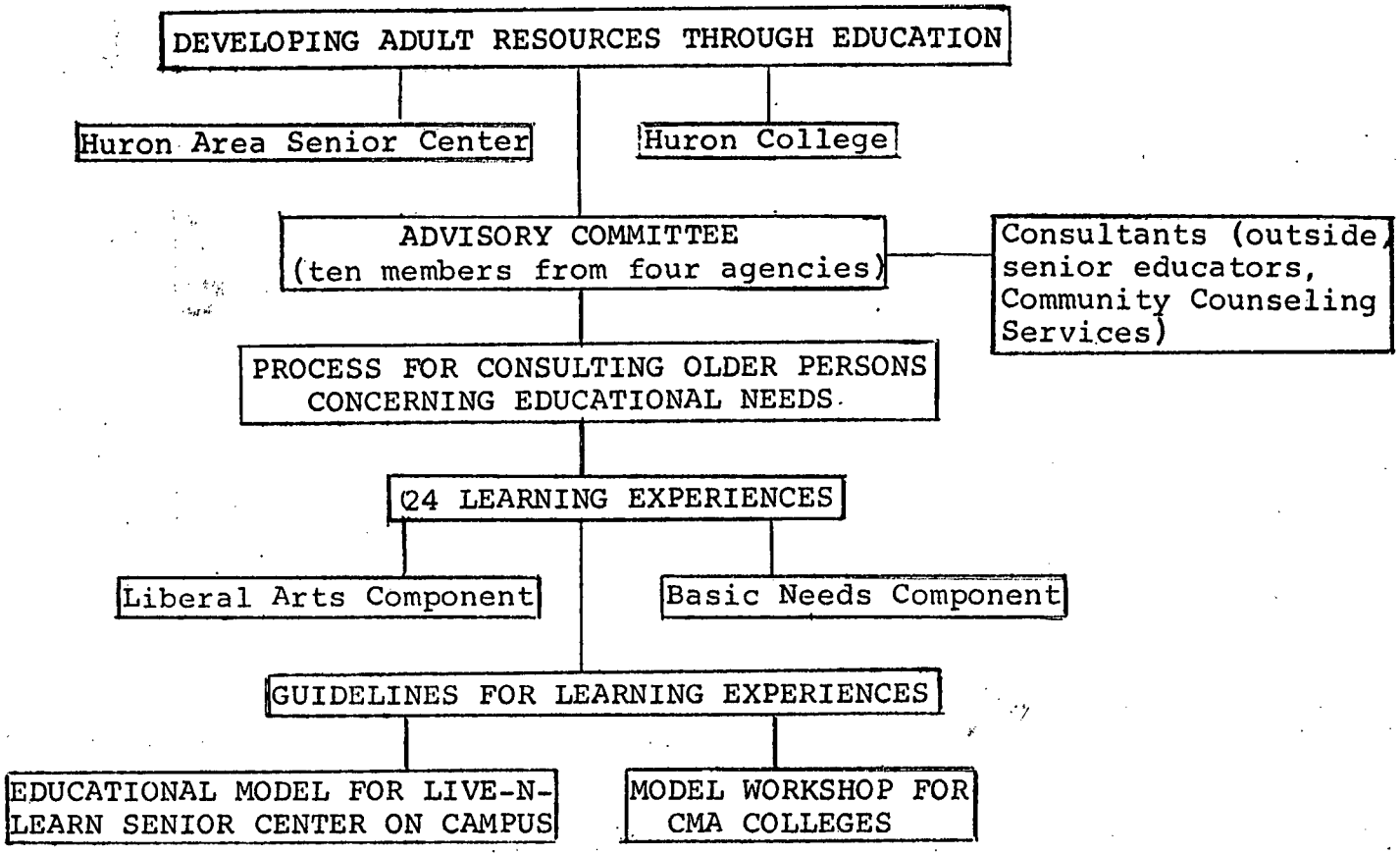
The DARE program and the State plan for community service and continuing education.—The State plan calls for a "unified delivery system for continuing education," and that is precisely what the Huron College Community Learning Center is attempting to develop in Huron and the vicinity. The DARE program is intended as one component in a comprehensive program designed, in the words of the amendment to "make a fuller and better use of existing resources of traditional postsecondary institutions" and to "provide access for greater numbers of citizens to postsecondary continuing education, including a broader range in age and socioeconomic levels."

The amendment places special emphasis on the educational needs of older persons, describing their need for better delivery systems as "one of South Dakota's crucial social needs." On page 6, the amendment devotes considerable space to the problem of "improving access in educational opportunities for older Americans."

Huron College has been in the vanguard of the attempt to improve that access. The LAOA program has been successful. The institution acted this past spring to reduce tuition for older persons. The offer of McDougall Hall as a possible senior center for Huron residents is indicative of the college's commitment to better education for older persons in the region.

Direction of the program.—Toward rural problems.

Objective.—To develop a unified delivery system for educational services to older persons in Huron.


DEVELOPING ADULT RESOURCES THROUGH EDUCATION
Huron Area Senior Center
Huron College
ADVISORY COMMITTEE
(ten members from four agencies)
Consultants (outside senior educators, Community Counseling Services)
PROCESS FOR CONSULTING OLDER PERSONS CONCERNING EDUCATIONAL NEEDS
24 LEARNING EXPERIENCES
Liberal Arts Component
Basic Needs Component
GUIDELINES FOR LEARNING EXPERIENCES
EDUCATIONAL MODEL FOR LIVE-N-LEARN SENIOR CENTER ON CAMPUS
MODEL WORKSHOP FOR CMA COLLEGES

NARRATIVE REPORT

The goals of the DARE program.—The DARE program is designed to produce the following results:

(1) Provide a mechanism for unifying existing and future educational programs for older persons in the Huron area;

(2) Furnish additional on the educational needs of older persons; and

(3) Utilize the educational resources of the entire Huron community to meet the needs of older persons.

Specific objectives of the DARE program.—The DARE program is intended to produce these results:

(1) A minimum of 24 short noncredit learning experiences for older persons.

(a) To be offered in four phases beginning September 1976, January 1976, April 1976, and June 1976.

(b) Each learning experience to normally last an equivalent of 10 contact hours (continuing education unit equivalent).

(c) Precise subjects and formats to be decided by the director in consultation with the advisory committee and older persons involved the process for consulting them.

(d) To include a liberal arts component (9 courses) and a basic needs component (15 courses).

(e) To be taught by a combination of Huron College faculty and community resource persons.

(2) A process for regular consultation with older persons on their educational needs, thereby developing a model workable for other communities.

(3) A unified planning, organizing, and publicity system for the learning program, supervised by Huron Area Senior Center staff and with educational and administrative assistance from the Huron College Community Learning Center.

(4) A training process for Huron College faculty centered on the planning of the liberal arts component of the learning program.

(5) A refined set of guidelines for planning learning experiences for older persons.

(6) An educational model to be utilized in the event that the "live-n-learn" senior center becomes a reality in McDougall Hall on the Huron College campus.

(7) A 1-day model workshop designed by the Huron College Community Learning Center to be shared with participating institutions in the colleges of mid-America consortium for the purpose of helping these institutions develop their own programs for older persons. Workshops to be presented during 1977–78.

Procedures for achieving the DARE objectives.—The DARE program will employ:

(1) An advisory committee consisting of 10 members, including 3 senior center members, and the director, 2 Huron College faculty, and 2 representatives each from the Retired Teacher's Association and the National Association for Retired Federal Employees.

(2) Five educator-senior consultants—persons who have been educators and are older persons. They are:

Dr. Phillipp Mergler, former dean of Huron College;

Mr. Frank Smith, former Huron College dean and economics professor;

Miss Gladys Pyle, former public school teacher;

Miss Bea Koch, former college professor;

Miss Leta James, former public school teacher.

(3) Two outside consultants on aging and education (via telephonic consultation):

C. B. Lord, associate director, Georgia Center for Continuing Education.

James Peterson, liaison officer between the Ethel Percy Gerontology Center, University of Southern California, and the NRTA–AARP, Los Angeles, Calif.

(4) The consultant services of Central South Dakota Community Counseling Services.

(5) The administrative and educational assistance of the Huron College Community Learning Center and the college's support offices, including public information, academic affairs, and the business office.

Calendar for the DARE program.—DARE activities are tentatively planned on the following timetable:

July 1976:
- Organize advisory committee.
- Plan meeting for consulting older persons.
- Telephonic consultations, consult with community counseling services.
- Plan first six learning experiences.
- Orient staff for learning experiences.
- Develop first draft of guidelines.

August 1976:
- Evaluate process for consulting older persons.
- Meet the senior consultants.

September 1976:
- Consult older persons.
- Implement phase I learning experiences.
- Meet with senior consultants.

October 1976:
- Evaluate phase I learning experiences.
- Revise guidelines and consulting process.

November-December 1976:
- Plan phase II learning experiences.
- Consult older persons.
- Work on educational model for new senior center.
- First draft of model workshop.

January 1977:
- Implement phase II learning experiences.
- Continue work on educational model.

February 1977:
- Evaluate phase II learning experiences and consulting process.
- Use data to modify educational model for center.
- Use data to modify workshop model.

March 1977:
- Plan phase III learning experiences.
- Consult older persons.

April-May 1977:
- Evaluate phase III and consulting process.
- Finalize guidelines for learning experiences.
- Finalize educational model.
- Plan phase IV learning experiences.

June 1977:
- Implement and evaluate phase IV learning experiences.
- Finalize workshop model.
- Evaluate entire DARE program.
- Set guidelines for future operation of the program.

Instructor resources.—The following persons will have assisted in or taught classes involving older persons:
- Marilyn Hill, instructor in sociology.
- Philip Wyse, instructor in music.
- Bruce Woodruff, instructor in drama.
- Kenneth Meyer, director of institutional research.
- Gene Denison, associate professor of political science.
- Frank Smith, professor of economics.
- Joyce Povlacs, professor of English.
- David Nichols, associate professor of history.
- Trudy Felix, YWCA director.
- Paul Felix, director, community counseling services.
- Matilda Tschetter, retired teacher.
- Lillian Wintle, retired teacher.
- Ted Kneebone, Huron public librarian.
- Newton Staley, retired Federal employee.
- Judy Schwartz, registered nurse.
- Ardis Gatons, Beadle County extension agent.

Competencies of the agencies to carry out the DARE program.—Huron College has manifested a growing competency in continuing education activities. This year, the community learning center was established with three staff members and the mandate to develop a comprehensive community service and adult education program. Dr. Keith H. Orr has taken educational services to churches and schools in the South Dakota region since 1972. Dr. David Nichols has administered adult education programs under five grants from the South Dakota Committee on the Humanities and is currently supervising the liberal arts for older Americans program, funded under title I.

The Huron Area Senior Center, Inc., is known as one of the finest in the State, with approximately 700 members. Under the direction of Shirley M. Overland, the center has grown and currently maintains a variety of activities that touch on health, welfare, educational needs of older persons in Huron and vicinity. The center supervises a number of Federal grant programs as well as funds furnished by the city of Huron and Beadle County.

Proposed commencement date of program.—July 1, 1976. Proposed completion date: June 30, 1977.

Governmental units, private organizations, and community agencies cooperating in the program.—Retired Teachers Association; National Association of Retired Federal Employees; community counseling; CMA Colleges: Briar Cliff, Buena Vista, Dakota Wesleyan University, Dordt, Mount Marty, Northwestern, Sioux Falls, Westmar, and Yankton.

Population to be served.—Older persons (55 years of age and older) in Huron and vicinity.

Geographic location.—Primarily in Huron at the Huron Area Senior Center and at Huron College.

SIGNIFICANCE AND UNIQUENESS OF THE PROGRAM

The significance of the DARE program is that:

(a) There is only one other program in South Dakota that approaches its comprehensiveness in an attempt to have a unified educational delivery system.

(b) It has the potential for producing a workable model of program development and cooperation that can work for other communities.

(c) The possibility of developing, as part of the DARE program, an educational program to be utilized in a college residence hall—senior center at Huron College is unique to South Dakota.

Evaluation procedures.—The DARE program will employ the following types of evaluation:

(1) Continuous monitoring:

(a) By the advisory committee.

(b) By community counseling services.

(c) Through evaluations by the older persons served in learning experiences.

(2) Final evaluation:

(a) By the advisory committee.

(b) By two outside evaluators to be selected by the advisory committee.

PROJECT COSTS

Method of financing:

Appropriations, 66⅔ percent.

Institutional funds, 33⅓ percent (including in-kind matching).

Funds: Huron College, $16,227 Federal; $8,657 Matching; $24,934 Total; cost per participant, $33.

BUDGET FOR DEVELOPING ADULT RESOURCES THROUGH EDUCATION PROGRAM

Personnel	Requested	Matching	Total
Project director: Estimated 240 hours at $10 per hour	$1,500	$900	$2,400
Faculty planning time: Equivalent of 4 days at $100 per day for 9 persons	2,700	900	3,600
24 course instructors:			
9 professionals at $500 per course	4,500	----------	4,500
15 nonprofessionals at $200 per course	1,500	1,500	3,000
Advisory committee: 6 days at $50 per day for 9 persons	1,800	900	2,700
Consultants (telephonic)	150	----------	150
Consultant services, community counseling services: 8 days at $100 per day	500	300	800
Senior-Educator consultants: 1 day at $100 per day for 5 persons	500	----------	500
Outside evaluators: 2 persons at $100 per day for 2 days plus travel and per diem	600	----------	600
Secretarial and office (including community learning center services, public information services, etc.)	700	1,000	1,700
Materials and publicity	1,000	----------	1,000
Equipment rental: Estimated rental for mimeograph machine and typewriter for 12 mo	100	----------	100
Other	727	----------	727
Indirect costs, 15 percent	----------	3,157	3,157
Total	16,277	8,657	24,934

ITEM 4. "KARE" PROGRAM PROPOSAL OF HURON COLLEGE, SUBMITTED BY SHIRLEY OVERLAND

MISSION STATEMENT

Be it resolved, That the Huron College Board of Trustees commits Huron College to becoming the lifelong learning center for all ages in central South Dakota.

This is a new thrust in Huron College history, and the trustees intend that it shall encompass the operations of the entire college.

The new program stands for redefinition of our historic Christian mission, expressing through education the reconciling love that is in Christ Jesus. Therefore, we welcome not only all ages, but all faiths to a reconciling community where every person is treasured for what he or she can contribute to learning.

At the same time, the lifelong learning center stands for practical education in a world where people will have many careers and must develop stable values to cope with life's uncertainties. To that end, Huron College's lifelong learning program will stand for excellence and commitment to fundamentals (reading, writing, speaking, and critical thinking) that will continue to be needed.

We intend Huron College to become one of the distinctive colleges in the Midwest.

Adopted by Board of Trustees, July 9, 1976.

STATEMENT OF DAVID A. NICHOLS, HURON COLLEGE, HURON, S. DAK.

THE PROPOSAL: THE "KARE" PROGRAM (KINSHIP OF THE AGES THROUGH RECONCILING EDUCATION)

Huron College proposes to establish a cross-generational learning community on its campus. This will be a demonstration model for what colleges must do to meet the needs of "the learning society" in the last quarter of this century. The project will be based on a cooperative effort with the Huron Area Senior Center, the foundation of which will be the conversion of a residence hall to a "live-n-learn" senior center featuring both living quarters and public activity space.

On this foundation, Huron College will develop an educational program unique in scope and conception. The college will seek to meet the educational needs of a large senior population, utilize older persons as educational resources for the young, and construct a cross-generational framework for lifelong educational renewal for an entire rural community and its environs.

This model program will produce a unique laboratory for social and educational gerontology, new curricular models for small colleges across the Nation, and contribute to a cross-generational redefinition of liberal arts education.

THE LEARNING SOCIETY: THE FUTURE IS HERE IN HURON

America is becoming an older society. Demographers predict that one in two persons will be above the age of 50 by the year 2000. This development will profoundly affect every American institution, including higher education. Colleges, if they are to survive and be worth saving, must become lifelong learning centers in a "learning society" (Hesburgh et al., Patterns for Lifelong Learning, 1973, p. 4).

South Dakota is already far advanced in this demographic revolution. One in eight South Dakotans is 65 years of age, compared to 1 in 10 nationally. The State ranks seventh in the Nation in the proportion of its population in this age group. From 1960 to 1970, the proportion of older Americans in South Dakota increased 11.1 percent. Sixty percent of South Dakota's older persons never completed elementary school and only 10 percent attended college, with 4 percent completing a college degree. These are persons with needs accentuated by the isolation and lack of services common to a low-income rural region.

These characteristics are even more sharply focused in the Huron area. In Beadle County, 17.2 percent of the population is 65 years of age and older and 25 percent are 55. The Huron area is a microcosm of 21st century America with all the problems and opportunities therein. It is an ideal laboratory for testing models for the learning society of the future adapted to the special needs of rural areas.

THE YOUTH-CENTERED COLLEGE: A FAILURE FOR YOUNG AND OLD

For the past generation, colleges and universities have generally operated as "youth ghettoes." Their programs, policies, and practices have been geared to high school graduates. Older persons rarely entered college programs and, when they did, they were forced into youth-oriented molds.

The recent interest in older American education has not broken the youth-centered paradigm around which institutions plan and operate their programs. With few exceptions, these colleges and universities have taken two courses of action: (1) They have set up segregated educational programs, conceived by younger professionals for older persons; (2) They have attempted to lure elders into the regular academic program. Most of the latter have not been very successful because older persons find themselves forced into programs and institutional environments geared primarily to prepare young people for the job market.

These programs fail to adequately meet the educational needs of older persons. They fail to utilize the older person's experience and wisdom as an educational resource for younger persons. They deprive younger persons of cross-generational social competencies necessary to effective functioning in a cross-generational work world. Finally, they accept a narrow definition of liberal arts education as an exposure to a variety of subjects. The learning society of the future demands something more.

NEED FOR THE LEARNING SOCIETY: A NEW IDEA OF A COLLEGE

The surrogate extended family concept—The learning society will demand that educational institutions reincarnate the cross-generational learning environment once furnished by the extended family. Ours is a society in which individuals and family units have become increasingly isolated. That isolation has been psychologically destructive for older persons and it has deprived the young of the experience, wisdom, and familial roots essential to healthy development.

Huron College proposes to integrate a surrogate extended family factor into its educational program through the establishment of a cross-generational learning community where both age groups have support systems adequate to encourage interaction.

Redefining the liberal arts—The cross-generational concept demands a broadening of the liberal arts definition to include exposure to a variety of people and ages. In other words, people learn from one another, not just books or teachers. A liberating education is not adequately provided in a marriage and the family class containing only young people who have never raised a family. It is insufficient to have business classes without experienced business persons as resources. Experience and knowledge are inseparable and an awareness of the life cycle should inform all subjects in the curriculum.

This redefinition is essential for the new kind of college. It will create the comfortable environment whereby older persons can profit from higher education in an atmosphere of respect for their worth as educational resource persons. It will also enable the young to benefit from the experience and wisdom of the aged. This interaction factor will be mandatory for education that claims to be liberating for any age group in the learning society. It will have impact on both content and teaching methods in the college classroom.

FOUNDATION FOR THE PROGRAM: THE M'DOUGALL HALL PROPOSAL

For 6 months, Huron College and the Huron Area Senior Center, Inc., have been involved in negotiations concerning the possible lease or sale of a large residence hall, McDougall Hall. The senior center, with its 700 members, has outgrown its present facility. The need for additional space, the shortage of additional low-income housing for older persons, and the success of the DARE program all encouraged consideration of the residence hall.

The Huron College trustees, at their December 11, 1975, meeting, decided to sell the building if funds could be secured. The Huron Area Senior Center then applied to the Department of Housing and Urban Development for renovation and purchase funds. The plan calls for the creation of from 23–28 low-income housing units for older persons and public space for senior center activities. The building and lot, while owned by the center, would function as an integral part of the campus and center members could be provided with a wide variety of educational services. The senior center will hear on April 15 as to the disposition of the application.

Once established, the presence of this senior center and living quarters on the campus will provide the basis for the rest of the KARE program, an ideal laboratory for gerontology and lifelong educational services for the learning society. It will also furnish a support system for older persons that will provide the requisite security for participating in the broader campus life.

THE HURON AREA SENIOR CENTER

The uniqueness of the proposed project rests on the excellence of the Huron Area Senior Center, Inc. In a 4-year period, the center has grown from 75 to over 700 members. The leadership projects a potential membership of 1,500 members. Its range of services include home care, nutrition, RSVP, meals-on-wheels, and many others. The center has an extensive transportation program and is involved in servicing 400 additional senior center members in five satellite centers in Beadle County. The Huron Area Center, under the leadership of Director Shirley Overland, has gained a reputation as the finest operation of its kind in the State and region.

HURON COLLEGE AND THE COMMUNITY LEARNING CENTER

Huron College is a 4-year, liberal arts college associated with the Presbyterian Church. Established in 1883, the college presently has 360 students. In 1975, the college community declared its commitment to Christian principles in education—in particular, the principle of reconciliation. That statement includes the following:

"In working for reconciliation, we include people of many backgrounds, interests, ages, abilities, and beliefs. We seek to learn from the culture and heritage of many, particularly those who are indigenous to our area—rural and urban, young and old. . . .

"We have a special commitment outside our campus to the area we live in, serving as a catalyst for reconciliation and a center of learning and culture for central South Dakota and beyond. Interaction among students, faculty and members of the larger community helps free us all from limited knowledge and narrow attitudes.

"We encourage lifelong learning and careers that involve people's whole lives. . . ."

To these ends, the college established an office called the community learning center. This office is intended to go beyond the extension educational services normally associated with colleges and universities. The community learning center provides a variety of educational services (workshops, programs, courses) for adults in South Dakota. It has been involved in attempts to institutionalize a

cross-generational learning community on the campus by developing programs and policies designed to serve mature adults in the regular academic program. As a result, students above the age of 25 number one in four of Huron College students. In addition, the learning center has furnished a number of noncredit learning experiences, involving a cumulative total of over 300 senior citizens in short, noncredit courses in the past 8 months.

Under the codirection of Dr. Keith Orr and Dr. David Nichols, the center is developing a comprehensive plan for community education for Huron and the region. The community learning center's 5-year plan calls for a reorientation of all college personnel, programs and policies to serve lifelong learning needs. This program is an unprecedented attempt to make the entire institution into a community learning center, a source of lifelong educational renewal for the Huron community and the region it serves. If successful, the Huron College program will become a model program for post-secondary education in the learning society. The KARE program is therefore the centerpiece of a larger comprehensive community education program.

SPECIFIC OBJECTIVES OF THE KARE PROGRAM

(1) To encourage constructive attitudes toward and knowledge of the life cycle among all age groups in the college community.

(2) To eliminate agism in college social and intellectual life.

(3) To serve the special educational needs (both basic survival needs and enrichment needs) of older persons.

(4) To utilize older persons as resources for learning and counseling, cultivating the intellectual circle of young and old.

(5) To foster surrogate extended family relationships among young and old.

(6) To reorient college personnel, policies, and programs to the needs of older persons.

(7) To redesign disciplinary and professional fields of study to include aging components and educational methods utilizing older persons as resource persons.

(8) To assist younger students in acquiring cross-generational competencies for effective service in the learning society of the future.

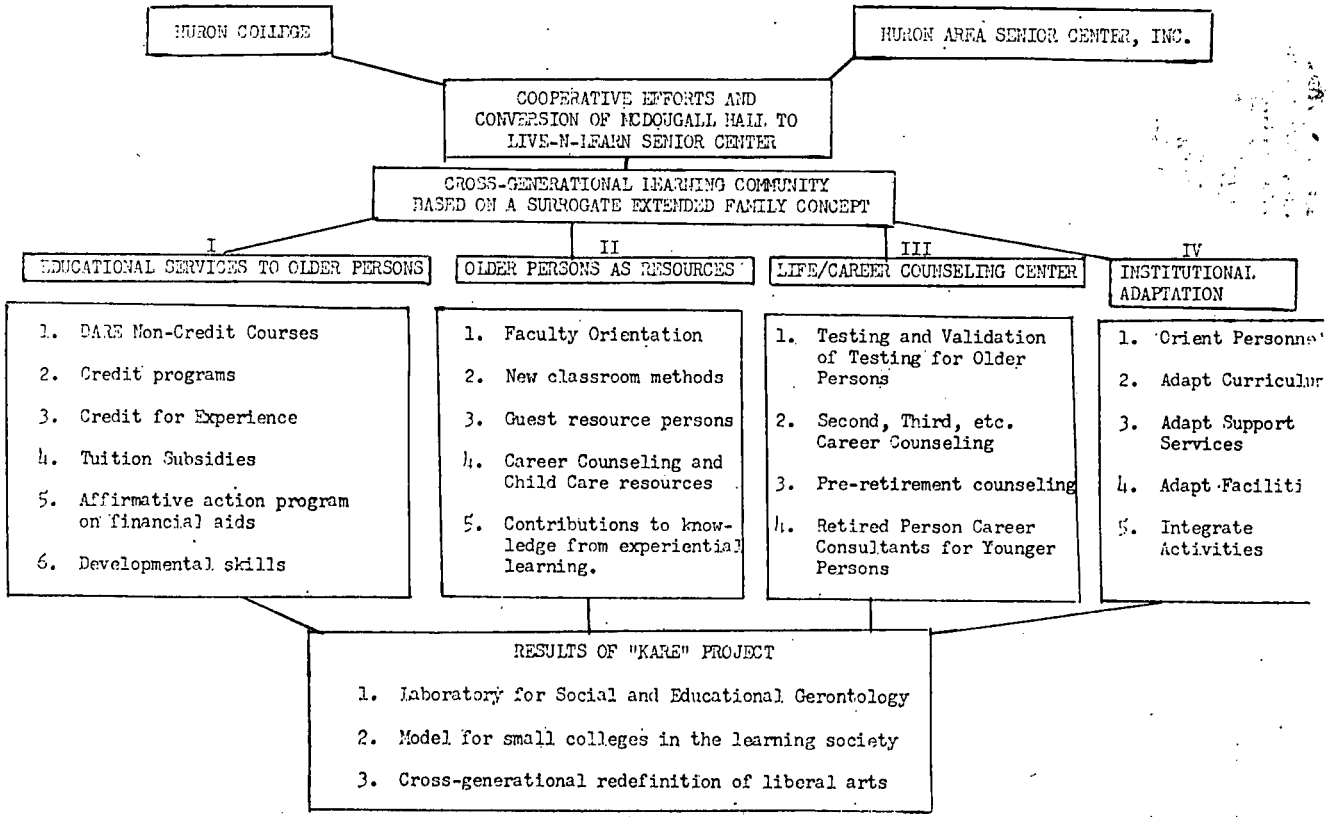
(9) To provide counseling to meet cross-generational needs in planning first careers, second careers, and retirement.

(10) To utilize the young-old educational framework as the grounding for servicing the lifelong learning needs of older age groups between youth and the aged.

(11) To establish a living laboratory for social and educational gerontology to benefit preprofessionals and professionals.

(12) To demonstrate the utility of redefining the liberal arts to include an exposure to a variety of persons and age groups.

9. DIAGRAM OF THE "KARE" PROGRAM



WHAT WE INTEND TO DO: COMPONENTS OF THE KARE PROJECT

Component No. 1: Educational Services to Older Persons

(1) *What Huron is already doing—The DARE program of noncredit courses.*—In 1975, the community learning center received title I funding in the amount of $19,099 for a program entitled, "Liberal Arts for Older Americans." The premise of this program was that many educational programs aimed at senior citizens either focused them into educational molds conceived for young persons or provided segregated, paternalistic, and trivial learning experience designed by younger persons and based on myths concerning the learning capacities and interests of older persons.

The "DARE" program (developing adult resources through education), as it was eventually renamed, is predicated on the idea that older persons can and do value learning in traditional liberal arts disciplines, provided those disciplines and teaching methods are adapted to their special needs. The DARE program has become, therefore, a vehicle for faculty members to adapt their disciplines' content and methods to senior needs.

This program has been popular and successful. As it has developed, the advisory committee has moved to integrate learning experiences designed to meet basic needs (consumer education, defensive driving, estate planning, etc.) with the liberal arts offerings, an integrated delivery system for educational services. This integrated system was recognized with a second title I grant of $24,934 in January 1976 (funds to be released during fiscal 1977).

A major purpose of the DARE program has been to, where possible, encourage cross-generational learning activities. A sociology of leisure class (summer 1975) was successful in involving persons with an age range of 19 to 80. Most recently, a January term course, "Myths of Aging," involved younger students at the College in a balanced program of study and field experience and cross-generational social activities with members of the Huron Area Senior Center. This class was one of the most successful January term courses in the recent history of the college. It demonstrated the utility of the integrative principle that underlies the proposal to establish a "live-n-learn" senior center on campus as part of a cross-generational learning community.

A cumulative total of more than 300 older persons have been involved in the DARE program and its auxiliary activities. To this point, however, these programs have taken place mostly at the current senior center (which is located some distance from the campus) and have been only peripherally integrated with regular college study. It highlights Huron College's successful track record in educating older persons, and it demonstrates our capacity for implementing the more comprehensive KARE project.

(2) *What Huron College seeks to do: The regular academic program.*—Where most colleges have failed, Huron hopes to succeed in integrating older persons into the degree-granting curriculum. The following constitute important factors in this program:

(a) The orientation of staff and faculty to serve older adults;
(b) A credit for life experience program;
(c) Tuition subsidies;
(d) An affirmative action program to guarantee older persons equal access to all financial aids; and
(e) A developmental skills program to assist older persons in adjusting to college-level academic work.

The orientation of staff and faculty will be covered more thoroughly below, but it is essential to integrating older persons into course work. The redefinition of liberal arts described above will assist in this because it treats older persons not merely as students but as resource persons.

The credit for life experience program is already in operation at Huron College, but there has been insufficient personnel time available to go through the process of applying it to senior citizens. The college needs additional funds to hire personnel to accredit experiential learning properly.

Huron College has taken steps to open all financial aids to adult students and some younger adults have taken advantage of this program. However, older Americans need special attention and help in putting together Federal family financial need statements necessary to receive basic opportunity grants, work-study funds, low-interest loans, and other aids.

These aids will not be sufficient for some older persons on low incomes. Huron College currently charges $99 per unit (40 percent of the regular tuition) for credit and $25 for audit (50 percent of the regular fee) for senior citizens. As a small private college, Huron cannot afford to cut these fees further and needs tuition subsidies to help provide educational services to older persons.

Finally, one of the great concerns for older persons entering college work centers on their study skills. A major objective will be to validate the McGraw-Hill basic skills, writing, reading, and vocabulary tests, and the Brown-Carlsen listening comprehension test with older persons and adapt them to their needs. At the same time, in line with the cross-generational emphasis, the Huron College study skills clinic will attempt to utilize older persons as developmental skills assistants in working with younger students needing assistance.

Component No. 2: Older Americans as Educational Resources

Fundamental to the KARE program is the idea that utilizing older persons as educational resource persons enriches both the learning of younger students and provides the foundation for comfortable entry of seniors into degree-granting college programs. Older persons have experience, wisdom and perspective to bring to learning experiences which they can profit from the fresh ideas of younger persons.

Huron College seeks to systematically utilize the elder educational resources that will be so readily available due to the establishment of the senior center adjacent to the campus. Specifically, Huron will seek to:

(1) Orient faculty to the valuable resource in older American experience;

(2) Develop classroom methods to effectively utilize older persons who enroll in the academic program;

(3) Establish a program of paid guest-resource persons drawn from the senior population;

(4) Develop a program utilizing the professional experience of retired persons in career counseling (see the life/career counseling component below);

(5) Identify, utilize, and preserve the contributions to knowledge that can be obtained from older adult experiential learning (e.g., oral history, etc.); and

(6) Utilize the child care competencies of older persons in a child care program integrated with educational programs and serving younger single parents-students with child care needs.

Component No. 3: A Life/Career Counseling Center

South Dakota has no sophisticated career counseling center for any age group in the State. Persons can expect to change vocations as many as five times prior to retirement. Huron College proposes to meet the need by establishing a unique cross-generational counseling center. A feature of this center will be the utilization of retired professionals as career consultants. At the same time, an effort will be made to provide second career counseling (or beyond second careers) and preretirement counseling.

The counseling center will be predicated on a recognition of the inevitability of career changes. It will assist persons all along the age spectrum in achieving positive perceptions of the life cycle and avoid the "on the shelf" syndrome for older persons.

Younger students (including mature adults planning a second career) will go through the following steps:

(1) Interview with a career counseling clinician;

(2) Take interest and personality tests;

(3) Have test battery results evaluated by the clinician;

(4) Interview with a retired professional career counselor (an older person experienced in law, business, medicine, etc.);

(5) Have a composite evaluation prepared by the clinician and the retired person; and

(6) Have a conference for sharing evaluation results.

The older person-consultant will be involved in steps four and five. These persons will be hired on a consultant basis.

In counseling older persons, a major concern of the center will be appropriate testing procedures. At present, no comprehensive set of tests are available that are appropriate to the needs of older persons.

The Huron College Counseling Center, under the leadership of Dr. Tyra Talley, will attempt to validate instruments and establish fresh norms to assist older persons. The following instruments will be utilized:

(1) The Minnesota Mutiphasic Personality Inventory;

(2) Dr. Grace Kent's Emergency "D" scale to assist in sorting out persons not suited to academic work and identify different interests;

(3) The general aptitude test battery to establish criteria for over-all expectations; and

(4) The Strong vocational inventory test (would be useful in identifying areas of critical interest for alert and aggressive older persons).

The counseling center staff will attempt (in cooperation with the developmental skills program utilizing the McGraw-Hill study skills tests) to adapt these instruments to the needs of older persons and provide a model career and retirement counseling program for the region.

Component No. 4: Institutional Adaptation to the Cross-Generational Learning Community

(1) *Orienting personnel:* Huron College seeks to orient all personnel (both teaching and nonteaching) to the needs, value, and roles of older persons who will be connected with the senior center on campus. All other plans cannot be operationalized without adequate orientation of staff. To this end, Huron College will:

(a) Hold not less than four staff workshops on aging and the needs of older persons during 1976–77;

(b) Employ consultants to meet with every administrative and academic unit in the college to assist in adapting policies and programs to the new situation; and

(c) Involve faculty in planning (both released time, summer and January term) for the adaptation of their subject areas to the needs of a cross-generational student clientele.

Fundamental to this reorientation process will be strict requirements that staff provide visible evidence (in the form of written plans, active performance, course plans, etc.) that they have, in fact, adapted and internalized new knowledge concerning older persons and the aging process.

(2) *Adaptation of the curriculum.*—Related to the orientation of teaching staff will be a process for implementing the study of aging in the curriculum. This will be done through:

(a) Specialized social and educational gerontology courses;

(b) Design of gerontology modules for utilization in existing disciplines; and

(c) Design of workshops and noncredit offering that can be provided both on and off campus.

The college will seek consultant assistance in this program and is negotiating with the University of Michigan Gerontology Institute concerning a possible consultant relationship with that institute. Dr. Howard C. McCulsky has already consulted with Huron College personnel and will be visiting the campus later this spring in that capacity.

In this program of curricular adaptation, Huron College hopes to provide a model for other small private colleges. We anticipate that no discipline or professional field will be left untouched by an aging factor. Specific examples may include:

(a) History: An increased emphasis on preserving the oral history of the region and the eye-witness accounts of 20th century events that can only be provided by the persons who lived through them.

(b) Sociology: An emphasis on personification of the life cycle, drawing on the expertise of older persons in family matters, career and retirement problems, etc.

(c) Psychology: An increased emphasis on longitudinal studies of human behavior and the impact of aging on human psychology and intelligence.

(d) Physical education: A move away from sports emphasis to increased focus on recreation and lifelong physical fitness, with personification of particular problems and field experience for recreation directors of the future.

(e) Music: Adaptation of music education methods to the needs of older persons. In the DARE program, one Huron College professor already has adapted the famous Carl Orff music education method to senior citizens on

the premise that music educators of the future must be able to educate all ages.

(f) Education: As a prominent teacher-training institution, Huron College will adapt its methods and theory courses to the realities of a lifelong learning society and the need to produce educators with the compentencies for teaching all ages.

These are only a few examples of the curricular adaptation process that must take place at Huron College. There are obviously others, especially in the sciences. This will require staff time, consultant help, and careful consultation with older persons themselves.

(3) *Adaptation of support services.*—Huron College plans to offer, beyond the sale of McDougall Hall, a range of support services to Huron Area Senior Center members. These will include:

(a) Free access to the college library and development of library holdings in gerontology and senior services;

(b) Free access to college activities;

(c) Free access to college recreational facilities, including the swimming pool;

(d) Free access to services in the Huron College Campus Center;

(e) Food service;

(f) Public information office services;

(g) Business office services; and

(h) Health care services (campus nurse).

These services are costly and the college must seek outside funding in order to provide them. Their provision is fundamental to the establishment of the cross-generational learning community envisioned in the KARE project.

(4) *Adaptation of facilities.*—Huron College has facilities other than McDougall Hall which older persons will utilize and which require modification for safety and adequate service. Specifically, the college needs to:

(a) Build ramps and handrails at a variety of locations on the campus;

(b) Remodel the gymnasium and swimming pool area to remove safety hazards;

(c) Install an elevator in Voorhees administrative and classroom building and elevator ramps in the library and campus center; and

(d) Install a closed-circuit cable television production system of educational service to shut-ins.

SPECIAL MECHANISMS FOR IMPLEMENTING THE "KARE" PROGRAM

Huron College will utilize the following mechanisms in implementing the KARE program:

(1) An educational needs assessment process for older persons (the DARE program has produced one significant survey and developed some informal consultation processes);

(2) A cross-generational advisory committee representing both elder and younger student interests and community leadership, to number 12 persons: and

(3) Working alliances with the South Dakota Office on Aging and other State social agencies, senior organizations (including the Retired Teachers Association, Retired Federal Employees, etc.), the Gerontology Association for Training and Education of South Dakota (GATE), and consultant personnel from the University of Michigan Gerontology Institute and other such institutions.

CALENDAR FOR IMPLEMENTATION

The calendar for implementation is currently in preparation. It is dependent, in part, on word from the Department of Housing and Urban Development concerning the purchase of McDougall Hall. That approval is expected on April 15, 1976. Thereafter, negotations will be completed and a timetable for renovation of the building can be established. The following is therefore quite tentative.

The assumption of the proposal is that KARE activities can begin in the fall of 1976. The activities for 1976–77 include:

Orientation of staff (workshops and travel),

Renovation of campus facilities,

Employment of project director and counseling director,

Pilot credit, tuition and skills development activities,
Pilot utilization of support services,
Introduce gerontology into the curriculum,
Establishment of advisory bodies, and
Pilot use of older persons as educational resources.

The second year will be concerned with:

Expansion of the counseling staff,
Completed adaptation of curriculum units,
Expansion of services to satellite senior centers,
Employment of an assistant project director,
Development of pilot workshops, teaching modules, and
Integrated activities of every kind.

The third year will focus on services outside the campus, including:

Expanded services to professionals serving seniors,
Educational services to nursing homes and their personnel,
Dissemination of project results through workshops, seminars, teaching modules,
Expanded services to satellite senior centers, and
Production of literature and scholarship on aging.

In general, the implementation pattern will call for an emphasis on orientation, planning and pilot projects the first year, institutionalization of the full-blown program the second year, and dissemination of information and service beyond the campus the third year.

IMPLICATIONS OF THE KARE PROJECT BEYOND THE CAMPUS

The program will eventually have an impact beyond the college campus. Huron has two sizeable nursing homes and eventually both the professional personnel and the residents of those homes will be served by the Huron College program. The Huron Area Senior Center assists five Beadle County satellite centers and they will benefit from the cooperative relationship with Huron College.

Huron College participates in GATE (Gerontology Association for Training and Education), the State organization, and the Huron program will be a significant component in the statewide gerontology program. The GATE organization will become the major vehicle for disseminating knowledge and program skills gained through the KARE project.

PLANS FOR DISSEMINATING KNOWLEDGE AND PROGRAM SKILLS

Through the community learning center, Huron College has the competent personnel, experience, and means for disseminating information about aging and service programs for elders. This will be done through the development of workshops for both public school and post-secondary educators and seminars for social service, nursing home, and senior center professional personnel.

The GATE organization, with its connections with institutions of higher learning and senior organizations, will be a major channel for the dissemination of information.

Huron College will attempt to share knowledge through provision for visits and research by scholars, programs on the campus, and articles for journals. The college will also attempt to package teaching modules on aging that can be a major channel for the dissemination of information.

Huron College will attempt to share knowledge through provision for visits and research by scholars, programs on the campus, and articles for journals. The college will also attempt to package teaching modules on aging that can be utilized by organizations and educators.

EVALUATION OF THE KARE PROJECT

The KARE project will utilize an outside evaluator process, drawing evaluators from the South Dakota Office on Aging, the University of Michigan Gerontology Institute, and the GATE consortium. These consultants will assist in the identification or construction of evaluative instruments for each of the four components of the program.

Internal evaluation will be conducted by the cross-generational advisory committee and each administrative unit in the program. Older persons themselves will be given opportunity to evaluate the program at all points.

A major component of the first year's program will be concerned with developing adequate evaluative instruments.

NATIONAL SIGNIFICANCE OF THE KARE PROJECT

At present, three private colleges (to our knowledge) have or are planning to establish living quarters for elders on their campuses. These are Bucknell in Pennsylvania, St. Benedict's in Minnesota, and Fair Haven (the "bridge" program) in Washington State. The University of Syracuse also has living quarters for seniors and a number of other institutions are considering utilizing empty residence halls for housing. A few community colleges have helped to start senior centers as part of their operation.

To our knowledge, none of these situations envision a cross-generational learning community of the type described above. None of them involve a senior center with the range of services, membership, or reputation for excellence associated with the Huron Area Senior Center. None are seeking to so fundamentally alter the operating assumptions of higher education in redefining the liberal arts. Huron College is, in the words of consultant Howard McClusky (University of Michigan Gerontology Institute) "changing the rules of the game."

The project is highly significant for the low-income rural region that is central South Dakota. The life/career counseling component, when operational, will provide the only sophisticated career counseling available in the entire State. There is nothing like the KARE counseling conception closer than Minneapolis, Minn. (United Theological Seminary), and that program does not utilize retired professionsl as counseling resources.

Finally, the Huron College project will provide a unique laboratory for social and educational gerontological field study in a rural State where educational innovation has been rare. It will be a model for rural educational development for small private colleges and the communities they serve. The density of its senior population makes it a demonstration model of education for the learning society of the future. In the KARE program, the future has already arrived at Huron College.

ITEM 5. MEMORANDUM FROM BETTY J. CLAYMORE, CLINICAL SOCIAL WORKER, PUBLIC HEALTH SERVICE, EAGLE BUTTE, S. DAK.; TO JACK CLAYMORE,[1] DATED AUGUST 16, 1976

There is a need for an intermediate care facility on the Cheyenne River Reservation so that residents with deteriorating health will not have to move to a foreign environment in their last years. The closest nursing home is 70 miles away in Gettysburg. Mobridge and Pierre nursing homes are about 90 to 95 miles.

Our office is now involved with social services to 12 Indian patients residing in off reservation nursing homes. I am sure that there are that many again with whom we have no contact in addition to that many non-Indians from Eagle Butte who would also prefer to remain in this community.

One of the problems we are constantly dealing with is elderly in the Manor apartments whose health is deteriorating to the point where they can no longer be unattended.

We cannot find live-in homemakers willing to work 24 hours per day and if we did find two or three homemakers willing to do shift work there would still be no funding under supplemental security income which is the primary income of most of our recipients.

Many of our people prefer to speak Lakota and, when they are in non-Indian facilities, seldom communicate with staff and other patients due to the language difference. Relatives seldom visit because of the distance and cost involved and patients become depressed quickly and refuse to eat, resulting in early demise.

BETTY J. CLAYMORE.

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[1] See statement, p. 278.

ITEM 6. STATEMENT OF IYONNE GARREAU, NUTRITION PROGRAM PROJECT DIRECTOR, CHEYENNE RIVER SIOUX RESERVATION; SUBMITTED BY JACK CLAYMORE

At the present time, the nutrition program for the elderly—the home site, located in Eagle Butte—is serving three communities on a daily basis. Twice a week, we serve two other communities, located on the far west end of the reservation. Funding is through title VII funds.

The Cheyenne River Sioux Tribal Council has, by resolutions, indicated its support by authorizing the use of tribal government revenue sharing funds to open and maintain a meals site for the elderly at the far east end of the reservation. This site provides a noon meal daily to two communities.

This year, through supplement title VII funds, we will be able to provide daily meals, home delivered, to the two communities on the west end, and also contract with the BIA school to provide a noon meal to another community on the west end.

Our goals and objectives are to reach out to the five remaining communities.

In order to accomplish this goal, we need adequate transportation. At the present time, we are operating with three buses and the use of private vehicles to pick up and deliver participants to the congregate site and home deliver the noon meal.

Transportation is at the top of our priority list. We have a total of 420 enrolled eligible elderly persons within the Cheyenne River Reservation.

ITEM 7. MEMORANDUM FROM DOROTHY CLARK, SOCIAL SERVICES REPRESENTATIVE, PUBLIC HEALTH SERVICE; TO JACK CLAYMORE, DATED AUGUST 11, 1976

Some of the needs for the Elderly needed on the reservation are:

(1) More homemaker services—to give services such as cleaning, helping with meals, and general housework.

(2) Transportation getting to places of business, such as shopping for groceries, etc., is still a problem.

(3) Protection services from other family members who are intoxicated and run the elderly out of their own homes.

(4) More workers to haul wood, fuel, and water.

(5) More money for home improvement.

Thank you.

ITEM 8. LETTER FROM SANDRA LE BEAU AND BLAINE CLOWN, SR., CHEYENNE RIVER SIOUX TRIBE; TO NANCY SNYDER, DIRECTOR, FOOD STAMP DIVISION, U.S. DEPARTMENT OF AGRICULTURE, DATED JULY 22, 1976; SUBMITTED BY JACK CLAYMORE

DEAR MS. SNYDER: Pursuant to our telephone conversation earlier this month concerning the expiration date for the food distribution program on Indian reservations, I contacted four of our local programs who are directly involved with persons who receive commodities to get their comments. Copies of their comments are enclosed for your information.

I believe it is obvious by the four memorandums that these programs are frightened by the aspect of going totally to a food stamp program. Economic factors alone, which involve the cost of hiring a car to come to a town that has a store runs around $20. The average income for our people on this reservation is $2,300, and for our elderly people it is substantially lower. Other factors such as time, distance, limited availability of the stamps, lack of staff for the program, etc., all enter into the picture.

We have had the food stamp people present a workshop to our tribal council concerning their program. I believe it was the general concensus of the council and others who work with the poor and elderly that, given the right education

on the food stamp program, the younger people would gradually accept it, and at some time in the future the people themselves would make the switch from commodities to food stamps. It was also the concensus of our people that if the commodity program is terminated our people will go hungry, especially the elderly.

I do not feel it is the intent of the Federal Government to deny services to those in need, and I sincerely hope we can work with your office to work out a solution to this problem. As I stated on the phone, we extend an invitation for you to come to Cheyenne River Sioux Reservation at your convenience. I believe if you could visit Bridger or Red Scaffold you would understand more the hardship terminating the commodity program would cause our people.

I am also enclosing a copy of our Tribal Resolution 40–76–CR and a map of Cheyenne River Reservation for your information. If we can assist you in any way, please let us know.

ITEM 9. RESEARCH PAPER PREPARED BY EDWARD P. HOGAN,[1] Ph. D., DEPARTMENT OF GEOGRAPHY, SOUTH DAKOTA STATE UNIVERSITY

Every Eighth South Dakotan

INTRODUCTION

In the U.S. "Census of Population: 1970," statistics on the age composition of the national population indicate that every tenth person is an older American—age 65 years and older. According to the U.S. Department of Health, Education, and Welfare, the older Americans in 1975 numbered almost 22 million people and comprised over 10 percent of the Nation's total population.

America has experienced a significant change in the age composition of its population during the last 70 years. In 1900, only 4 percent of the total population, or 3 million individuals, were 65 years of age and over. The increase during the last 75 years of some 19 million people more is due to a number of factors. Among them are: increased population, increased life expectancy, improved health services, a higher standard of living, and various other factors.

The U.S. "Census of Population: 1970" for South Dakota showed even more significant data concerning the older American in that State. While nationally every 10th American is 65 years of age and older, every 8th South Dakotan is an older American. In other words, some 12.1 percent of the people in South Dakota are 65 years of age and older. Recent projections by Robert T. Wagner[2] of the Department of Rural Sociology at South Dakota State University estimate that in 1975 older Americans comprised over 12.3 percent of the population of South Dakota.

Herman B. Brotman, Assistant to the Commissioner of the Administration on Aging of the U.S. Department of Health, Education, and Welfare, prepared a paper entitled "Every Tenth American." It described the characteristics of the older American in 1970. This paper, "Every Eighth South Dakotan," is designed to provide the reader with a summary of the characteristics of the older South Dakotan. In this manner, the reader will be able to see what the older population in South Dakota is like, especially in comparison to the older American population in general.

The older South Dakotan will be examined in relation to: number, age, sex, health, life expectancy, income, expenditures, education, marital status, living arrangements, mobility, isolation, voting, and various other major problems. Some conclusions and recommendations will also be included at the end of this paper.

NUMBER

From 1900 to 1970, the population of the State of South Dakota increased 66 percent. During that same 70-year period, the total population of the United States increased almost 300 percent. It can, therefore, be seen that the population of South Dakota has grown at a far slower rate than the Nation as a whole.

The number of people in South Dakota in 1970 65 years of age and over has increased to 6.27 times its size in 1900. In comparison, the national older popula-

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[1] See statement, p. 294.
[2] See p. 297.

tion has increased in size almost seven times since 1900. Therefore, the increase in the older population in the State has almost equalled the percentage increase in the Nation. However, the increase in the older population of South Dakota is even more significant when one considers that the Nation grew about four times faster than the State.

From 1960 to 1970, the older South Dakotans increased in number from 71,513 to 80,434 people, or an increase of 11.1 percent. This figure is very significant when compared to the State's total population, which decreased 2.2 percent during the same 10-year period. This, of course, also reflects the fact that the younger populations are much more likely to out-migrate. In comparison, the number of older Americans increased 21 percent from 1960 to 1970. The total population of the Nation as a whole increased 13.3 percent during that same 10-year time span.

This growth trend continued into the seventies. From 1970 to 1975, the U.S. Census Bureau estimates that the number of South Dakotans increased 2.2 percent to 682,000 people. During that same 5-year period, Wagner estimates the population of older South Dakotans as increasing 4.4 percent to over 84,000 people. Thus, even with growth in the total population of the State, the older population continues to increase in number at a more rapid rate.

In the last 15 years, the older population in the United States has increased in number at a faster rate than the population under 65 years of age. During that same period, South Dakota's older population grew at an even more impressive rate than the Nation, considering the State's overall loss of population and slow reversal of that loss.

AGE

In regard to the age of the older South Dakotans, the majority are under 75 years of age. Half of the older South Dakotans are under 73 years of age and 31.3 percent are under 70 years. In 1970, some 6,709 South Dakotans were 85 years of age and older. It should also be noted that some 299 South Dakotans were 100 years of age and over.

In the Nation as a whole, the age comparison of the older American is similar to that of the older South Dakotan. The majority of the older Americans are under 75 years of age. Half are under 73 years of age and a third are under 70 years old. Some 1.5 million or 7.5 percent of the elderly are 85 years or older.

There is relatively little difference in the age of the older American and the older South Dakotan. However, while 7.5 percent of the older Americans are 85 and older, some 8.3 percent of the aged in South Dakota are in that group.

SEX

Most of the older citizens in South Dakota are women. In 1970 there were 43,966 women 65 years of age and over, compared to 36,518 males in the same age group. In South Dakota there are 120.3 females 65 years of age and over for every 100 males in the same age group. The ratio of females per 100 males increases as the age gets older. From age 65 to 69 years, there are 109.8 females per 100 males. At ages 70 to 74 years, there are 123.3 women in South Dakota for every 100 men of the same ages. For those individuals 85 years of age and over, there are 151.9 women for every 100 men.

Nationally, the sex ratio for older Americans as a group is even greater. Of the 22 million older Americans, over 13 million are women. In the Nation, for the total population 65 years of age and over, there are about 139 women per 100 men. The ratio, in fact, increases from 124 per 100 men from 65 to 69 years of age to 179 females per 100 males at age 85 years and older.

In comparison then, it can be said that the sex ratio of the older citizen in South Dakota is more favorable than in the Nation as a whole.

HEALTH

In regard to the health of the older South Dakotan, a survey entitled "Social Indicators for the Aged in South Dakota" was conducted by the Business Research Bureau of the University of South Dakota in 1971. The survey conducted in cooperation with the older Americans program of the South Dakota Department of Health provides some interesting facts concerning the health of the older South Dakotans.

In general, the health of the older South Dakotan is such that over 91 percent of them rate it as varying from average to very good. Some 57 percent have no

chronic conditions, disease, or impairments of any kind. In fact, over 81 percent indicated that bad health only prevents them from doing everything they want once in a while.

Some 90 percent or more of the older South Dakotans indicated that they have no difficulty feeding themselves, watching TV, eating solid food, dressing, or putting on shoes. Over 85 percent of South Dakota's elderly found that they had no difficulty getting around the house, washing and bathing, getting out of the house, or hearing over the telephone. About 75 percent of them stated that they had no difficulty cutting their toenails. Lastly, over 67 percent of the older South Dakotans indicated that they do not encounter problems when going up or down stairs.

The health of the older South Dakotan is such that 80 percent of those surveyed indicated that they had not been sick in the month preceding the survey. In fact, over 90 percent indicated that they were ill less than 7 days that month. Only 6 percent of those surveyed were bedridden.

Some 64 percent of the older South Dakotans have undergone a physical exam in the last year. About three-fourths of the elderly believe that their health is superior to that of other people their age. Only about 4 percent of the older South Dakotans believe that they have a health problem that is not currently being treated.

In comparison with the national population, 81 percent of the older Americans get along well on their own. Surprisingly, only 14 percent of the elderly do not have any chronic conditions, impairments, or diseases of any type. However, the vast majority of the older Americans can and still do manage by themselves.

According to HEW, in 1973 some 38 percent of the older persons were limited in their major activities due to chronic conditions. A 1972 study by that department indicated that 18 percent of the older Americans face mobility problems due to chronic conditions. Some 6 percent need help to get around, another 7 percent needed mechanical aids, and 5 percent were essentially limited to their home.

One of the major health problems of the older South Dakotan or American is the fact that they are more subject to illness and disability than younger age groups. In 1973 older Americans averaged 6.5 physician visits per person per year. One out of six of them will be hospitalized during the year. Once in the hospital, they will average a 12.2-day stay.

Some 92 percent of the older Americans wear eyeglasses or contact lenses. About 5 percent of them use hearing aids. However, the elderly do not seem to utilize dental care on the same scale. Over half of the older Americans have either never visited a dentist nor had a dental checkup in the last 5 years.

In 1970 the per capita health care costs for the elderly was $791. Some $534 of that bill was paid by governmental programs. However, operating with their limited incomes, the elderly citizen still had to pay $257 of the bill. It should be noted that medicare only paid 42 percent of the medical health costs of the elderly.

By 1973 about $22.5 billion was spent on personal health care for the Nation's older citizens. This amounts to a per capita health care cost for the elderly of $1,052, over 2.5 times the costs for younger Americans. Some $682 of the bill was paid by governmental programs. However, the elderly individuals share of their health care cost increased to $370. This is a 43 percent increase over a 3-year period and far exceeded increases due to inflation during that same period.

It is important to note that the vast majority of older Americans and South Dakotans get along well on their own. The older South Dakotans are perhaps in better health than the average older American, since a larger percent of the elderly in the State do not suffer chronic conditions, impairments, or diseases.

LIFE EXPECTANCY

The life expectancy or length of life a person can expect to attain varies according to year of birth, specific age, and sex. A child born in 1900 had a life expectancy of 47 years. A child born in 1973 has an expectancy of 71 years. This is an increase of 24 years in life expectancy of the American child since the turn of the century. If that child is a male, his life expectancy is 67 years. However, if the child is a female, her length of life expectancy is over 74 years or over 7 years longer than the male. In other words, women have a significantly longer life expectancy than men.

In regard to the older citizen, whether they be in South Dakota or in the Nation, at age 65 they have a life expectancy of another 15 years. Males at 65 years of age can expect to live another 13 years, and females at that age over 17 years. At age 75 the life expectancy is another 9 years, 8 for males and 10 for females. For those citizens reaching the age of 85, life expectancy is another 5 years.

If the Nation does not experience any significant change in the present death rates, 80 percent of the female children and 65 percent of the male children will live to attain the age of 65 years. Once a person reaches the age of 65 years, they have a 50–50 chance of living to be 80 years old. At age 85 they have a 50 percent chance of living to be 90 years of age.

INCOME

In the United States in 1970, the total aggregate income of the older population was over $60 billion a year. Some 52 percent of that total came from retirement and welfare programs which serve this population. Another 29 percent of the total aggregate income of the elderly came from employment. The remaining 19 percent is returns from investments and contributions.

In South Dakota, the older citizens have less than 50 percent of the income of the younger population. About half of the older South Dakotans have incomes of under $3,000 a year. In fact, almost 30 percent of the older South Dakotans have incomes of less than $2,000 a year. Unfortunately, over 1 percent exist on incomes of less than $500 per year.

In the Nation as a whole in 1970, some 50 percent of the families headed by older Americans had incomes of less than $5,053. The older American living alone or with nonrelatives had a median income of $1,951. Nationally, one-fourth or 5 million older Americans were living on incomes of less than $3,000 a year, or $58 a week.

A 1973 study by the U.S. Department of Health, Education, and Welfare indicated that some married older Americans were well off. Almost 1.2 million older couples had incomes of over $10,000 that year. However, over half that number also had incomes of less than $3,000 a year. HEW also found that almost 1 million older persons living alone or with nonrelatives had annual incomes of less than $1,500 a year, or $29 a week.

It is amazing to think that in modern, industrial America one out of every five poor people is 65 years of age or older. Unfortunately, many of these individuals became poor upon reaching age 65 through forced retirement or health problems.

It is important to note that about half of the older South Dakotans have incomes below $3,000, while only one-fourth of the older Americans are in the same economic position. This is due to a variety of factors. Among them are:

(1) South Dakota as a whole has a lower median income than the Nation.

(2) Since it is a predominantly agricultural State, it is significant to note that farm income is lower than income in industrial areas.

(3) The State has open shops so that the economic impact of unionization has yet to be experienced on a significant scale.

(4) Most retirement programs in the State are several years behind comparable programs in eastern areas of the United States.

EXPENDITURES

The older citizen, whether in South Dakota or in the Nation, spends a greater percentage of his income on food, shelter, and medical services and care than younger individuals. They often have a great deal of difficulty finding basic needs, such as clothing in shopping areas. In other cases, the older citizen does not buy other items or luxuries because they simply cannot afford to purchase them.

In South Dakota, the older citizen is, as mentioned previously, in a tighter economic position than in the Nation as a whole. Yet, many of them fail to realize this fact. Interestingly enough, some 65 percent of the older South Dakotans see themselves as being in the same economic situation as others their age. Less than 9 percent indicated that their income does not meet their present needs. However, over 26 percent anticipated future economic problems with their present incomes.

Unfortunately, in a State with half of its older population in 1970 below the poverty line in incomes, less than 6 percent of the older people used food stamps.

The older South Dakotans do not make use of food stamps because of a variety of factors. Among them are: not eligible; a dislike for welfare or charity; a lack of knowledge about what they are or where to get them; and some people are simply embarrassed to use them. Nationally, many older Americans fail to utilize food stamps for similar reasons.

In the last 5 years, many of the problems which prevented older citizens from using food stamps have been overcome. Inflation has forced more older South Dakotans to use them whether they wanted to or not. The development of the State Tie-Line (1–800–583–1865) phone system has enabled older citizens to obtain information on food stamps and related programs at no cost. The government itself has done a better job of bringing needed information and help to the needy.

EMPLOYMENT

In 1974, about 14 percent of the older Americans were still in the labor force. This equals 2.9 million people or 3.1 percent of the Nation's labor force. Of those employed or actively seeking work, 1.9 million were males and 1 million were females. Some 3.4 percent of the older Americans in the labor force were unemployed.

It is interesting to note that 19.3 percent of the older male workers are employed in agricultural jobs which tend to be lower paying. It is also important to note that only 5.5 percent of the males in the Nation's labor force are employed in agriculture. This is an important factor to be aware of in South Dakota, for the older citizens in this State have some additional employment opportunities available to them in Agriculture which are not available to older urban citizens.

The number of older males in the labor force has decreased steadily from 66 percent in 1900 to only 20 percent in 1974. The older female participation rate in the labor force for 1900 and 1974 were essentially the same, about 8 percent.

EDUCATION

Almost 61 percent of the older South Dakotans never completed elementary school. Some 14.5 percent attended less than 4 years of high school, and less than 10 percent graduated from high school. It is interesting to note that over 10 percent attended college and that over 4 percent were college graduates or more.

Among older Americans, almost half never completed elementary school, while over 6 percent of the elderly are college graduates. It is important to note that over 3 million older Americans have had less than 5 years of schooling and are functionally illiterate.

In comparison, South Dakota has a significantly greater percentage of its older citizens who did not complete grade school. It also has a smaller percentage of elderly college graduates than the Nation as a whole.

MARITAL STATUS

Some 53 percent of the older South Dakotans are married according to the 1970 census. It is important to note, however, that while almost 70 percent of the older males in the State are married, only about 40 percent of the females in that age category are married. About one-third of the older males in the State have wives under 65 years of age. Most of the older women in South Dakota are widowed. In fact, there are four times as many widows in the State as widowers.

National findings are somewhat different, since in this country most older men are married and most older women are widows. In 1974, some 79 percent of the older males in America were married, while only 39 percent of the females in that age category were married. Some 52 percent of the older women in the United States are widows. There are over five widows in the Nation for every widower.

It is estimated that during the course of a year, some 35,000 older men and over 16,000 older women in this country marry. In approximately 14,000 marriages, both the bride and groom are 65 years of age or over. Some 22,000 older grooms marry women under 65 years of age, while only 2,000 older brides marry men under 65 years of age. In the case of 70 percent of the brides and 67 percent of the grooms, these older Americans were previously widowed and were remarrying.

LIVING ARRANGEMENTS

Over 63 percent of the older South Dakotans live as families. Nearly 30 percent live alone or with nonrelatives, and over 7 percent are in institutions. Almost 70 percent of the older males live in families which include their wives. However, only about 40 percent of the older women live in families which include their husbands. Over three times as many older women than men live alone or with nonrelatives.

Among the older Americans, over 6 out of every 10 individuals live in families. Over one-third are living alone or with nonrelatives. Only 5 percent of the older citizens of this Nation live in an institution. Nationally, one-third of the older women live in families that include their husbands, while two-thirds of the older men live with their spouses. In the Nation as a whole, 2½ times as many older women live alone or with nonrelatives as do older men.

ISOLATION

In South Dakota over one-fourth of the older citizens live alone. Most of these individuals are active and able to take part in community life. But thousands do live in isolation. Almost 16 percent of the aged in South Dakota do not receive one telephone call a week. Over 10 percent of the State's older citizens are not visited by another person at least once a week. Some 40 percent of the elderly do not attend even one meeting a month and over 6 percent consider themselves to be quite lonely.

Nationally, some 5 million older Americans live alone. Like most of the older South Dakotans, they are active and able to participate in and enjoy life. However, hundreds of thousands of them are isolated. There are no pone calls or visitors. No easy or affordable transportation and, unfortunately, no help or care programs are available to them in their communities. In some cases, these people live in such personal isolation that they are difficult to reach even when programs to break down the loneliness exist in their communities.

The State and Federal Governments are working to end isolation through programs providing transportation, senior centers, nutrition programs, telephone reassurance, friendly visiting, in-home services, opportunities to serve, and outreach services.

MOBILITY

In the period from 1960 to 1970, a significant shift took place among the older South Dakotans. The number of people in the 65 to 69 year age group decreased 3.4 percent. At the same time, the population of the 70 to 74 year age group increased 2.9 percent, and the 75 years and over group increased 37.9 percent.

During that same period, significant changes occurred in the areas in which the older South Dakotans live. The number of older people living in urban areas in the State increased over 20 percent. A similar increase of over 22 percent occurred in rural nonfarm areas. At the same time, the number of older South Dakotans living in rural farm territory decreased about 9 percent.

Thus, what has been occurring is a movement into the cities and towns of the State. This can be seen in the fact that the older population in urban places of 10,000 or more has increased almost 30 percent in the last 10 years. In urban places of 2,500 to 10,000 people, the increase in number of older individuals was only 6 percent. In towns of over 1,000 population, there was a 15 percent increase in the number of elderly. In rural towns of less than 1,000 people, there was a 5 percent increase.

So the movement of South Dakota's older citizens tends to be to the small towns and especially the urban areas of over 10,000 population. Among the reasons for this movement are: a greater concentration of medical services; increasing availability of low-income housing; the opportunity to be closer to others; better transportation; and recreational activities.

Among older Americans in 1970, some 8.6 percent moved from one house to another. Some 6 percent of the older citizens moved to another house in the same county, while 1.6 percent moved to a different county in the same State. Only 1 percent of the older Americans out-migrated to another State.

VOTING

In South Dakota today, 18.9 percent of all the registered voters in the State are 65 years of age or over. So potentially, one out of almost every five voters could be an older citizen.

Nationally, 57 percent of all the older Americans voted during the 1970 elections. Some 17 percent of all votes cast in this country that year were by people 65 years of age or older.

Presently, there is no significant evidence to indicate that the older American or South Dakotan votes as a block. They tend to either follow their own traditional party lines or vote independently, as they have for so many years of their lives.

SUMMARY

Today, one out of every eight people in South Dakota is 65 years of age and over. The people of South Dakota must understand that most of the older citizens are individuals who have worked hard during their lifetimes, only to be retired by society when they reach 65 years of age. They must also remember that the vast majority of the older citizens have likes and dislikes, wants and desires, needs, and the need to be needed.

NEEDS

At age 65 years and over, one does not automatically desire to become a hermit. Older citizens have the same needs for familial and social relationships as the rest of the population. Unfortunately, society tends to isolate or allow the isolation of some 5 million older Americans. Fortunately, the State and Federal Governments and some individuals realize this and have started a number of programs, including senior centers, meals-on-wheels, telephone reassurance, friendly visiting, and others, and are doing something to end isolation and meet the needs of the olderly.

The older citizen needs cultural and recreational activities, just as members of the younger generation do. Some of these needs can be met through the over 1,200 senior centers in this Nation. Other recreational needs can be met through community recreation programs, clubs and organizations, and family participation.

Like all Americans, the older American needs good health, both physicial and mental. They need access to good medical care. They also need nutritional programs to assure an adequate diet.

They need to be able to afford the foods necessary for health, as well as the clothing necessary for warmth and protection. One would think that with a market of about 22 million older Americans, some clothing company would be able to provide them with fashionable, protective clothing at a reasonable price.

Older Americans also need adequate housing if they are to live as they should. It should provide adequate space, necessities, comfort, and be attractive. They need good access to utilities and repair services at reasonable costs. Their residential areas should be safe and adequately protected by police and fire departments.

The older citizen needs areas to walk in, play in, or to just sit. They need transportation from their residence to areas of activity within the community, for example to stores, doctors offices, parks, and senior centers. They also need means of getting to church when they desire to attend. Too often younger individuals fail to recognize the importance of religion in the daily life of the older American.

The older citizens need an adequate income on which to live. As mentioned previously, most of the elderly poor in this Nation were not poor until they had to retire and their income was cut off. If they must live on a substandard income, they must not be expected to carry the same tax burdens as those individuals still employed. They also need tax reform on real estate taxes and estate taxes, since they should not be taxed out of their home or estate.

For those 5 to 8 percent of the older citizens who receive institutional care, there is the need to be visited, the need to be treated as individuals, and the need for help. Just placing an older person in a nursing home or extended care facility does not end one's responsibility to a mother or father or aunt or uncle. Those people living in institutions still have wants, needs and desires. Try as they may, the institutions can not meet all of them, for family love and involvement are essential needs of the older citizens, whether at home or in an institution.

The older American also needs an advocacy system. In many cases they need someone to help them and do not know where to go. They need: legal advice;

help getting better housing; better health care; work; recreation; housekeeping services; rehabilitation services; and other people. They need advocates in these areas and information on how to get help with these needs.

THE NEED TO BE NEEDED

The greatest need of the older citizen is the need to be needed. Fortunately in many families the older members are needed and actively involved as long as they live. In other cases, individuals are healthy or involved enough that they are always needed. But for some older citizens, the need to be needed was lost with the arrival of retirement or illness.

For these people, the State and Federal Government, senior centers, care facilities, schools, groups and individuals, are becoming increasingly active and creatively involved in developing and implementing ways in which the older citizen can realize their need to be needed. The South Dakota Office on Aging develops, sponsors, and assists communities in the implementation of programs such as: meals-on-wheels; senior centers; telephone reassurance; retired senior volunteer program; foster grandparents; in-house services; and many others. These programs and others have been developed in communities across the State and Nation. The State of South Dakota has introduced the Tie-Line (1–800–592–1865) to put the older South Dakotan and others in contact with individuals and agencies who can answer their questions and assist in solving their problems. Organizations such as the Congress of Senior Organizations, the South Dakota Association of Health Care Facilities, and others, are working for the interest of older South Dakotans in relation to their service areas. Gerontology Association for Training and Education (GATE) is a statewide consortium of education, statewide older American organizations and others working together to inform and assist the older citizen.

The State and Federal Governments, each of these organizations, and interested individuals have as their purpose to provide the older citizen opportunities to utilize their ideas, knowledge, and talents for benefit of others—to fulfill—the need to be needed.

South Dakota's Senior Population: 1980 and Beyond[1]

INTRODUCTION

Suppose during this 1976 election year you were running for State office in South Dakota, and to save time you arranged to gather all residents over 65 years of age in one place so you could shake hands with each and talk to them for no more than 1 minute. At 60 senior citizens an hour, working at the task 8 hours daily, Monday through Friday, you would begin shaking hands January 2 and finish August 31. Even then, better be prepared to return after Labor Day and shake more hands for another day and one-half: during the 34 weeks you stood shaking hands an additinal 666 residents would have joined those age 65 and over. For fact, the number of senior citizens in South Dakota is growing.[2]

GROWTH IN NUMBER

The number of senior citizens has grown since 1889, the advent of Statehood for South Dakota. In 1890 the number of residents 65 and over was 7,843, representing 2.4 percent of the total population. In 1960 this figure was 71,513, or 10.5 percent of the total. By 1970 the number increased to 80,484, 12 percent of the total.

Projection models for South Dakota[3] estimate the numbers of senior residents in 1975, 1980, 1985, and 1990 to be 84,000, 89,000, 93,500, and 97,000, respectively. Extrapolating this trend gives a 2010 population of 117,000 senior citizens a assuming no change in life expectancy.

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[1] By Dr. Robert T. Wagner, Department of Rural Sociology, South Dakota State University, Brookings, S. Dak. A discussion paper presented to the Gerontology Association for Training and Education, Spring, 1976.

[2] For a national parallel, cf., Herman B. Brotman, *Who Are the Aged: A Demographic View.* Ann Arbor, Mich.: Institute of Gerontology, U. of Michigan, November, 1968.

[3] Robert T. Wagner, Eugene T. Butler, Jr., and Karen A. McComish. *Population Projection Models for South Dakota: 1980, 1985 and 1990.* Brookings: South Dakota State University, Agricultural Experiment Station, Rural Sociology Department, Bulletin 631, May, 1975.

AGED DEPENDENCY

A past trend has been the steady increase in age dependency ratios for South Dakota from 1890 to 1960, an increase from 5 to nearly 19 (table 1). This steady increase stabilized from 1960 to 1970, attaining 21 in 1970. Projected age dependency ratios for 1980 and 1990 are 18.1 and 19.9 respectively, reflecting continued stabilization.

TABLE 1.—*South Dakota age dependency ratios: 1900–90*

Year	Ratio
1900	5.5
1910	5.3
1920	6.6
1930	8.6
1940	10.6
1950	13.6
1960	18.8
1970	20.8
1980	18.1
1990	19.9

The aged dependency ratio is a refined, although somewhat arbitrary measure, expressing the extent to which aged groups in an area are dependent upon the productive efforts of the 15 to 64 years old labor force.

Although dependency ratios have increased, the extent to which the active labor group must anticipate major increases in the dependent aged group has leveled since 1960 and will continue so the next 20 years.

SEX RATIOS

One dramatic shift in the composition of the senior population in the State from 1970 to 1990 will be in the sex ratio, or the number of men of a given age in proportion to the number of women. Table 2 reports the sex ratios for the population 65 and over and 75 and over in 1970 and projected to 1990.

TABLE 2.—*Number males per 100 females, senior age groups, 1970 and 1990*

Age cohorts	
65-plus:	
1970	83
1990	68
75-plus:	
1970	75
1990	50

Sex ratios have real implications for the aged, for the hugh number of widows becomes as key a determinant as age regarding social, economic, family, and living statuses. When the sex ratios are examined in terms of nuptuality for any representative group of 100 South Dakotans 75 years and older, the number of each sex married and unmarried varies dramatically (table 3). In 1970 the proportion of unmarried females 75 and over was 2.5 times greater than for their male counterparts: in 1990 it will be 3.75 times.

TABLE 3.—*Number married men and women, 75 and over, 1970 and 1990*

1970:	
Men:	
Married	25
Unmarried	18
Women:	
Married	12
Unmarried	45
1990:	
Men:	
Married	19
Unmarried	14
Women:	
Married	13
Unmarried	55

Men are more favored in terms of living with a spouse in later years, particularly because society allows them to reach down and have second marriages with senior sweethearts who are younger than they. Obviously, this increasing disparity will have implications for housing needs and the incidence of personal isolation among elderly in the next 15 years.[4]

LIFE EXPECTANCY

All of the preceding assume that changes in the size and composition of senior South Dakotans will not be affected by changes in life expectancy from age 65 onward. However, changes may well occur due to technological advances that have the capacity to double average years lived beyond age 65.

Biologists appear confident today that major breakthroughs will occur in immediate years that will affect the life expectancy of the elderly. This confidence is supported by:

(1) Discoveries regarding the viability of human cells and culture.

(2) Awareness of the known variabilities in ages among species, whereby extreme cases double or triple the accepted life expectancy.

(3) Knowledge regarding the years added to life through the conquest of communicable disease and the predicted conquest of degenerative.

(4) Indicators that health can be viably maintained by rigorous changes in diet, exercise, etc.

(5) Evidence that the use of vitamins, hormone therapy, blood transfusion, and organ replacement may extend life.

(6) Current replacement of worn parts with nylon arteries, silver pins, and hip hinges, ear trumpets, heart pumps, etc.[5]

With this kind of technology, at age 75 life expectancy which currently averages about 9 years, could be increased. Table 4 gives the anticipated increases in life expectancy for persons 75 years old if technology could eliminate deaths due to specified causes.

TABLE 4.—*Increased life expectancy at age 75 due to elimination of selected causes of death*

Elimination of death due to	*Increase*
Malignant neoplasm	8 mos.
Vascular lesions	13 mos.
Heart disease	3 yrs., 10 mos.
Cardiovascular-renal disease	8 yrs., 8 mos.

ENVIRONMENTAL HISTORIES

Perhaps the most important demographic insight relative to the aged in South Dakota is the recognition that different age cohorts represent different "environmental histories."[6] That is, contemporary senior citizens share different life experiences than those who will be 65 and over in 1990 or 2110. Nowhere is this fact more dramatically illustrated than when comparing the years of formal schooling completed by those 65 and over in 1970 and those 65 and over in 1990.

TABLE 5.—*Median school years completed by South Dakotans 65 and over, 1970 and 1990*

Age:	
65–69	
1970	9.2
1990	12.5
70–74	
1970	8.8
1990	12.3
75 (+)	
1970	8.6
1990	11.9

[4] Brotman *op. cit.*

[5] Belle Boone Beard, "Demographic Characteristics of the Aged: The Relation of Sociological and Biological Research in Gerontology," *Geriatrics*, 44, October, 1959; Brotman, *op. cit.*

[6] Wilbert E. Moore "Aging and the Social System," *Aging and Social Policy, John C. McKinney and Frank T. deVyver*, eds. New York: Appleton-Century-Crofts, 1966.

The shift is even more dramatic when one realizes that even with a median formal education level of almost nine for 1970, 61 percent of older South Dakotans had not completed grade school and less than 10 percent graduated from high school. By contrast, Bureau of the Census projections indicate that by 1990 49 percent of those 65 years of age and over will have completed high school.[7]

MIGRATION

Whereas the out-migration of young adults from South Dakota has been a pervasive pattern since 1930, current indicators suggest a substantial reduction in net out-migration from the State, and even imply a possible shift to low levels of net in-migration in the future. Census Bureau estimates for 1975 number South Dakota's population at 682,000, an increase from 1970.[8] Although it remains to know whether this turn-about is more than a short-term reaction to lessened economic activities in the Nation, the long-range forecast favors some optimism regarding retainage of our young adult population and potential in-migration. Should the return-to-the-country movement, now visible in countries surrounding metropolitan areas in other States, eventuate in the western corn belt and eastern wheat belt of the upper Great Plains, South Dakota can anticipate increased retainage of resident population and possible net in-migration.

CONCLUSIONS

The demographic data support the following conclusions:

1. The absolute number of persons 65 years and over in South Dakota has grown and will continue to grow over the next 25 years although the relative proportions and dependency ratios for the aged will stabilize. This will be particularly true when the baby boom of the 1950's becomes the gerontology boom of 2010.
2. The number of men to women will decline, increasing the disparity between the proportion of elderly married men and women, especially for those 75 and over.
3. Life expectancy for those age 65 will increase somewhat, perhaps even dramatically.
4. Median years of completed formal education will increase to 12 years and more.
5. Out-migration of young adults from the State will decline during the next 15 years, especially as the number of young people entering adult status in subsequent years declines, a consequences of lowered fertility since 1966.

IMPLICATIONS

1. The increase in the absolute number of elderly residents in South Dakota will generate need for additional services from both public and private sectors. Although proportional pressures on the active working population to support the elderly in the State will not increase, elderly residents may seek a greater allocation of State resources and demand more expensive programs in their behalf.
2. The dramatic changes in the sex ratio and the decline in the proportion of elderly married women will increase feelings of isolation and cause further "anomia," especially for those women who locate their personal status in the status of a husband. New forms of polygynous marriage, or formalized living arrangement may become socially legitimated among and for the elderly.
3. New health technology may expand life expectancy so that societal substitutes for dying may have to be found that operate in the same way retirement serves to substitute for death in industrialized societies, creating opportunities for younger cohorts advancing in age.
4. The fact that future senior South Dakotans share environmental histories that provided more educational opportunities, associated higher occupational and income statuses and exposure to an era of expanding public welfarism may mean that they will be less inclined to accept reduced status positions within the larger society than are the elderly today. A number of factors will help contribute to this:

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[7] U.S. Bureau of the Census, "Democratic Projections for the United States," *Current Population Reports, Series* P–25, No. 476, Feb., 1972.

[8] The Bureau of the Census, "Federal-State Cooperation Program for Population Estimates," *Current Population Reports, Series* P–26, No. 101, April 1975.

(a) During periods when larger numbers of children enter adulthood, the availability of surplus but recently trained young adults tends to make the labors of older citizens obsolete and unvalved. The fact that the number of children now born who are advancing toward young adulthood is lower than for previous decades will mollify this obsolescence and devaluing.

(b) Higher completed education levels among the elderly may fortify their legitimate feelings that they have "wisdom" strengthened by experience which ought not be disregarded. From the knowledge and skill perspective, old age and status may become positively related.

(c) Nostalgia may replace scientism and technology as a fundamental American value. If so, the elderly will have an advantage.

(d) Previously, two aspects of retirement explain in part the perceived loss of status by the elderly. At retirement a person not only severs his connection with an organization, but he also relinquishes his occupational location in society. Without these two affiliations, the retiree usually becomes a person of unknown and uncertain achievement.

Elderly in the next decades may not be so willing to relinquish their status locations, especially when they share higher educational levels within a leisure oriented society where work opportunities for all age groups are few.

5. The changes in the magnitude of out-migration from South Dakota will reduce isolation and feelings of relative deprivation among the elderly as younger kinfolk remain in their locality. More sophisticated technology in communication and transporation services will further inter- and intra-governmental interaction, as the machine substitutes for interfacial contact. The advent of new childbearing patterns, whereby the having and rearing of children is not conditional upon female fecundity, may delay parenthood until later years. In this event, a societal norm may assign child bearing and rearing responsibilities to the aged.

6. Due to changes in environmental histories, the elderly of tomorrow will insist even more persuasively that relative poverty and lack of access to employment are not necessary concomitants of aging, but are the consequence of educational shortcomings and insufficient retraining. Demands for continuing education for the elderly and developmentally oriented learning opportunities will increase.

SUMMARY

The elderly will play more significant roles in South Dakota in the future, both numerically and positionally. A consequence will be the expansion of human services with senior citizens and possible modifications in both policy and program.

Appendix 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM WINNIE LEE, OUTREACH WORKER, AGING SERVICES CENTER, SIOUX FALLS, S. DAK.; TO SENATOR DICK CLARK, DATED AUGUST 18, 1976

DEAR SENATOR CLARK: I am an outreach worker for the aging services center and, although I contact elderly in the city of Sioux Falls, I believe the problems these people face are much the same as those faced by the elderly in their neighboring rural areas.

Lack of adequate transportation keeps many older people confined to their homes. The Red Cross does furnish rides to a limited number of aging for medical purposes (rides to a doctor, etc). Older people wishing to eat at the senior citizens center at noon contact the center for a bus ride, if such is needed. Residents of some housing projects may take a senior citizens center bus to specified grocery stores at specified times. But in most cases older people who do not live near a city bus route, cannot stand on a corner (with no shelter from wind, rain, and snow), or cannot climb up into the old-style bus are at the mercy of relatives, friends, and (in some cases) churches for rides. One 86-year-old lady recently told me, "Our church started running a bus on Sunday mornings about a month ago, and I've been to services every Sunday lately. I didn't get there Easter because I didn't want to ask anyone to take me."

We outreach workers have long been concerned about the welfare of the elderly during the cold winters in South Dakota—and the cost of fuel to keep these people comfortable. I was interested in learning this week that in Ohio a $7,500 trial grant from the Federal Community Services Administration is providing "energy stamps" in order that needy people, many of them elderly, in Lorain County, largely rural and agricultural, will be able to pay their fuel bills. If this energy stamp program works, I would suggest that it be expanded to help people in other States.

In some cases, I believe that older people are more lost and invisible in Sioux Falls than in small towns or on farms. If the older person has moved here late in life, or even if he has lived here but his children (if any) have left, due to the mobility common to our life style, he can easily get lost in the shuffle. E.g., at a party at the senior citizens center last week, a lady I did not know said to me: "Winnie Lee, I know you are an outreach worker and you called on Jane Doe once a while ago. I wish you'd go back. She is a very independent person and probably told you she was fine, that her children were taking care of her. Actually, she has scarcely enough to get along on. Our church has been helping her with food, and she is losing her eyesight fast. I wish you'd visit her on a regular basis and get her the services she needs—be an advocate for her."

There are woefully few of us outreach workers in Sioux Falls. I am employed part-time. I feel that it usually takes me two or three visits to gain the older person's trust and begin to discover what his real needs are. In the meantime, other elderly people in the community should be called on but aren't.

The depression and other problems connected with mental health that I see so often in older people are usually not taken care of by RSVP, churches, or neighbors; at least, that has been my observation. Maybe we should not try to "cure" these people, but should listen to them more closely. If, for instance, they are depressed because of their forced retirement—because of the upper age barrier—let us get laws passed to prohibit discrimination in employment for those over 65 (or whatever), regardless of the individual's ability to do the job. Our legislators are needed to help us with this task. Keeping people in the mainstream

of society and getting them back in are certainly two worthwhile (and much neglected) goals for programs on aging in this country. I, myself, would like to learn about how to do these.

As president of the NAACP, Sioux Falls Branch, I see many needs of both blacks and Indians of all ages. However, I believe we have plenty of laws. What we need is a better understanding of each other. I am familiar with groups that are attempting this on a local and State basis. I would recommend that the Federal Government do more to understand and help the Indians of South Dakota.

ITEM 2. LETTER FROM ELAINE M. TOBIN, DIRECTOR, SPINK COUNTY SENIOR CITIZENS, INC., REDFIELD, S. DAK.; TO PHILIP CORWIN, STAFF MEMBER, SENATE COMMITTEE ON AGING, DATED AUGUST 20, 1976

DEAR MR. CORWIN: Though I was unable to attend the hearing in Sioux Falls on August 18, 1976, I would like to make some statements concerning the problems we find every day as we work with the elderly in South Dakota.

One of the most pressing concerns is that of sufficient income. Senior citizens once past the retirement age, whether forced or voluntary, have problems in maintaining an income sufficient to meet their minimum needs. If one should save and have even $2,000, which is $500 over allowance for assets under SSI, then that person is dropped from that program to struggle once again on a little over $90 a month until their assets once again meet the standards required. How are the elderly to help themselves if they are not allowed to do so? Of course there is a limit, but is $2,000 too much for one who does not have life insurance or resources to cover nursing home expenses should the need become a reality? We all know that the answer is no. Under the present limits you are forcing persons to be dishonest in order to survive. I ask that careful consideration be given to the adjustment of the allowance made for social security and SSI so as to bring some balance to the increasing problem of poverty among the elderly.

Another priority in the rural areas is that of transportation. We find not only a problem in general transportation because of the distances involved, but also a special need for transportation in relation to medical attention and facilities. This brings to light another concern, that of medical care for the elderly.

Though much has been done in South Dakota to see that periodic geriatric clinics, including vision and hearing clinics be made available, the medical problem seems to stem from the inability of persons in need of medical care to receive the care when needed. This happens even when the person is covered under the medicare program. Instead of decreasing the anxiety of the elderly concerning their health problems, the anxiety is increased because of the lack of cooperation among clinics and medical staff. I suggest that appraisal of the situation be made and recommendation for correction be issued through the proper channels.

Revenue sharing funds have played an important role in the growth and development of senior citizens programs in South Dakota. Continuance of this funding is vital to rural areas and to the field of aging. We in Redfield could not support the county-wide program and offer the services or facilities we do without the help of revenue sharing funds.

Forced retirement is another problem that begets others as a result of its discrimination due to age. Income maintenance then becomes a problem as well as the self-image and pride of the individual, as they find themselves dependent after years of struggling to become self-sufficient and independent.

Nursing home care for the elderly is an ever present problem, though Redfield itself is fortunate in having facilities available. It has, however, been brought to my attention that there is a definite lack of nursing home facilities on the reservations and that the cultural shock of being transplanted outside their natural environmental surroundings is detrimental both mentally and physically to the Indian people. This should be investigated so to provide the Indian people with the same opportunity that we in other communities have in staying close to home in spite of the fact that we must have nursing home care.

The remarks above do not in any way complete the ever growing list of concerns found in working with the elderly in the rural areas. It does however put a priority on some of the need which I feel need immediate evaluation and attention.

We invite anyone interested in what the needs are in rural areas to come and visit our centers and talk to the people face to face, giving them a chance to speak for themselves as well as give detailed accounts concerning some of the problems mentioned.

Your time and effort in behalf of the older American and their needs is greatly appreciated.

ITEM 3. LETTER FROM RAY B. FLEMING, PRESIDENT, REDFIELD (S. DAK.) CHAPTER SENIOR CITIZENS CLUB; TO PHILIP CORWIN, DATED AUGUST 20, 1976

DEAR MR. CORWIN: There are many of our senior citizens in our community who at times need medical aid at the moment, and because of our doctor's setup they are not able to make an appointment for an examination. This is not an unusual situation, but rather one of chronic proportions. This has been called to the attention of our doctors, but it seems they either disregard the problem or do not care to take care of these people. Social security should be informed of this problem from the top so it may be appraised and corrected.

There are those in this area that are taking advantage of the food stamp program and welfare aid. Some are desperately in need of these programs and cannot take advantage of them for reasons of transportation or are uninformed of the qualifications. On the other hand, there are those who take advantage of these programs who are not qualified because of laziness, lack of initiative to work when offered, and will not keep a job when they have a few dollars in their pocket. Our aged people should have preference and be informed of the right to participate.

Housing and tax relief for the senior member of our society is not being made available in many areas of our State. Our Indians are, for the most part, very poor and need some low-rent housing and good supervision in the care of same.

Our State is of a peculiar nature in its agriculture. Intensive farming takes precedence in eastern South Dakota on ranching and large operations in the western part. One may say that Highway 281 (American Legion Memorial Highway) is the dividing line between the two types of farming. Many of the small communities have no low-rent housing and must travel miles to receive this accommodation. Information on tax relief should be more actively pursued for the elderly.

The above problems are humbly submitted and should be made top priority from your committee.

ITEM 4. LETTER FROM DAVID A. NICHOLS, ASSISTANT TO THE PRESIDENT, HURON COLLEGE, HURON, S. DAK.; TO SENATOR DICK CLARK, DATED SEPTEMBER 13, 1976

DEAR SENATOR CLARK: Thank you for the opportunity to present testimony to the committee concerning the significance of the cooperative project between Huron College and the Huron Area Senior Center. I know that you have been adequately briefed by center personnel on their program and needs. Therefore, we will focus on the educational program we hope to build on the foundation of the McDougall Hall project. We call this program KARE (Kinship of the Ages through Reconciling Education).[1]

Through this program, we intend to do nothing less than provide a model for what small rural colleges must do in the last quarter of the 20th century. Our society is getting older and colleges must serve that older population and, even more important, develop new educational models for helping the generations live and learn and work together.

Even without outside help, heroic efforts are being made to realize this dream in Huron. The senior center has leased McDougall Hall and is implementing its program as best it can despite the desperate need for Federal funds.

The Huron College Board of Trustees adopted a new mission statement on July 9 in conjunction with the signing of that lease that commits Huron College

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[1] See also appendix 1, item 5, p. 330.

to becoming a lifelong learning center for our region. A copy of that new mission statement is attached. The implementation of our new mission statement resulted in my appointment as assistant to the president for lifelong learning—a position unique to any college in the region.

All this reflects the comprehensive nature of our program. We seek a cross-generational learning community that will serve all ages in superior fashion.

That is the uniqueness of our project. It is cross-generational and not segregated as is the case with most other programs. It aims at a comprehensiveness in college programs that is not envisioned by most institutions involved in senior educational activities. Finally, you will look far to find any college-senior center cooperative project that involves a senior center with the excellence and range of services furnished by the Huron Area Senior Center.

Something significant is happening in central South Dakota. We have a vision of the future that will serve the Nation as we become an older society. On Tuesday, September 14, the senior center will move its operations to our campus. That event demonstrates our determination to realize the dream regardless of financial difficulties. But we need your help, not only with the HUD money, but with other Federal fund sources so that the entire KARE educational program can become a reality. The Congress could make no finer investment.

Thank you for the opportunity to testify.

ITEM 5. LETTER AND ENCLOSURES FROM ROD KRANZLER, ADMINISTRATIVE ASSISTANT, SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES; TO PHILIP CORWIN, STAFF MEMBER, SENATE COMMITTEE ON AGING, DATED AUGUST 13, 1976

DEAR PHIL: Although you had asked persons preparing testimony for the South Dakota hearing next week to submit their testimony to you in care of the Sioux Falls Senior Citizen Center by today, Friday, August 13, 1976, we are unable to do so.

To substitute for our failing on this part we have enclosed a complete first draft of the unsummarized version of our testimony on South Dakota's rural elderly.

A shortened, summarized version, which will be presented orally at the hearing, will be sent to you in care of the Sioux Falls center before the hearing. Please accept our apologies for not being able to comply with your request. We hope that the longer draft version is an acceptable substitute for you in your preparation for the hearing.

P.S.—An attachment to the long version of the testimony dealing with Indian aging programs is also enclosed in complete form.

[Enclosures.]

THE OLDER POPULATION: DATA AND CHARACTERISTICS

NUMBER AND DISTRIBUTION

South Dakota covers an area of 77,047 square miles on which reside the total population of 682,900 inhabitants of all ages, 115,000 (17 percent) of whom are 60 or older. This represents a population ratio of 8.86 inhabitants per square mile (compared to a national average of 57.5 persons per square mile) and 1.5 persons over age 60 per square mile.

South Dakota remains predominantly rural, with 55 percent of the population remaining on farms and in smaller towns and 45 percent located in communities of 2,500 or more inhabitants. There are only 26 towns throughout the State with a population of 2,500 or more.

Average county population of persons age 60 and over is 1,724 persons. Forty-four of the sixty-seven counties, or 66 percent, have older populations which fall below the 1,724 State average. In those counties the average falls to 859 persons. Twenty counties have 700 or fewer persons in that age category.

American Indians comprise 2.3 percent (10 times the national average) of the State's population age 60 and over. Approximately 8,400 square miles, or 11 percent, of South Dakota is designated as Indian reservation. The nine reservations vary in size, population, economics, ethnicity, and politics and are interspersed

among nonreservation counties in each quadrant of the State. Indian and white lands and population are intermixed and some of the boundaries are uncertain. Indian populations comprise 90 percent of the minority groupings in the State and are located in all counties, but the majority of the 32,365 American Indians reside on reservations.

ECONOMICS AND NEEDS

According to "Poverty in South Dakota," a study made by the South Dakota Economic Opportunity Office in July 1975, there are "a total of 119,543 persons living below poverty level in South Dakota" (19 percent of total population).

Currently, 30,423 persons, or 26 percent of the State's population age 60 and over have incomes below poverty level.

Average per capita income in South Dakota is $4,980, compared to a national average of $5,834. South Dakota ranks 36th in the Nation (only 13 States have per capita incomes lower than South Dakota) in per capita income (1975).

Lack of employment opportunity is fundamental among the multiple causes of poverty in the State. The prime industries of agriculture and tourism do little to meet the demand of the unemployed or underemployed. This problem is compounded for elderly persons. Only 5.6 percent of the South Dakota work force is age 65 or older according to the South Dakota Department of Labor.

As of July 1976, the percentage of unemployed persons in South Dakota was 4.7 percent—State average. This compares to an average of almost 46 percent for the State's nine Indian reservations (the lowest being 21 percent and the highest 66 percent), according to the South Dakota Office of Indian Affairs.

"Housing remains the paramount problem of poor and elderly persons," according to the "Poverty In South Dakota" study. "Inadequate and dilapidated housing is about all financially disadvantaged persons can afford. Blighted housing conditions contribute to the physical, mental, and social instability of their occupants."

Unemployment, rising energy and food costs, and inadequate housing all pose serious problems for elderly persons, especially those with fixed incomes.

"Whether viewed in terms of access to employment, food, health and medical care, or simple church attendance, social or recreational opportunities, it is clear that transportation is vital, especially in a predominantly rural environment," the study says. "For those not able to afford an automobile and its increasingly higher operational and maintenance costs, the dilemma of distance is great. Thus, the logical alternative is public transit." But public transportation is greatly inadequate in the State; only the largest city has intracity service.

Age discrimination and mandatory retirement also contribute to income levels of elderly persons. Social security and supplemental sceurity income benefits do not keep pace with inflation and cost-of-living increases which confront unemployed elderly persons.

Beyond income needs are unresolved problems relating to social isolation, transportation, recreation, nutrition, mental health, and home health services, any or all of which may be of critical importance to an older person trying to maintain his independence.

DISTANCE AS A PROBLEM IN RURAL SERVICE ACCESS AND DELIVERY

Even in urbanized areas of the State, lack of transportation keeps many elderly, disabled, and poor persons from getting to vital services. "Thirty-eight percent of the elderly population (South Dakota) walk, take a taxi, or ride as a passenger" in someone else's vehicle. This fact and an analysis of other data in "A Household Transportation Needs Assessment" prepared by the South Dakota Economic Opportunity Office, March 1, 1976, indicatse that "there is a significant transportation problem in rural South Dakota. It affects low-income and elderly more severely than the general population."

It was the consensus of the 1971 White House Conference on Aging that distance is a major problem in delivery of Older Americans Act programs and services in rural areas. This is also true of most social services provided by other programs in South Dakota.

A key means to confronting the problems which distance poses to rural service access and delivery is transportation services for the elderly. A local or community social service agency such as a senior citizen center may provide one or more of a number of services for the elderly in the locality. In all areas of the State the service agency must overcome a number of obstacles in order to provide its services.

The first of these is distance between various recipients or potential recipients of services. If the service agency is providing homemaker or outreach services, for example, the workers must have a means for getting from one recipient to another. In addition to the costs of operating and maintaining vehicles, time at driving 55 miles per hour is costly. Persons most in need of services are usually most isolated because of distance from their homes to the service agency. This usually necessitates location of homemakers or outreach workers in each of the communities of the agency's service area. Thus, most homemaker service or outreach agencies are community-based.

If the service agency is providing transportation services for the elderly that agency may find that distances between recipients of services are also great, especially in the sparser portions of the State, particularly if attempt is made to include rural residents. Usually, the agency has a number of pickup points at various locations, or one major pickup point at the local senior center. But then persons who wish to benefit from the service must find means to get to the pickup locations. This is difficult, if not impossible, for handicapped or disabled persons, who have the greatest need for such service.

The success of nutrition programs for the elderly is crucially dependent upon efficient provision of supportive services such as transportation, outreach, escort, nutrition education, health and welfare counseling, shopping assistance, information and referral, and recreation services. Provision of these services means that problems or distance unique to each of these services must be dealt with.

To aid in overcoming these obstacles of distance, a sizable amount of title III moneys are spent on transportation systems and services for the elderly. Other methods of service delivery are also being used more effectively than in past years (see next section below). A complex system of direct telephone lines to various communities and a State WATS line supplement service delivery. Careful planning of staff travel also helps, as do location of four outstationed coordinators, and effective newsletter and public information activity.

Next to transportation systems, communication is another means to overcoming the obstacle of distance. Communications with communities, service providers and projects, other State agencies, local governments, and senior citizens themselves are ongoing processes. A network of senior organizations composed of the State's over 225 senior citizen centers and clubs, the Congress of Senior Organizations, the Association of Senior Citizen Centers, as well as many other organizations, are of critical importance in provision of services in both community and rural localities.

South Dakota is indeed a "land of infinite variety" that is sometimes reflected in the pride of its people, although this is also the source of one of its major problems. Congress assistance could consist of facilitating development of special transportation systems especially applicable to rural areas.

Nature of the Human Service Delivery System in South Dakota

SENIOR CITIZEN CENTERS AND ACTIVITIES

The State's 225 senior citizen centers and clubs, mostly located in rural communities, are perhaps the most significant focal point for delivery of social services to the elderly. The programs and services that these centers can provide are potentially unrestricted, barring limited resources of manpower, community involvement, and funding.

More and more senior citizen centers are becoming multipurpose senior service centers, providing a broad spectrum of services beyond recreation. Such services include information and referral and outreach, nutrition and nutrition education, home-delivered meals, education and life enrichment, health services, volunteer services, counseling and assistance on social security, SSI, sales tax relief, medicaid and medicare, and other problems.

For many older people a real sense of belonging, involvement, and life enrichment are provided by these senior citizen service centers. Most of them have developed directly or indirectly through efforts of Older Americans Act programs or grants, and nearly all of them today are locally funded and operated.

Under new regulations the definition of a multipurpose senior center means being open to constituents 30 hours per week and having a full-time director. If a center must meet these requirements to be eligible for Federal support, it may deny benefits to people in sparsely populated areas. This would have impact

on senior centers statewide in South Dakota. Thus, exceptions to this regulation should be allowed where elderly populations are small.

For many of South Dakota's small communities a location for a senior citizen center is a prerequisite for successful senior center services and activities. Many of these small towns have acquired unused or older buildings in need of repair for their senior center.

However, these buildings were not designed for senior center purposes, most having been places of business or large old houses, and are inadequate without repair, alteration, or renovation. Thus, the availability of Older Americans Act title V funds for acquisition, alteration, or renovation of these buildings is a welcome resource to the senior citizens of these small towns who need to improve their centers but have limited financial resources.

Administration of title V funds is being carried out directly between prospective applicants and the Administration on Aging in Washington, D.C., though State units on aging have been called upon by AoA to assist in dissemination of information and application materials. However, time for submission of applications is much too short in terms of time needed to disseminate this information and information about the application process has been late in arriving at State units on aging, leaving very little time for applicants to prepare their applications. In fact, the final version of the application materials to be used had not arrived even 2 weeks before submission of applications was due.

The result has been frustration for applicants and an unnecessary burden on the State unit on aging, having been called upon to provide technical assistance, coordination, and manpower for this purpose.

NUTRITION PROJECTS AND SITES

There are 12 title VII nutrition projects operating in South Dakota with a total of 35 sites (one in North Dakota) serving congregate meals to elderly. Mentioned above, each of these sites are required to provide a continuum of supportive service enabling elderly persons to benefit from the nutrition services.

Many of these projects also provide home-delivered meals programs using volunteers to deliver meals. There are school lunch programs in the State serving meals to elderly persons, as well as a network of locally supported home-delivered meals programs.

TRANSPORTATION

Transportation poses a problem for all elderly, particularly rural elderly, and ranks as the primary concern among all sources of public need input in preparation of the annual State plan on aging. "Transportation on reservations is still imperative. Federal and State departments of transportation should continue their priorities for stronger emphasis on rural transportation," with consideration of disadvantaged persons such as "elderly, handicapped, low- and middle-income." These are recommendations made at the Bicentennial Governor's Conference on Aging, May 1976.

"Thirty-eight percent of the elderly population walk, take a taxi, or ride as a passenger." This fact and an analysis of other data collected in "A Household Transportation Needs Assessment" prepared by the South Dakota Economic Opportunity Office, March 1976, indicates that "there is a significant transportation problem in rural South Dakota. It affects low-income and elderly more severely than the general population."

During fiscal year 1975, of the $158,000 available to South Dakota under section 16(2)(B) of the Urban Mass Transportation Act, only $66,000 was used throughout the State. By contrast, of the $166,000 made available under this act as of July 1, 1976, grant applications totaling in excess of $100,000 are in process to date (July 28, 1976). These funds are to be used for capital expenditures only; operating expense moneys must be obtained from local resources, Older Americans Act, or other Federal grants.

This trend toward better utilization of available Federal dollars through generation of local matching funds is encouraging, but deserves further impetus by appropriate title III funding.

Through the use of volunteer drivers and local funding sources, local support of transportation is being increased. Yet cost per passenger mile and distances are great. The minibus is fast becoming a permanent and essential part of community transportation service delivery systems. Such transportation provides rides for many older persons to senior citizen centers and nutrition

projects, medical care, shopping, and other essential services. "South Dakota Department of Transportation Statewide Public Transportation Inventory, 1976" indicates that 134 senior citizen centers or other local organizations now have transportation services available for the elderly.

South Dakota has made a real start in development of effective transportation programs for older people, although Federal laws on transportation lag behind the proven benefits of the minibus transportation system and rural transportation needs.

The Senate and House committees on transportation should take a good look at what is working and providing rural older South Dakotans with efficient and needed transportation. Such transportation combats isolation and loneliness while tapping the resources of older people in volunteer and senior center programs. 1975 Older Americans Act amendments making transportation a national priority service is a needed impetus for expansion of such services.

OUTREACH SERVICES

Basic needs of older citizens are not unlike those of the general population, but accessing appropriate services to meet those needs is much more difficult for older persons, particularly disadvantaged, low-income elderly. A mechanism for linking these persons with needed, helpful services is outreach.

Outreach workers can detect problems an older person may have with health, nutrition, transportation, housing, food stamps, and other needs and provide appropriate referral and followup to get the services for the older person.

Without the personal, one-to-one contact the outreach worker can provide, many older persons fail to benefit from a number of services eligible to them. The Office on Aging, through its grantees, has provided outreach services for an estimated 5,800 of the approximately 116,00 persons age 60 and over in the State.

Because of the role outreach plays in getting services to people, outreach services are vital, especially in very sparsely populated portions of the State.

INFORMATION AND REFERRAL AND TIE-LINE

Similar to outreach, but less personal than outreach in its approach, is information and referral. In July 1975 a statewide information and referral service called Tie-Line was implemented to provided toll-free access to all citizens with more than 6,500 public, private, local, State, and Federal agencies that can help them. The Office on Aging supports, through funding and technical assistance, the special efforts of Tie-Line to reach more older persons with needed information and referral.

Through training and conferences, the Office on Aging has linked up the State's existing network of outreach workers and community information and referral centers to expand services to rural older persons, decreasing the impact of distance is delivery of services to older persons.

TRAINING

An important part of service delivery is training. Through title IV–A and other funding, consultants and experts in the field of aging and gerontology have been organized to conduct training sessions on a wide variety of topics geared to increasing the expertize of service providers and the capacity of older persons to serve themselves.

Gerontology Association for Training and Education (GATE) provides for joint planning, cooperation, and funding from the Office on Aging to carry out such training and education, developing and tapping resources of the States' educational institutions to support and stimulate increased and better services for older persons. Continuing and increased Federal aid to education of this sort is needed to help service providers and elderly overcome problems of service access and delivery.

PROGRAM DEVELOPMENT AND COORDINATION BY THE OFFICE ON AGING

The Office on Aging annually develops and administers a plan on aging and awards grants serving older persons in all counties. Efforts continue to build the capacity of comprehensive and coordinated programs for older persons

throughout the statewide planning and service area. The Office on Aging responds to a variety of functions:

(1) Promotion of good working relationships with State, local, public, and private service and consumer agencies through (a) establishment of an interannual Governor's Conference on Aging; (b) annual Governor's Conference on Aging; (c) support of local aging groups in approaching local government; (d) bimonthly meetings of the South Dakota Advisory Council on Aging; and (e) bimonthly publication of the office newsletter, 3,600 copies per edition.

By functioning directly with local programs the Office on Aging is strengthened for its work with legislative and executive agencies. These relationships have led to valuable input, policy analysis, and statutory inroads into State processes such as permissive legislation for senior use of school buses, school lunch facilities, county and city mill levies, and an increased awareness of needed legislation benefiting elderly citizens.

(2) Through the legislative consultation on aging sessions, composed of senior organizations, needs have been prioritized for joint planning and advocacy of increased supplemental security income, property tax relief, and amelioration of utility rate structures for the elderly.

(3) The State office and field coordinators gather and update information about social services resources throughout the State. Data exchange is emphasized by the various interagency working agreements now in force. This flow of resource continues. For example, updating and enlarging Tie-Line's list of more than 6,500 resources.

(4) Older Americans Act grantees are also encouraged to utilize objective setting and monitoring processess similar to that used by the Office on Aging. Training and technical assistance has been and continues to be provided for this purpose. Benefits include improved planning, grant applications, and grantee program administration in delivery of services.

(5) During fiscal year 1976 negotiations were undertaken with 20 separate agencies which could benefit the lives of older citizens; seven agreements were signed, including a title XX agreement.

(6) The Office on Aging is in a unique position to coordinate delivery of existing services and pool untapped resources.

(a) Being located in the department of social services, the State's title XX agency, it is able to provide prompt input to affiliated State level staff regarding needs of the services for the elderly.

(b) Four outstationed field coordinators and central office staff promote coordinated planning and development of services and resources among senior organizations, agencies, and State and local governments.

(c) Current title III and title VII grants provide services to 64 of the 67 counties. The remaining three counties also have senior citizen activities and access to State training, public information, technical assistance, and information and referral.

(d) All school districts have been canvassed to determine potential for increasing the number of school lunch programs serving the elderly. Fiscal year 1977 State plan on aging goal is to increase this number from 20 to 26.

(e) Senior service centers have increased from 157 in fiscal year 1975 to 172 in fiscal year 1976.

(f) Establishment of a statewide consortium of public and private colleges and interested organizations in Gerontology Association for Training and Education (GATE) has been facilitated by the Office on Aging.

(g) Resources other than title III and title VII have increased 69 percent from $815,994 in fiscal year 1976 to $1,375,459 in fiscal year 1977.

(7) Assessment and other site visits made of each activity include views of participants. Conferences, task forces, and training events elicit additional participant comment. During fiscal year 1976, a review of 7 major and 29 ancillary I & R sites was conducted. The Office on Aging requires that participant evaluations be an integral part of all training and education activities supported by title IV–A, title III, and title VII grants.

(8) The Office on Aging conducted and/or approved conduct of five, instead of the required one, public hearings on the fiscal year 1977 State plan on aging. A field survey to determine user satisfaction with Tie-Line is planned. Professional staff make frequent site visits and are on hand for public appearances at meetings to listen and respond to questions and to record testimony and statements of need. The annual Governor's Conference on Aging also serves this purpose.

(9) Requests for data by Federal and State agencies and the general public are satisfied through periodic updating of reports and data on file and flowing into the Office on Aging or by special survey, as needed. Plans are underway to review report documents in light of revision of the Administration on Aging quarterly report. Standardized data collection instruments will result. Information on needs is reported publicly to service organizations.

(10) This vital function is assured by the activities of our entire professional staff, particularly those of four field coordinators, and through workshops, training sessions, aid dissemination of written information. Frequent phone contact and site visits provide year-round responsiveness to technical assistance needs. Semiannual title III and quarterly title VII assessment schedules will assure even greater onsite availability for technical assistance in conjunction with assessment findings.

(11) The Office on Aging has encouraged existing legal services for elderly and low-income persons, and special participation by the University of South Dakota Law School. The fiscal year 1977 State plan includes a separate legal services objective. Application will be made for title III section 308 funds, per AoA–PI–76–31, dated June 23, 1976.

(12) The responsibilities of one full-time professional staff person include close coordination with the Federal ACTION agency and its related nine retired senior volunteer program (RSVP) and two foster grandparent program (FGP) projects in South Dakota. The Office on Aging assisted an application for an ACTION senior companion program (SCP), which narrowly missed approval at the regional level, during fiscal year 1976. State offices on resource development and children and youth have been contacted about service opportunities.

(13) The South Dakota Advisory Council on Aging, conforming to the criteria in Older Americans Act regulations, has been very active for many years.

(14) The views of recipients of services are solicited at every opportunity by the State office and field staff from on-site face-to-face contact, through such means as telephone contact, public hearings, workshops throughout the State, field studies, newsletter of the Office on Aging articles requesting specific or general input, letters to organizations, and the previously mentioned hard-working and very vocal task force sessions at the annual Governor's Conference on Aging.

While the 1975 Older Americans Act Amendments did increase the amount of administration funds for small States like South Dakota to $200,000, that has been consumed by the effects of inflation. The 1976 and transitional quarter appropriations have given more than a 50 percent increase in programs funds, but only a 10 percent ($20,000) increase for administration over the 1973–74 level.

The Older Americans Act is the only federally funded program where State Administration is not related to the total amount of funds allocated to the State to administer. If Congress does not move to increase funding of the Older Americans Act to the funding level projected in the authorizing legislation, small State's, including South Dakota, will have difficulty administering title III, part of IV, title V, and title VII.

Older Indian Programs in South Dakota

In 1972, not a single program for elderly Indians was administered by any Indian reservation in South Dakota, and most older Indians were not benefiting from the many other Federal programs available such as social security, food stamps, and others.

Since that time, however, the Office on Aging has made a major effort to develop older Indian programs, working with Indian tribes on reservations, and providing technical assistance and Federal funds.

Older Indians comprise 2.34 percent of the State's population age 60 and over; 10 times the national average.

Allocation of resources to reservations is based on three factors of need: absence of tax base, lack of employment opportunity, and high incidence of poverty.

During fiscal year 1976, 24 percent of title III moneys were awarded to tribal organizations. Sixty percent of model project moneys were granted to Indian tribes (including four grants for a special supplemental security income outreach project on reservations). Twenty percent of title VII moneys were awarded to tribal organizations for nutrition and allied transportation and supportive services.

The South Dakota Advisory Council on Aging and Office on Aging staff have made substantial efforts to achieve better understanding of problems facing older people on the State's nine reservations. Council members and Office on Aging staff have made visits to reservations to see for themselves the problems which must be confronted.

The Coordinator of the Office of Indian Affairs has permanent membership on the South Dakota Advisory Council on Aging, and tribal chairman and planners are included in planning activities.

At the Bicentennial Governor's Conference on Aging, May 1976, a Task Force on Indian Affairs was convened to discuss needs of older Indians. Recommendations of this group reaffirmed the continuing need for transportation services and alternative care and homemaker services. The desire for location of skilled nursing facilities on reservations is undiminished. Planning grants, funding of an aging coordinator for each reservation, a special session with the South Dakota Advisory Council on Aging regarding Indian/reservation concerns, and information and training in grantsmanship were also recommended.

Because Indian reservations occupy the least desirable and least productive areas of South Dakota, unemployment is high, averaging almost 46 percent. Transportation is nearly negligible, and distances are measured in hours of travel rather than blocks or miles.

See attached summary of services and programs for Indians prepared by Theda Olson, Office on Aging.

Special Concerns

Speech and Hearing Problems

The Office on Aging has made two grants to two colleges, the University of South Dakota and Northern State College, to carry out speech and hearing screening and communications disorder education programs in the northeastern and southeastern portions of the State, respectively.

These two projects have resulted in data that is almost certain to change the approach to speech and hearing problems of older people and approaches to dealing with older people. Although there has been some research in this area, the bulk of colleges and universities offer graduate programs in speech and hearing which focus practically all of their energies and resources on school aged children. Older persons' problems with speech and hearing have been relegated to the attention of hearing aid manufacturers and dealers and a few doctors.

However, even with adequate screening and instruction, only one-third (approximately) of older persons benefit significantly from hearing aids alone. Hearing and/or speech losses are much more prevalent among older people. National health surveys indicate that this is true of older people in nursing homes, senior centers, and the community.

Most people do not admit that they have a hearing loss, or they are unaware of a growing hearing loss of the years. Secondly, most hearing screening now being done is what is called pure tone screening or testing. Hearing and understanding is much more than simply hearing a sequence of tones and, as a result, many people with hearing losses are not identified by this type of testing.

Because of many factors—brain cell damage or deterioration with age, mild or severe strokes or arteriosclerosis, psychological confusion, noise damage, infections, cumulative hearing loss, and slower reaction time—many older persons hear the tone but fail to understand the instructions of their doctor, or the details of social security, medicare, and other benefits, activities at the senior center, conversations with family and friends, etc. Others often mistakenly react to the person with such problems as if senility were encroaching, or that the person can no longer care for himself.

In a very limited experiment, costing about $90,000 for both projects, teams from both schools, including audiologists and speech clinicians, went to nursing homes, senior citizen centers, community events, and other activities where elderly were present to perform comprehensive testing.

The testing including pure tone, comprehension, inner ear and bone tests, and speech testing. Results indicated that a very high percentage of persons in nursing homes (90 percent) have speech and/or hearing problems of significance, and that in the senior centers, nutrition projects, and other community gatherings of older persons, 70 percent of the persons had significant hearing or speech losses.

Since speech problems tend to complicate hearing, problems of disengagement, irritability, isolation, and interpersonal relationships often result.

Fortunately, effective techniques have been developed that can restore effective communication for 70 to 90 percent of the people with losses. Some need medical treatment, others need hearing aids, but all need information about the nature of their hearing or speech losses. Information and counseling about hearing and speech losses and use of hearing aids is also useful.

Thus, treatment of speech or hearing losses is comprised of several important elements. One is communications disorder education for persons with losses and the family, relatives, or associates of that person. Such education includes practical aids to communication such as looking directly at the person with the loss, enunciating clearly, and eliminating background noises.

Training in speech or lip reading is effective for those who cannot benefit from a hearing aid, as well as speech therapy.

Mobile equipment and traveling educational and therapy teams have proved the feasibility of communication disorder screening and education in the many small communities and rural areas of the State. The results of such screening and education have significant impact upon independence of older persons. Hearing or speech losses often mean the difference between independence and dependence.

MENTAL HEALTH OF OLDER PERSONS

Isolation, physical problems, death of loved ones, family problems, economic worries, psychosomatic illnesses, and other problems confront the older person. Ways in which mental health services can be provided to older persons are greatly needed.

Despite efforts, little progress has been made to link mental health clinic services to the needs of older citizens, especially rural South Dakotans. Older persons are often fearful of mental health clinics, fearing that they will be labeled as senile and be commited to an institution.

Older people often do not see these clinics as relevant to their problems. They do not understand the terminology used. They may not get much help where the mental health clinics are staffed with persons who are trained and oriented to work with younger persons.

SOUTH DAKOTA OFFICE ON AGING: SUMMARY OF INDIAN AGING PROGRAMS, APRIL 15, 1976

(Prepared by Theda M. Olson, Indian Affairs, Office on Aging)

LOWER BRULE SIOUX TRIBE

The tribe has been operating a title VII nutrition program since December of 1973. The unduplicated number of people served has been 50. Approximately 25 meals are served per day. Transportation is provided by a minibus purchased with tribal funds and operating expenses paid out of title VII funds. Regularly scheduled trips are made to Chamberlain for grocery shopping, food stamps, and other needs. The CETA (Comprehensive Employment Training Act) program is providing the bus driver and cook's helper. Title VII pays for a project director, assistant director, and cook. Nutrition education is provided by two extension persons once or twice a month. The home economics class from the local high school is planning to have the students visit the elderly shut-ins. A nutrition and history project with the participants is also being discussed.

This has been an interesting project to observe. In the beginning, the senior citizens were very quiet and were not interested in any activities other than the meals. Now they have a birthday party once a month and crown a king and queen for the day. Bingos and dances are a big hit. The women are involved in quilting and the men have requested an arts and crafts project where they make knick-knacks out of bottles, egg cartons, etc.

The tribe is very supportive of this project. The interest is evident in that out of a total of six CETA slots for the reservation, two are employed by the nutrition program. A building has been donated by a member of the tribal council for use by the senior citizens until their new center is completed. The tribe donates vegetables such as squash, corn, and potatoes from the tribal truck garden. Meat is donated from the hog farm and buffalo herd.

Fundraising activities have been held to purchase a slide and movie projector, and other items needed at the center.

There is excellent coordination between the nutrition program and other agencies and programs such as Indian Health Service, Bureau of Indian Affairs, and

the extension office. Persons from these agencies are represented on the nutrition project council.

CROW CREEK SIOUX TRIBE

A meals-on-wheels project is funded under title III of the Older Americans Act and is nearing completion of their second year of funding

The center of activity is located at Ft. Thompson. The meals are purchased from the tribal restaurant at a cost of $1.60 per meal. The meals are then transported to 40 people in town and the surrounding area. A building is being renovated for use by the senior citizens and, upon completion, the meals will be prepared and served there. By having a congregate meal site, more elderly will be able to participate in the meals program.

A minibus was purchased with title III funds and operating expenses are provided from title III also. Approximately 100 elderly people take advantage of the transportation program.

The director is the only staff person paid with title III funds. Other staff, an assistant driver, and secretary/bookkeeper is provided by the tribe. Trips are made on a regular basis to Chamberlain for shopping, food stamps, etc.

The Tribal Office of Management and Planning has been delegated to supervise the meals-on-wheels project. Their office acts as an information and referral center for the elderly. They have been assisting the senior citizens in making application for the South Dakota tax relief for the elderly. SSI outreach is an ongoing activity of the project.

The project requested a waiver of the declining match ratio due to a lack of local funds. They have been funded at 75–25 for both years.

SISSETON-WAHPETON SIOUX TRIBE

A center and transportation project was funded with title III funds direct to the tribe. They are nearing the end of their first year of funding. The Sisseton-Wahpeton Senior Center is located in the town of Sisseton three to four blocks from the Sisseton Senior Center.

The tribe has donated a building for the center and has provided tribal funds and labor for renovation and minor repairs. Three and one-half full-time people are employed through CETA and Green Thumb. The center is open 8 to 5, 5 days a week. Older people from the outlying areas, when in town for shopping, use it as a place to rest and relax. The tribe donates $125 a month for coffee and snacks, and once a week a meal is served to approximately 20 people.

A minibus was purchased with title III funds, and transportation is provided to bring people to the center for meals, to obtain medical services, shopping, food stamps and commodities, to the tribal office for business, and several other activities.

The Area IV Senior Citizens Advisory Council, Inc., administers a title VII nutrition site at the Sisseton Senior Center. The Indian elderly comprise 2 percent of the aging population in Sisseton; 24 percent of the participants are American Indian

ROSEBUD SIOUX TRIBE

"Services for senior citizens" is funded under title III with meals being served in four sites: Parmalee, St. Francis, Mission (Antelope Community), and Rosebud. Parmalee has a center component and Rosebud a transportation component. Approximately 120 meals are served per day, 5 days a week. During warm weather the count is higher. Three positions are paid from the title III grant. Other personnel is furnished by the tribe.

The St. Francis site (Owl Bonnet Senior Center) is the newest of the sites. The community built the building and completely furnished it with couches, chairs, lamps, TV, stereo, freezer, refrigerator, stove, and a three-compartment sink. A small apartment is included for the caretaker/cook. This site has an ample number of volunteers as well as donations of food, etc. This center is active in quilting, bingo, arts, and crafts. The St. Francis community was the first Indian community in the Nation to receive a bicentennial designation by the American Revolution Bicentennial Committee. They were also the first community in South Dakota to merit a bicentennial designation. The Owl Bonnet Center group will participate in the bicentennial celebration by serving a traditional Indian meal to the tourists and by having an arts and crafts display at the center. The profits from these two activities will go to the senior citizens programs.

The Parmalee Center is active in bingo, quilting, arts, and crafts. This center is unique in that the elderly participants in the meals program do not wish to be served soup. They want chicken, turkey, roast beef, etc. They feel they eat enough soup at home. In all the other meal sites in South Dakota, the elderly participants want more soup on their menus. The elderly have taken quite an interest in this program and are very vocal in letting their needs be known.

The meal site at Mission (Antelope Community) was the first meal site on the Rosebud Reservation. They've been serving meals for 2 years. Approximately 40 meals per day are served. Almost half of the participants are non-Indians. They have been trying for a year now to get the county commissioners interested enough to put moneys into their project. To date, they have been unsuccessful.

Recently the tribe has given a total of $8,000 to the four sites for equipment, such as steam tables, and any items the individual sites feel they need. Additional moneys were given to the program for travel expense. The tribe has donated buffalo meat and fresh grown vegetables to the sites and individuals as well. The Corn Creek and Norris communities were given moneys by the tribe to build a center. Labor to be provided by CETA and $2,000 for equipment. During the 2 years of operation, this project has generated a lot of community support. Recently the tribe passed a resolution allowing free tribal fishing licenses to anyone on the reservation over age 65.

PINE RIDGE RESERVATION

The Office of Native Americans Programs in Pine Ridge is funded for a reservationwide transportation project. The first year the title III funds were used to purchase three minibuses. A special grant from ONAP in Denver provided two more minibuses plus drivers and operating expenses. The second-year funding from the Office on Aging provided $6,000 for operating expenses. Approximately 885 people have used the transportation system. The minibuses are stationed at Martin, Kyle, Red Shirt Table, and two in Pine Ridge. The buses in Pine Ridge assist the nutrition program with transportation.

The Pine Ridge Village Council was awarded the title VII nutrition grant. Meal service was initiated a week prior to the grant with funds provided by the village council. Approximately 80 meals per day are served. This project does get a lot of volunteer help. Transportation is provided by the title III program. The project is relatively new so not much data is available at this time.

The Kyle Village Council was awarded a title III grant for a meals program on July 1, 1973. For 2 years they prepared the meals on site; July of 1975 they began contracting with the school for $1 per meal. Approximately 20 to 30 meals are served per day. Transportation is coordinated with the title III project at Pine Ridge.

STANDING ROCK SIOUX TRIBE

On February 6, 1976, the Standing Rock Sioux Tribal Council accepted the nutrition for the elderly program. A project director, two cooks, two cooks' aides, two bus drivers, and two janitors were hired. The only staff paid from title VII funds is the project director. All other positions are CETA slots.

The North Dakota site is located at Cannonball in the St. James Church Community Building and, in South Dakota, Bullhead has their own building. Twenty-five meals per day are projected at both sites. The tribe purchased a minibus for the Bullhead site and a bus is furnished by a church group at Cannonball. Meals are not in service as of this date. A target date of 2 weeks is projected.

This project is unique in that the South Dakota Department of Social Services and the North Dakota Social Services Board entered into a joint funding agreement. South Dakota has been delegated lead agency. The North Dakota board sends the grant moneys to South Dakota to administer.

This will be the first aging program to be implemented on the Standing Rock Reservation other than the special SSI outreach project.

CHEYENNE RIVER SIOUX TRIBE

The transportation project on the Cheyenne River Reservation consists of three vans. One was purchased with title III funds, two with tribal funds. The title III bus coordinates closely with the nutrition program. Approximately 12 people per day are transported from the Bear Creek and Dupree communities.

Thirteen food trays are also delivered to those communities. In the town of Eagle Butte, 50 to 60 people are transported daily to the meal site. The minibus is also used for wakes and funerals, shopping trips to Pierre, Rapid City, Gettysburg, and several in-town trips. The operating expenses for these buses were converted from title III to title VII on April 1, 1976.

The home supportive service workers of the Cheyenne River Reservation are stationed in the elderly manors in Timber Lake, Isabel, Dupree, and Eagle Butte. Many of the elderly in these manors should really be in a nursing home, but they do not want to leave the reservation. The supportive service workers assist the elderly with house cleaning chores, cooking, and taking their medicine. They also provide limited transportation for the seniors in the manors. They have been given the same training as the CHR's (community health representatives). This has been a very worthwhile project. The staff turnover is practically nil. In the 2 years of operation, only one person quite, and this was due to a knee injury. Funding has been sought from several different agencies for this project; to date, none has been obtained.

The title VII nutrition grant to the Cheyenne River Sioux Tribe was the first direct grant to a reservation in South Dakota. It was also one of the first projects in South Dakota to begin operation. They are in their third year of funding. Approximately 170 meals are served per day at Eagle Butte and Swift Bird. Meals are delivered to Cherry Creek on Tuesdays and Thursdays. This project coordinates with the Indian Health Service, Bureau of Indian Affairs, community action agency, county extension, SSA, and several other agencies. The tribe is building a new senior citizens center in Eagle Butte and equipping it with a kitchen large enough to accommodate the nutrition program. The interest of the tribal council in the elderly is great and the elderly seem to be a high priority on the Cheyenne River.

This summary deals with the current grants of Older Americans Act funds awarded by the Office on Aging. Under preparation is a history of aging grants on the reservations. This report does not include the off-reservation projects that are serving American Indians.

OLDER AMERICAN INDIAN PROGRAMS, APRIL 15, 1976

Grantee: Lower Brule Sioux Tribe.
Project: Title VII nutrition program.
Project director: Judy Whitney.
Project period: August 1, 1975 to June 30, 1976, third year.
Title VII funds: $33,877.
Total budget: $42,388.

Grantee: Crow Creek Sioux Tribe.
Project: Meals-on-wheels.
Project director: Paul Harrison, Sr.
Project period: July 1, 1975 to June 30, 1976, second year.
Title III funds: $30,120.
Total budget: $40,160.

Grantee: Sisseton/Wahpeton Sioux Tribe.
Project: Senior center and transportation.
Project director: Pansy Crawford.
Project period: April 1, 1975 to May 31, 1976, first year.
Title III funds: $10,875.
Total budget: $14,495.

Grantee: Rosebud Sioux Tribe.
Project: Services for senior citizens.
Project director: Olive Pretty Bird.
Project period: July 1, 1975 to June 30, 1976, second year.
Title III funds: $54,662.
Total budget: $77,506.

Grantee: Office of Native Americans.
Project: Older American Indian Busing System.
Project director: Michael White.
Project period: July 1, 1975 to June 30, 1976, second year.
Title III funds: $6,000.
Total budget: $21,000.

Grantee: Pine Ridge Village Council.
Project: Meals for the elderly.
Project director: Elizabeth Roubideaux.
Project period: January 19, 1976 to June 30, 1976, first year.
Title VII funds: $20,774.
Total budget: $27,164.

Grantee: Standing Rock Sioux Tribe.
Project: Nutrition for the elderly.
Project director: Basil Mentz.
Project period: January 26, 1976 to January 25, 1977, first year.
Title VII funds: $21,899 N.D. share. $21,899 S.D. share.
Total budget: $75,238.

Grantee: Cheyenne River Sioux Tribe.
Project: Home supportive service workers.
Project director: Jack Claymore.
Project period: August 1, 1975 to July 31, 1976, second year.
Title III funds: $47,250.
Total budget: $52,500.

Grantee: Cheyenne River Sioux Tribe.
Project: Meals program for the elderly.
Project director: Lyonne Garreau.
Project period: August 1, 1975 to June 30, 1976, third year.
Title VII funds: $69,863.
Total budget: $91,331.

Grantee: Kyle Village Council.
Project: Meals for the elderly.
Project director: Lillian Ralston.
Project period: July 1, 1975 to June 30, 1976, third year.
Title III funds: $7,000.
Total budget:

SUMMARY: OFF-RESERVATION AREAS SERVING OLDER AMERICAN INDIANS

Grantee: Bennett County Senior Citizens Center, Inc.
Project: Meals for the elderly.
Project director: Edison Ward.
Project period: August 1, 1975 to June 30, 1976, third year.
Title VII funds: $50,490.
Total budget: $71,832.

The nutrition project at Martin serves approximately 66 meals per day. Forty-two percent of the meals are served to American Indians. The project director is an enrolled member of the Oglala Sioux Tribe on the Pine Ridge Reservation. This center is most interesting to visit because of the unique activities they have initiated, but mainly because the Indians and non-Indians have a true caring for one another. There is no racial tension in this center. The recreation program is an active one including TV, pool playing, painting lessons by a local artist, nutrition education lectures and demonstrations. This project has generated a lot of support from the county, city, and local merchants. The volunteer effort is to be commended because of the number of volunteers as well as their reliability. The project director, bus driver, and secretary are paid with title VII funds. Effective March 31, 1976, the title III transportation was converted to title VII. A minibus, operating expenses, and driver are now paid from title VII funds. The transportation project operates solely within the nutrition project. This provides participants transportation to the meals, shopping, doctor and dentist appointments, bank, post office, social security office, etc.

Grantee: South Central Community Action Program, Inc.
Project: Outreach and coordination.
Project director: Dee Brown.
Project period: January 1, 1976 to June 30, 1976, second year.
Title III funds: $36,858.
Total budget: $61,451.

This project has contacted approximately 150 Indian aged and has assisted them in filling out the forms for the tax relief for the elderly. A staff of seven

perform the outreach and coordination activities. None are Indian but recently they've been coordinating with a job services' person who is Indian. He works mainly with the Indian elderly. According to the 1970 census, the Indian aging population comprise .01 percent of the total elderly population. There are four Indian representatives on the SCCAP board.

Grantee: South Central Community Action Program, Inc.
Project: Transportation.
Project director: Winnie Jo Jons.
Project period: April 1, 1975 to March 31, 1976.
Title III funds: $10,295.
Total budget: $20,590.

The transportation program employs a director and bus driver. One minibus operates solely with the nutrition project. Twenty percent of the passengers are Indian. Transportation is provided in the towns of Wagner and Lake Andes.

Grantee: South Central Community Action Program, Inc.
Project: Nutrition program for the elderly.
Project director: Fern Sondgeroth.
Project period: August 1, 1975 to June 30, 1976, third year.
Title VII funds: $92,241.
Total budget: $122,986.

Five sites are operating at Lake Andes, Wagner, Herrick, Burke, and White Lake. An average of 25 meals are served per day at Lake Andes; 34 percent of the meals are served to American Indians. At Wagner, 39 meals are served per day with an average of 12 meals served to Indians. During the first year of operation, a site was opened in the tribal office at Greenwood. It closed 9 months later because of a lack of participation. The elderly are transported to Lake Andes and Wagner for meals by the community health representatives. Six people are employed by the nutrition program. The site manager at Wagner is of Indian descent. Indians are represented on the site councils as well as the project council.

Grantee: Rapid City Indian Service Council.
Project: Minneluzahan Senior Center.
Project director: Margie Twiss.
Project period: August 1, 1975 to July 31, 1976, first year.
Title III funds: $20,562.
Total budget: $27,416.

This center has been in operation for almost a year. The city has given them a building to use until their new senior center is completed. This is considered an Indian project but they serve a large number of non-Indian elderly. The community, city, and county commissioners are very supportive of this program. A meal is served once a day to approximately 30 people. The seniors are active in arts and crafts and are making chair pillows to sell at the Governor's conference. Staff is provided through title III, Green Thumb, and the county welfare office. They are hoping to have a title VII site when the new center is completed. A seven-passenger Volkswagen bus was purchased with donations and city funds. Transportation is provided for shopping needs, doctor and dental appointments, banking, food stamps, and other needs as required by the senior citizens.

Grantee: Western South Dakota Community Action Agency.
Project: Meals program for the elderly.
Project director: Marie Rogers.
Project period: August 1, 1975 to June 30, 1976, second year.
Title VII funds: $73,302.
Total budget: $122,242.

The meals program was funded under title III for 3 years. Two years ago, they converted to title VII. The project director is Indian. There are three sites in Rapid City, one in Keystone, and one in Hill City. The central kitchen, located at 804 Chicago, is considered the Indian site; and 46 percent of their meals are served to non-Indians. The meals are prepared there and transported across town to the two meal sites. For the month of March, they averaged 225 meals per day. This project has generated support from the community, city, and county commissioners, church groups, and other interested individuals. The working relationship between the project director and four site managers is excellent.

Grantee: Northeast South Dakota Community Action Program.
Project: District IV Vista.
Project director: Bruce Miller, acting director.
Project period: July 1, 1975 to June 30, 1976, second year.
Title III Funds: $4,756.
Total budget: $11,260.

This project has 15 volunteer Vista workers, two are American Indians. They have contacted approximately 200 elderly Indians to assist them with the tax relief forms, and encourage them to attend health screening clinics and educational functions. Indians are represented on the senior citizens advisory committee and boards. The CAP agency coordinates and involves Indian people in all of their activities.

Grantee: Northeast South Dakota Community Action Program.
Project: Multipurpose senior centers.
Project director: Carol Seurer.
Project period: March 1, 1975 to May 29, 1976, third year.
Title III funds: $4,325.
Total budget: $8,650.

The outreach worker for this program has contacted 150 to 200 elderly Indians. She has a good working relationship with the elderly. She makes home visits and tends to their needs.

The winterization program funded through NESDCAP repaired at least 25 homes of Indian people. The CAP agency coordinates with the tribal gardens project, the tribal senior center, and provides publicity for the cannery which is owned by the tribe. Of course, they are involved in many other activities too numerous to mention.

Grantee: Area IV Senior Citizens Planning Council, Inc.
Project: Area IV Senior Citizens Nutrition Project.
Project director: Mildred Anaka.
Project period: August 1, 1975 to June 30, 1976, third year.
Title VII funds: $112,287.
Total budget: $174,209.

This project has three sites located at Sisseton, Huron, and Waubay. Sisseton serves approximately 115 meals per day; of those, 24 percent are served to Indian elderly. Waubay serves an average of 23 meals per day, and 15 percent are served to American Indians. Older Indians also participate in the supportive services such as transportation, nutrition education, and health care. At Sisseton a staff of five has two Indian members, one a cook and the other a bus driver. Waubay employs two people, and both are non-Indian. Indian people did not apply for these positions.

Grantee: Greater Missouri Community Development Corp.
Project: Greater Missouri Nutrition Project.
Project director: Ardrie Hermes.
Project period: August 1, 1975 to June 30, 1976, first year.
Title VII Funds: $45,000.
Total budget: $61,866.

Sites are operating at Timber Lake and Isabel. The total meals served per day is 10. Of these, 17 percent are served to American Indians. The project personnel consists of two non-Indians, two Indians and one Hawaiian. The Indian elderly participate in the supportive activities offered by the project.

Greater Missouri Community Development Corp. also has an outreach grant. There is one outreach aide, an American Indian, for all of Walworth County.

Inter-Lakes community action program in Madison does serve a few Indian people in Flandreau and surrounding areas. However, the number of elderly Indian people is very small.

REPORT OF STATUS OF GRANTS/CONTRACTS TO MINORITY INDIVIDUALS UNDER APPROVED AREA PLANS ON AGING AS OF JUNE 30, 1975

PSA No.: NA; total population in PSA: 666,236; number and percent of total population which is minority: 32,365 (4.86 percent); area plan budget: $527,639,[7]

[7] 24 percent of title III moneys were awarded to Indian tribes.

$140,000;[8] total number of grants/contracts under area plans: 42, 12; number and percent of grants/contracts awarded to minority individuals: 6 (14 percent), 7 (58 percent); total amount of funds awarded to minority individuals: $128,431, $85,250.

REPORT ON STATUS OF GRANTS/CONTRACTS TO MINORITY INDIVIDUALS UNDER THE TITLE VII NUTRITION PROGRAM AS OF JUNE 30, 1975

Total State population 60 or over: 109,677; number and percent of minority population 60 or over: 2,561 (2.34 percent); number of population 60 or over designated as eligible for title VII: 109,677; number and percent of minority population 60 or over designated as eligible for title VII: 2,561 (2.34 percent); total number of grants/contracts (including subgrants/subcontracts) under title VII: 8; number of grants/contracts and amount of funds awarded to minority individuals: 2 ($99,969).[9]

Report of grants/contracts to Indian tribes under titles III, VII, and Model Projects as of June 30, 1975

Title III:

Crow Creek Sioux Tribe, Fort Thompson:	
Meals-on-wheels	$15,000
Transportation	15,120
Rosebud Sioux Tribe, Rosebud:	
Meals program, Mission	29,097
Senior center, Parmalee	11,175
Transportation, Rosebud	12,825
Cheyenne River Sioux Tribe, Eagle Butte: Transportation	6,222
Oglala Sioux Tribe, Pine Ridge: Transportation	17,807
Kyle Village Council, Pine Ridge Reservation: Meals program	10,310
Sisseton Wahpeton Sioux Tribe, Sisseton:	
Senior center and transportation	10,875

Title VII:

Lower Brule Sioux Tribe, Lower Brule	36,989
Cheyenne River Sioux Tribe, Eagle Butte	62,980
Model projects: Oglala Sioux Tribe, Pine Ridge: Bilingual information and referral	10,000

Cheyenne River Sioux Tribe, Eagle Butte

Home repair	$18,000
Home supportive service workers	47,250

Four special outreach for SSI grants are presently being negotiated with the tribes. Approximately $20,067.92 will be used for this purpose. The reservations to receive the grants are: Sisseton-Wahpeton Sioux Tribe, Crow Creek Sioux Tribe, Standing Rock Sioux Tribe, and Rosebud Sioux Tribe.

This report does not include the grants to nonminority agencies which are serving a large percentage of American Indians.

27 percent of all Older Americans Act moneys are going to reservations.

A title III grant was made to the Rapid City Indian Service Council for a center program with outreach, education, and transportation components in the amount of $20,562. The project period began on August 1, 1975.

ITEM 6. STATEMENT BY EUGENE L. ROWEN, OFFICE SUPERVISOR, AND FRANK COURNOYER, MANAGER, OFFICE OF TRANSPORTATION PLANNING, SOUTH DAKOTA DEPARTMENT OF TRANSPORTATION

PUBLIC TRANSPORTATION FOR THE ELDERLY IN SOUTH DAKOTA

The urban areas (5,000 or more in population) are served by scheduled motor coach lines, and the smaller areas on the bus routes are also served. The levels of service are far more adequate, but we cannot afford to pay the fares that would be required to provide the desired levels of service.

[8] 60 percent of model projects moneys were granted to Indian tribes. This includes four grants for the special SSI outreach project on reservations.

[9] This constitutes 20 percent of the title VII moneys awarded.

Section 16(b)(2) of the Urban Mass Transportation Act, which provides capital assistance to private nonprofit organizations to procure vehicles to transport the elderly and handicapped, was initiated in South Dakota in 1975. The first vehicles were obtained in early 1976. The chart on the following page gives pertinent information on the present program. An additional application was submitted to UMTA in August 1976 for 18 vehicles to serve 14 nonprofit organizations in providing transportation for their clients.

An inventory of all types of public transportation services in South Dakota was recently completed, and a copy of the report is attached. There are more than 200 senior citizen centers in the State, and more than half of the centers have some transportation service available even though it is insufficient or inappropriate in many cases. These services are briefly described in the inventory report.

Federal programs are very categorical, so no single program can meet our transportation needs. The categorical nature of these programs also makes it difficult to combine the programs to meet the transportation needs and still not violate the sets of guidelines governing the programs. Section 16(b)(2) is a capital grants program limited to providing transportation for the elderly and the handicapped; social services programs which can provide operating funds for transportation are not limited to clientele who are elderly or handicapped, so there is a reluctance to fund a project which does not provide a complete service for all eligible clients. Each Federal agency normally requires an audit on all funds, so bookkeeping and ridership records are difficult to maintain under combined Federal programs.

At least 2 years ago, a "new federalism" was being dicussed. Under this concept, many Federal sources of funds could be programed into a single project and, after approval by the funding agencies, the funds would be combined into a single budget. There would be only one audit of the project, and each funding agency would only need to be assured that programed work was accomplished. It would appear that Federal block grants to States, based on an allocation formula, would be easier to program and administer.

School buses cannot be effectively used to transport the rural elderly for the following reasons:

(1) Standard seating arrangement for school children is not suitable for adults.

(2) A period from 8 a.m. to 6 p.m. should be scheduled to transport the rural elderly to and from shopping and social and medical services.

(3) Better heating and air conditioning is required on buses used to transport the elderly.

(4) The elderly are reluctant to board a school bus.

The transportation needs of the rural elderly in South Dakota are more costly per person because of longer trips to services in our low-density population. They need transportation to and from shopping, doctor appointments, social and recreation purposes. Private automobiles and senior citizen buses are the main modes of transportation for the elderly. If neither mode is available, the elderly person is denied his basic needs.

The elderly require transportation on an average of once every 2 weeks to meet their minimum needs for shopping, doctor appointments and social and recreation purposes. Their minimum need to take advantage of hot meals served at some senior centers would be 5 days a week.

The elderly Indian living on-reservation is in a serious situation. Nearly all persons in this category are living on a monthly income that is less than one-half of the poverty level (monthly basis) Transportation is available on a for-hire basis, but the average cost per trip is approximately $20. On this basis, a trip even once in a month is a luxury. By the end of fiscal year 1977, it is in the overall State program to have transportation to serve the elderly on all nine of the reservation areas.

ITEM 7. STATEMENT OF MICHAEL G. GOODROAD, DIRECTOR, SOUTH DAKOTA TIE-LINE, PIERRE, S. DAK.

Senator Clark and members of the committee, as director of Tie-Line, South Dakota's statewide information and referral service, I am honored to be able to submit this written testimony, and regret that I was not able to give an oral statement at the hearing in Sioux Falls.

Tie-Line, South Dakota's statewide information and referral system, has been operational since July 1, 1975. Tie-Line serves as a central information center and provides South Dakotans with a toll-free service that offers direct and immediate access to over 8,500 public and private service providers.

In its first year of operation, Tie-Line reecived approximately 38,830 calls. Of that number, 2,547 calls, or 6.71 percent of the total number of calls, were placed by or on behalf of senior citizens. The range of the types of requests made by senior citizens generally reflects those of the rest of the population, but there are special problem areas.

The most complicated and frustrating problems arise in dealing with social security benefit guidelines. The case of one elderly couple will serve as a good example. The husband was receiving social security retirement benefits and his wife, who has a respiratory disease, was receiving SSI benefits, which paid for her oxygen supply. The husband received a $3.40 raise in his monthly retirement benefits, which increased their total family income to $1.70 over the maximum limit allowed for SSI eligibility. As a result of this $3.40 raise, the wife lost vitally needed SSI and medicaid benefits which, up until that time, had amounted to $293 per month. The husband tried to refuse the increase but was told that he did not have the option to do so.

This is not just an isolated case. Tie-Line's information and referral specialists have encountered several similar situations which are the direct result of the inflexibility incorporated within social security guidelines and regulations. Other case examples are available upon request. There is a definite need to provide a certain amount of flexibility within the guidelines which would allow each case to be judged on its own merits and extenuating circumstances taken into consideration.

A corollary of the aforementioned problem is the appeals process a person encounters when his or her claim for benefits is denied. An individual making an appeal is faced with a bureaucratic system which at times seems to be working against the client, when it should be facilitating the process. An individual appealing a judgment is often hampered by his own ignorance of the appeals process, and is usually not able to obtain sufficient counseling from social security office personnel on the best way to proceed in building a strong argument for the appeal.

Serious consideration should be given to the implementation of a system of citizen advocates, which would be independent of the Social Security Administration. The function of an advocate would be to facilitate the appeals process for the individual who could not afford to retain the services of a private lawyer. The duties of a citizen advocate would include:

(1) Making the client aware of his rights, options, and obligations in the appeals process;

(2) Aiding the client in the construction of the best possible argument for the appeal; and

(3) Appearing as the client's representative, if necessary, when the case comes before the appeals judge.

Tie-Line staff have encountered several complicated social security problems which have ultimately gone through the appeals process. In the effort to find assistance for those persons making appeals, Tie-Line has located only two citizen advocates of the type described above, but only one of these is able to serve as the client's legal counsel when the case comes before the judge. Considering that Tie-Line has been able to locate only two advocates for all of South Dakota, implementation of a system of citizen advocates would do much to alleviate a serious service gap in this area.

One final point relating to the appeals process involves the waiting period between initiation of the appeals process and the actual hearing of the appeal. It is not uncommon for an individual to have to wait for 6 months before his appeal is heard by the judge. The individual may well be awarded back benefits if the decision is favorable, but he is often left without any financial resources whatsoever during the waiting period, unduly increasing both the economic and emotional pressure on the individual.

Since the lengthy waiting period is usually a function of the heavy caseload carried by the appeals judge, consideration should be given to either increasing the number of appeals judges within the area, or reducing the size of the geographic area for which each judge is responsible.

In addition to the need for citizen advocates, Tie-Line's information and referral specialists have encountered several other service gaps in senior citizen needs.

A major service gap occurs in the area of dental services for senior citizens. There are several public programs which provide financial aid for dental services to several different target groups within the State. Unfortunately, the elderly is not one of these target groups. A senior citizen living on a fixed monthly income does not usually have the resources necessary to pay for extensive dental work, such as the construction of a set of dentures. If a person cannot afford to pay for dental services, he or she will usually learn to do without it, but the impact of foregoing needed dental work can be very damaging, not only from a nutritional aspect, but also from one of maintaining self-respect and dignity. Tie-Line is sometimes able to obtain aid for a senior citizen by contacting a local fraternal or charitable organization, but funds allocated for such purposes are usually limited and available only in a few areas. There is a definite need for some type of comprehensive dental services plan for senior citizens.

There are several service gaps which are ramifications of the rural nature of the State. Isolatedness of rural communities, subsequent transportation problems, and lack of sufficient numbers of outreach personnel all contribute to the lack of onsite service delivery programs (meals-on-wheels, homemaker services, etc.) in some areas, or serious problems with extant programs. Programs like these are important because they provide the elderly with services that permit them to maintain an independent and dignified life style.

Tie-Line is able, to a certain extent, to negate the effects of isolation by providing senior citizens in rural areas direct and immediate access to service providers. The information and referral specialists are able to act as coordinators/facilitators in making senior citizens aware of what services are available to them and then, by working with service providers, making sure the needed service is delivered.

In summary, the problems facing the rural elderly in South Dakota tend to be exacerbated by the very nature of a rural environment, which promotes a physical isolation of the rural elderly from those providing needed services. However, an equally important problem lies in educating the elderly as to exactly what services are available to them, and then constructing viable service delivery systems which will be to deliver those services on a compassionate and individualized basis.

Senator Clark and members of the committee, thank you.

ITEM 8. STATEMENT OF DAVID A. KEMPER, DIRECTOR, SOUTHEASTERN HUMAN DEVELOPMENT PROGRAM, SIOUX FALLS, S. DAK.

My name is Dave Kemper and I am the director of the southeastern human development program, a community action program which serves a six-county area in the southeastern corner of South Dakota.

I will keep my remarks very brief because I realize you are here to listen to testimony from our older citizens and I also realize that those older persons get tired of younger people attempting to speak for them.

Naturally, serving in my position, I am very concerned about services to the poor. Unfortunately, many of our elderly people fall into that economic classification with no hope of escape. They are either unable to work or find employment because of their age.

The elderly poor, and especially the rural elderly poor, need to be given special attention when drafting and implementing older American's legislation. It troubles me that many of the past beneficiaries of programs funded under the Older Americans Act of 1965, and subsequent amendments, have not been poor. I cannot offer you accurate data to substantiate this statement. However, after being involved with elderly programing in two States, I am convinced that a special effort needs to be made to reach those people who truly need those services. Indeed, I believe if you will think back to all of the contacts you have had with senior citizen groups and programs, you may come to the same realization. The poor are not involved as they should be.

Please, do not misunderstand me. I believe senior citizen organizations and centers serve a very worthwhile purpose. I have also found that the people involved in older American programs are concerned and usually make every effort to reach the elderly poor. Nevertheless, I would urge your committee to consider ways of assuring that services intended for the elderly are designed to reach the elderly poor. This may be done by mandating that each grantee address the problem in their funding proposals. Another possibility is to concentrate on those services which are most likely to reach the rural elderly poor, such as: outreach programs, home care services, viable legal services and/or ombudsman programs, rural transportation services, as well as others.

I realize that some of these services I have mentioned are national priorities already and I also realize that resources are limited. Unfortunately, I don't have any easy answers. I do hope you will consider the issue I have raised and I am sure there are smarter people than myself who can find some answers.

I would like to briefly make two other points while I have the opportunity. First of all, I want to emphasize the need for outreach services in rural areas. We are fortunate to have the aging services center in this area, which we work with in our own outreach effort. In other areas of the State, as over much of America, these services are provided by community action agencies which provide services to the poor. Since 1965 CAA's have, in many areas of our country, taken the lead in developing services for the eldrely. In fact, in most rural areas the CAA is probably the only viable service delivery mechanism in existence. These agencies must continue if the rural elderly are ever going to be served adequately.

Second, in considering the needs of rural as well as urban elderly, don't overlook the administrative complexities which keep many elderly people from achieving an adequate income and proper nutrition. Programs such as social security, social security disability, food stamps, and SSI need to be simplified and streamlined. Far too many persons are not taking part in these programs, even though the need exists, merely because of the bother or humiliation involved in applying. We have several case studies which we would be happy to make available to the committee if they might be of benefit to you.

Thank you for your time.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing in Sioux Falls, S. Dak., on August 18, 1976, concerning "The Nation's Rural Elderly," I would have said:

The following replies were received:

RAY A. BAGLEY, MADISON, S. DAK.

Small towns need more transportation. South Dakota had a very bad drought. It would be very good to have work programs such as Green Thumb expanded for the elderly. That would have to do for the elderly. I also thought that some grocery delivery service sounded pretty good. There could be room for expanding for school help, transportation, and nutrition. I enjoyed the meeting at Sioux Falls.

HAZEL M. BOEHLER, CANTON, S. DAK.

Transportation is a big need in this State, but if the elderly had the money, the transportation would be available.

The young mothers on aid to dependent children are well taken care of and lack for nothing, but the grandmothers and grandfathers are sadly in great need. At election time the elderly are taken to the polls and votes are solicited, but at any other time they are not important.

DORTHY BROWN, LAKE ANDES, S. DAK.

As a service provider, I probably consider needs of the rural elderly in a somewhat different light than others would do. The following points are based upon personal convictions, as well as upon observation of certain Federal programs. These points are not prioritized, nor are they purely restricted to the Nation's elderly.

Outreach efforts within a rural setting are of upmost importance. These outreach efforts conducted within a nonurban area must include elements which are not usually identifiable with the term, for the common term usually implies that a staff-clientele basis is ordinary on a one-to-one basis. However, the feasibility of applying this same type of concept to rural living and keeping it monetarily effective is absolutely impossible. Rural outreach efforts must embrace two approaches: the traditional and the group basis. Rural elderly persons and urban elderly persons may at some time need assistance in meeting needs or problems; however, few of them know where to go. Other factors coupling the difficulty of finding results, especially for the rural elderly, are transportation and communications. If one must travel somewhat for consultation or to obtain direct assistance, the elderly usually can't manage it for a multitude of reasons. Communications of available opportunities and/or services are not particularly easy to get for a locality if one must rely on a small town newspaper. News of the human services do not, unfortunately, often travel that route.

As a service provider, different efforts and measures must be used. This is where the rural outreach worker steps in. It must be allowed, and I dare say encouraged, to function both on the one-to-one basis and the group basis. These persons must not only work on the individual's need, but also be involved with establishing and/or strengthening the middleman approach. If, for instance, a local volunteer or a senior citizen center becomes involved with this "middleman" approach, then total generation efforts may have the multipler effect. I truly believe that this type of multipler effect is the only possible approach one may use when trying to serve thousands of rural elderly persons scattered over thousands of square miles, as we are trying to do.

Federal program requirements, primarily designed to be of service either directly or indirectly to rural elderly persons, are many times inappropriate to available resources and the realities of rural living.

Example 1. Social Security Act's title XX programs mandate a lengthly, complex certification process. If these types of programs are to be of service in rural America, the harsh realities of geography and proper staffing are continuously undermining the best of intentions and efforts.

Example 2. Requirements of medicare and medicaid of having a physician review each resident or patient each few weeks or requiring institutions of this type having diets checked by a licensed dietitian. Rural areas don't usually have an abundance of professional persons lying around unoccupied, yet the programs are in essence negatively differentiating between the professional haves and the professional have-nots.

In closing national programs are to be just that, national programs. However, elderly persons in rural South Dakota are of need as is the elderly New Yorker. As a service provider, I must again stress that rural South Dakota is trying to assist its elderly persons and we, in turn, expect our governmental officials to return the compliment. Remember: I have to travel 72 miles to see a traffic-signal light in South Dakota.

MAE MULLINIX, CANTON, S. DAK.

Thank you for the privilege of meeting you and taking you for a ride in our van.

Everyone really enjoyed it. I finally got ahold of a picture from the office on aging in Sioux Falls, so I put an article in our local newspaper. Thought you might like a copy.

J. F. SMITH, SIOUX FALLS, S. DAK.

Please have the States reduce their taxes on homes of the elderly and do something about the schools always wanting more and more. They say South Dakota doesn't pay its teachers as well as other States. Why then are there so many teachers from other States teaching here?

We have lived here for 28 years and our taxes have gone up every year. My husband has retired from Morrel and his pension is $214 a month. After 28 years of work and $433 social security, the rate things are going we will have to give up our home because, when we *do* get a social security raise, by the time we get it everything is higher and we worry more. They always have millions for foreign countries, but never for us.

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