NURSING HOMES AND RELATED LONG-TERM CARE SERVICES

HEARINGS

BEFORE THE

JOINT SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

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Part 2

WASHINGTON, D.C.—MAY 6, 1964

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Note.—Three hearinps on nursing homes were held at follows:
Part 1—Washington, D.C., May 5, 1964.
Part 2—Washington, D.C., May 6, 1964.
Part 3—Washington, D.C., May 7, 1964.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

	Page
Mother M. Bernadette de Lourdes, administrator, St. Joseph's Manor, Trumbull, Conn., and vice president, American Association of Homes for the Aged	83
Rev. William T. Eggers, administrator, Home for Aged Lutherans, Wauwatosa, Wis., and chairman, Accreditation Committee of American Association of Homes for the Aged	92
Father John J. Humensky, director of Catholic hospitals, Cleveland, accompanied by Frederick N. Elliott, M.D., associate executive director, Cedars-Sinai Hospital, Los Angeles, and Kenneth Williamson, associate director, American Hospital Association	110
Dr. H. Close Hesseltine, chairman, National Council for Accreditation of Nursing Homes, accompanied by Alton Barlow, vice president, and Alfred S. Ercolano, executive director, ANHA	132
Dr. Herbert Notkin, member, Medical Care Section, American Public Health Association, and Medical Director, Onondaga County Welfare Department, Syracuse, N.Y	149

STATEMENTS

American Medical Association	157
American Nurses' Association	170
Eggers, Rev. William T., supplementary statement	105
National Federation of Licensed Practical Nurses, statement of functions of the licensed practical nurse	176
Notkin, Dr. Herbert, member, Medical Care Section, American Public Health Association	149

ADDITIONAL INFORMATION

Accreditation of nursing homes, American Hospital Association, appendix V	257
Accreditation program, Wisconsin Council of Homes and Hospitals Serving the Aged, appendix III	223
Accreditation standards of the National Council for Accreditation of Nursing Homes, comments on	106
American Association of Homes for the Aging, summary of meeting, appendix I	179
Brownstein, P. N., Commissioner, Federal Housing Administration, letter dated June 5, to Senator Moss	109
Guides for medical care in nursing homes and related facilities, AMA	168
Guiding principles for agreements between general hospitals and long-term-care facilities	118
Hesseltine, Dr. H. Close, chairman, National Council for Accreditation of Nursing Homes, appendix VI	265
Joint Commission on Accreditation of Hospitals, appendix IV	238
Standards for accreditation, appendix II	190

NURSING HOMES AND LONG-TERM CARE

WEDNESDAY, MAY 6, 1964

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

The subcommittee met, pursuant to recess, at 10:20 a.m., in room 4232, Senate Office Building, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Morse, Randolph, Yarborough, and Fong.

Also present: Frank C. Frantz and Jay B. Constantine, professional staff members, and John Guy Miller, minority staff director.

Senator MOSS. The joint subcommittee will come to order.

We will continue with our hearings. We have testimony today from four very fine organizations and we want to hear from them.

First on the agenda will be the American Association of Homes for the Aging, Mother Bernadette de Lourdes, administrator of St. Joseph's Manor, its vice president, and Rev. William T. Eggers, administrator of the Home for the Aged Lutherans, are two who are scheduled.

Mother Bernadette, we are very pleased to have you with us this morning and we look forward to your testimony.

Mother BERNADETTE. Thank you, Senator.

Senator MOSS. You may proceed.

STATEMENT OF MOTHER M. BERNADETTE DE LOURDES, ADMINISTRATOR, ST. JOSEPH'S MANOR, TRUMBULL, CONN., AND VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGED

Mother BERNADETTE. Mr. Chairman, Senators, ladies, and gentlemen, I am Mother Bernadette, vice president and board member of the American Association of Homes for the Aging. I am the administrator of St. Joseph's Manor, in Trumbull, Conn.

It is a wonderful inspiration for me to participate in such a gathering as this since my personal life has been dedicated to services for the aging; and may I take this opportunity to congratulate you on your desire to increase the comfort and security of the senior members of our society.

I am grateful for this opportunity to speak to you who are so interested in what is happening to our older people and I hope that the message I bring will be of some use in making life just a bit more pleasant for those whose lifespan is drawing to a close.

Our times have witnessed many changes. Practically every aspect of life has been affected by these changes. I am not concerned here and now either with cataloging such, or passing on their merits. What I am sure you and I are interested in is to focus our serious attention to the problem that confronts us in caring for the aging. And, even though I have just used the word "problem," I personally prefer to consider it a challenge.

The day is long past when old age was looked upon as a disease. No longer are those over 65 classified as the aged, the dying, and the dead. Old age has come into its own. Roughly about 10 percent of our entire population embraces those 65 and over—a considerable segment, you must admit. Like every age, old age has its problems. As in every age these problems cry for a solution.

These problems have many facets—physical, social, psychological, and spiritual. Research in these fields, barely underway, is proving conclusively that old age can, for the majority of people, be most happy and useful—and, in all situations, at least tolerable to the point that adequate care under competent supervision, can ease pain, distress, and mental anguish.

The one great medicine, almost a specific in many cases, uncovered by scientific research in the field of social gerontology and geriatrics, is one known and used by the church for 19 centuries—personalized services to the aging. It is the individual love of man for man grown out of the love of God.

It is a love that makes the aging know they are loved and wanted. It takes out of their lives the horrible and terrifying fear of insecurity. It is a love that replaces the friends that death has taken from them.

It is a love that substitutes for relatives and dear ones long since departed. With this shown, then they no longer walk alone. No longer are they disturbed, cast aside, rejected, with no suitable place in the community. They are useful citizens—members of society because someone took time out to be the good Samaritan to follow Christ's command "Love thy neighbor as thyself."

I should now like to speak of the changing trends in nonprofit homes for the elderly. Recently I sent out questionnaires to 520 Catholic homes caring for older people. So far 168 have responded showing that 8,641 beds were used by the well aged, and 5,463 by older people requiring nursing care. These figures clearly indicate the high percentage of persons receiving nursing care in just one religious group of voluntary nonprofit homes throughout the country.

When all the homes respond we will have a much better picture of the extent of medical services in these homes—127 of the homes use volunteers, 131 have organized medical programs, and 132 have a planned activity program.

All of us here know from experience that just because a person has reached his 65th birthday, he does not give up his spirit of independence. Therefore, in planning facilities, services and programs for our aging Americans we must ever keep this in mind and plan accordingly.

The religious community of which I am a member, came into existence in New York City in 1929, specifically to provide a type of care which would more adequately meet the needs of our aging citizens, and thus enable them to live out their later years in an environment

which would manifest our appreciation of the dignity and respect due to those blessed with a long life.

Many seem to think that because a person is older in years he automatically loses good judgment and even the right to make his own decisions. All of us here today, I feel certain, know that this is a false premise. The older person is and always should be essentially free. Once we accept the fact that a person is free to make decisions, then we concede to him other rights such as choosing his own dwelling place.

I need not tell you of the great need there is for the proper type of living arrangements which will satisfactorily meet the varying and changing needs of our older people. This brings me to the consideration of suitable and adequate housing. I have always felt that in order to make a successful and happy adjustment to life in a residence for the elderly, the individual must feel absolutely free to enter such a residence or remain in his own home.

However, the real problem is that residential care facilities offering comprehensive services which will meet the long-term needs of the older person are already overcrowded, and those who operate such facilities, are, I am afraid, becoming a little bit like the discriminating landlord.

While the executive director or administrator would be most happy to accept all who apply for admission, it is virtually impossible and therefore, only those in greatest need are admitted.

Some people still have a very dismal concept of congregate or group living facilities—traditionally known as "homes for the aging." They visualize them as grim, dreary places for which they would apologize if it were necessary for a relative or a friend to enter such a residence.

The main reason for this erroneous interpretation is that the general public is not cognizant of the great advances and notable changes which have taken place in these homes in recent years. These residential care facilities—call them homes, hotels, or any other name—are really becoming places any one of us, if it were necessary would not at all mind living in.

In many instances the "home for the aging" is the most satisfactory answer for the older person who needs specialized care which cannot for a variety of reasons, be made available in his home.

The modern, nonprofit home for the aging is, first a place to live, and, when necessary, provides a variety of degrees of care, not only to preserve and restore health, but to enhance the well-being of the older person, offering opportunities and services to make his life worthwhile.

A nonprofit home for the aging is concerned with the total person, and unlike most commercial facilities which provide only the services for which the older person can pay, the nonprofit home will even seek subsidy, when necessary, to make available needed services for its residents.

The nonprofit home is accountable for the total well-being of each resident to its board of directors, to the voluntary denominational or governmental sponsoring group, and to the overall community which it serves as an integral part of the network of services.

In fact, in many communities the nonprofit home is a focal point of varied services for all older people in the community.

Since time does not permit me to enter into a detailed description of the facilities, services, and programs of such a home, I should like to mention very briefly some of the services we have found it necessary to make available for our residents at St. Joseph's Manor, and which I am convinced are definitely needed.

Admission procedure: Our present practice is to receive before admission a referral from the personal physician of the applicant, a social summary, and an application signed by the older person himself. A personal visit by the older person to the manor is a requirement. This enables the person to see the environment, meet some of the people with whom he may decide to live and thus be in a better position to determine if this is the kind of living arrangement which will best meet his present needs.

Medical care: Immediately after admission the older person has a very complete physical examination and other tests. This health study is valuable to the older person and to us. We are now in a better position to plan more effectively for his or her medical care, rehabilitation, and participation in outer activities within and without the manor. This health supervision is continued for as long as the older person remains in residence.

Nursing service: In my experience there are very few older persons who enter any kind of residential facilities designed for the elderly who do not need some degree of nursing service. It is important, therefore, that we are prepared to offer this service.

Physical medicine and rehabilitation: Some years ago many illnesses suffered by older people were fatal. With the advance in medicine and surgery this is not true today.

Older people survive these illnesses but are often left with some physical limitations. Physical medicine, rehabilitation, and retraining in the activities of daily living can often enable the older person to care for his personal needs, become self-sufficient and hopefully even participate in useful and meaningful activities.

Occupational therapy: All of us desire to be useful and productive as long as we live. This is certainly true of the elderly who have been for many years contributing members of our society. A person who is skilled in occupational therapy uses the media of creative activity to continue the program of rehabilitation and thus increase the older persons degree of independence. She can usually teach an older person some craft which is within his physical strength.

It may take a long time to accomplish results, but the time and patience expended are well worth while when the older person eventually succeeds in producing some serviceable article. It is a most rewarding experience for both the therapist and the older person.

Recreation: Recreation in its many forms is a significant part of the total program of the modern home for the aging. When I speak of recreation, I am thinking not only of the weekly movie, the canasta and bridge players, bingo, and other games, I am thinking too, of the stimulating effects of good concerts, glee clubs, variety shows, and special performances by professional entertainers. All of these and many others have their place in the program.

Older people are very individualistic, their past experiences vary greatly, therefore, if we are attempting to satisfy and meet the in-

terests of all we must devise and plan for a great variety of kinds of stimulating entertainment.

Our residents write plays and put on their own programs several times each year. This has real value as it gives them an exhilarating sense of achievement, and pride, in their ability to produce, perform, and entertain.

Creative activities: Just as each of us have our special interests so is this even more true of older people. Therefore, we should encourage them to participate in the activity that is of deepest interest to them. We discovered that through a resident council many hidden talents were brought to light and used to advantage.

1. The members of the resident council are a very important group and have definite status during their term of office. 2. They appoint special committees and hold regular and special meetings. 3. A home paper is written and edited by the residents. 4. A library, a millinery shop, a fashion shop, a diversity shop, a gift shop, a ceramics studio, and other similar interests supply innumerable opportunities for creative activities.

Social service: The door of the social service department in the residence should always be open to receive and welcome residents who need counseling, guidance, and assistance. This service should also be available to the relatives and friends of the older people.

Religious services: In mentioning some of the services which are usually available in the modern residence for retired persons, I should not like to forget to mention religious services. As people grow older usually their appreciation of spiritual values increase and they look forward to a future life.

Death is not the end. Their faith tells them that the Creator who made them has a reward awaiting their well-spent lives.

So far I have been speaking of services and programs that are not only desirable but necessary if we are to adequately meet the total needs of our older people and enable them to enjoy to the fullest the added years that medical science has given them.

My allotted time is almost up and I have only briefly mentioned some of the services needed by our aging citizens. Before concluding my remarks, I would like to say that it is rather difficult for me to conceive of one kind of facility for all apparently well older people, and another for those who are disoriented and confused, another for those who are blind, another for those who have physical disabilities, another for those who are suffering from long-term illnesses, and so on.

It seems to me that such a plan would be very limiting and would offer a minimum of security to older people whose requirements often change quite unexpectedly.

In my opinion what older people really desire is long-term security and the assurance that they will get the care they need when they need it, without having to move from one facility to another. Varying degrees of care under one administration seems to be desirable and this can be provided in the same or in separate buildings geographically reasonably close to each other.

It has been a privilege and a pleasure to speak to you on a subject that I could talk on all day. There are so many services that I should like to have discussed in detail, but time does not permit this and there must, of necessity, be some things left out.

Life is a very complex affair at best for the youngest of us. It does not get less complex as we advance in years, but it is up to us to make straight the way for our older people so that the necessary changes that come with age may be taken in stride and when they arrive at the last milestone along the journey they need have no fears.

We can well be proud of the progress that is being made with regard to adequate care for our aging population, but we must remember that there is yet a great deal to be done and it is only by concerted effort that we can accomplish our goal. Our 17 million older Americans need your helping hand.

They not only need, but are entitled to:

Adequate medical care; rehabilitation—physical, psychological, social, and spiritual; occupational therapy and educational opportunities in arts crafts and skills of interest to them; recreational activities—a wide variety should be made available to meet the interests of different persons; good nutrition, proper diets for health and enjoyment—mealtime should be a social as well as a nutritional event; proper housing to meet particular individual needs; economic security to enable each older person to maintain the dignity and respect which should accompany age; social contacts with family and friends and continued active participation in community affairs such as voting, and other civic interests; productive activity that has a commercial value or in some way brings remuneration for work accomplished; religious services—these are most important to those whose appreciation of spiritual values have grown with the years.

All of these activities properly used, under professional supervision, have a real therapeutic value and, as such, should be made available and be participated in according to the individual ability by our older people.

That, my dear Senators and friends, just about finishes the message I have tried to bring to you today. Thank you very much and God bless you.

Senator Moss. Thank you, Mother Bernadette. That was a most excellent statement and we do appreciate your coming here to bring it to us today, to be part of our record in this hearing.

What is the size of St. Joseph's Manor, how many residents?

Mother Bernadette. Senator, we have 285 residents, ladies, gentlemen, and couples.

Senator Moss. It is a very sizable institution. I was interested in following your statement that 131 of the 168 homes returning your questionnaire have an organized medical program. This is about 80 percent.

Would you expand a little, tell me just what does the organized medical program consist of?

Mother Bernadette. Senator, I just sent this questionnaire out very recently, this is why we have such a small number of responses. I made the questionnaire very brief just to get an idea how many people in each home were considered well aged; by well, I do not mean perfectly healthy, but able to take care of their personal needs.

By nursing care I had in mind persons who require the services of a professional nurse. By an organized medical program I had in mind that the medical program would be under the general supervision of a

medical director or physician. The medical services would be available to persons in the building who are in need of health care.

I have not studied the answers very carefully yet, except to get the statistics mentioned from them. When all questionnaires come back, which I hope will be in the next 2 weeks, I shall look at them more carefully.

Senator MOSS. This would be health services in the institution itself?

Mother BERNADETTE. Yes, sir; there would be a medical doctor in charge of the medical program, and other health services would be available within the home or there would be some plan to get them from outside facilities.

Senator MOSS. I was very interested in your advocacy of offering a variety of kinds and levels of care under one administration. I can say that I have great sympathy with that, but I gather that our present Federal programs of assistance in buildings do not lend themselves too well to this concept.

Do you have any views on that?

Mother BERNADETTE. Well, of course, I think there are some Federal programs which provide housing, without services, for older people who are I would call the very young old-age group, persons from 60 or 62 on, and these people are young, rather well aged generally. I also believe that there is a program that provides housing for the well aged and also allows for a certain percentage of nursing care beds. And another that provides for total nursing care; however, these are usually separate facilities and I feel that an older person because of his changing needs likes to feel and to know that if he comes in ambulatory, in apparently good health, if he should happen to suffer a stroke or a heart attack, or any other severe illness that would limit his activity a great deal, he would still be cared for either in the same building or in another offering more intensive nursing care. This plan offers the older person more security and is much less frightening than transfer to a hospital, and then having his family or friends or some social service department find him some other place to live at the very time in his life when he is most in need of care.

Senator MOSS. The uprooting experience, you think, is very difficult?

Mother BERNADETTE. Yes, Senator; it is always difficult for an older person to move even from one room to another in the same building.

Senator MOSS. Thank you very much. Senator Fong may have a question or two, Mother Bernadette.

Senator FONG. Yes. Mother Bernadette, I was very interested in hearing your statement, it has given us a very fine insight as to how homes are administered and what you have been doing for the aged.

St. Joseph's Manor, I believe you stated, originated in 1929.

Mother BERNADETTE. No, Senator; our community came into existence in New York City in 1929. At the present time we have about 30 homes throughout the country, and we care for older people in these different homes.

We have five homes in New York City, we have one here in Washington, and we have others in different parts of the country. Our community came into existence in 1929, in New York City, specifically to care for older people.

Senator FONG. So you have had over 35 years of experience?

Mother BERNADETTE. That is right, Senator, I have been working with the aged since 1932 myself.

Senator FONG. Could you give the committee some idea as to how you are meeting your expenses?

Mother BERNADETTE. Yes, Senator; I will speak of the one where I am now and this applies to our other homes. We accept persons who are either on public assistance, State aid, or whatever the public assistance or old-age pension grant is called in the State where the home is located.

Our minimum rate in the home I am in right now, with a capacity of 285 is $182.50. We accept persons on public assistance and at present we have 84 on State aid (MAA). We also have persons who can pay the full cost of care, and some persons who can pay more than cost of care.

Our homes operate from monthly income paid each month either by the resident from personal funds or by the resident's family or by a combination of social security and some other kind of pension or MAA.

Our minimum rate is always the rate set by the State for persons on public assistance in that State. We do not exclude anybody because of their financial situation. We accept them.

Sometimes a person comes in with some money, and after a short time it becomes necessary for him to go on State aid. This makes no change. He will still remain in his private room, or double room, and he will be treated the same as when he was paying from private funds. No distinction is made, this is our policy.

Senator FONG. How much is the State of New York paying?

Mother BERNADETTE. Senator, the rate varies in each State. In Connecticut at the present time our minimum rate for a person in a home classified as a rest home with nursing supervision is $182.50 a month. Those who are on the floors approved as a chronic convalescent hospital receive $285.92.

Senator FONG. How many rates have you?

Mother BERNADETTE. Two State rates, $182.50 for rest home with nursing supervision and $285.92 for chronic convalescent hospital.

Rates vary in each state.

Senator FONG. Do you charge the same rate whether a person pays for himself or the family is paying for him?

Mother BERNADETTE. Each person must pay as much as the State pays for persons on public assistance. Usually a little more is paid by those paying from their own funds.

The donated services of the Sisters makes a difference in our operating costs.

Senator FONG. How many Sisters do you have?

Mother BERNADETTE. Twenty-one and we have 168 paid employees. We also have a large number of senior and junior volunteers. In case of need the diocese will supplement so we can meet our expenses.

Senator FONG. If the Sisters were not giving their voluntary services and you had to hire help to take care of the services that the Sisters provide, what would you think that the cost would be per individual?

Mother BERNADETTE. Well, Senator, our operating expenses for last year, based on 285 people was $1,186,000. The per diem cost was $11.62.

Senator FONG. Well, if your Sisters did not volunteer to help you could not make it on $182.

Mother BERNADETTE. No; Senator, I don't think so.

Senator FONG. Have you compared your costs with other costs in other homes like yours where there is paid help all the way?

Mother BERNADETTE. I have not, Senator, No.

Senator FONG. Now, you gave us a figure of 520 Catholic homes that have received questionnaires from you and 168 responded, and you state that out of the 168 responding there were 8,641 beds used by the well aged. And then you said 5,463 by older people requiring nursing care.

Could you differentiate between that?

Mother BERNADETTE. Senator, I sent a very brief questionnaire and all the information I asked was, how many did they feel were in the class of apparently well aged, generally able to take care of most of their personal needs, and how many did they consider needed intensive nursing care. I was interested in the figures and I was glad to see that we have so many persons in our nonprofit homes receiving skilled nursing care.

The general impression seems to be that most homes for the aged are still taking care of mostly the so-called well aged and I prefer to say apparently well, because most older people are not completely well. With an average age of 79 or 80, in most homes today, and I do not feel they can really be well, that is why I was so interested in the figures, but since I just sent this questionnaire out recently, when I get all the returns I will follow up on it.

Senator Fong. The residents in your home, once they come in, do they stay?

Mother BERNADETTE. Yes, Senator.

Senator FONG. They are permanent?

Mother BERNADETTE. Senator, we make no distinction, we accept all persons regardless of age, religion, race, or creed. The only persons who would be excluded would be persons who had a communicable disease, whom we could not care for or a person who would be definitely a psychotic.

If they are just confused we take them and we care for them until the end.

We have an affiliation with a general hospital, and if an older person needs surgery he goes to the hospital, and after surgery he comes back to us.

The medical staff at the manor are also on the staff of the hospital. If a resident wishes to choose a different hospital, he may do so and on discharge comes back to us.

Senator FONG. What percent of the people who reside there move out and seek their own homes?

Mother BERNADETTE. We have a small number, Senator, who were rehabilitated to the extent they could return to their family, but not too large a number, because our average age is 79 and most of those who come to us come because they have reached the point where they can no longer remain with their families, but we have had situations where a wife or a husband would have a stroke or some severe disability and after a period of rehabilitation and care was able to return to the family.

Senator FONG. All of the activity that you give them, you would wonder why anyone would want to move out.

Mother BERNADETTE. Senator, it has happened a few times that a husband and wife, it was very desirable for the husband or wife, depending on the situation, to return to the family, if he or she was able. We always let them know if they need to come back to us at any time we will give them priority on our waiting list.

Some of them return home and are not able to remain; after a certain number of months they find they cannot continue there and then come back to us.

Senator FONG. Thank you, Mother.

Mother BERNADETTE. Thank you, sir.

Senator MOSS. Thank you, Mother Bernadette. Just one question. You classify your manor, I suppose, as a home for the aged. Would you make any distinction between that and a nursing home?

Mother BERNADETTE. We are licensed according to Connecticut terminology as a chronic convalescent hospital and a resthome with nursing supervision and permission to take care of mild mental and also a special activity program.

This is the kind of licensing in Connecticut. In New York we are called a home for the aged with infirmary. However, I would call it a nursing home with a great deal of health services provided for each resident, including those who are apparently healthy and who come in with a medical referral. All have regular physical examinations and a complete medical chart is maintained.

Senator MOSS. Thank you very much, we do appreciate your coming. We hope you will be able to stay and hear some of the other witnesses who will testify.

Senator MOSS. We will now hear from the Rev. William T. Eggers, administrator, Home for Aged Lutherans, Wauwatosa, Wis., and chairman of the Accreditation Committee of the American Association of Homes for the Aged.

We are glad to have you, you may proceed, sir.

STATEMENT OF REV. WILLIAM T. EGGERS, ADMINISTRATOR, HOME FOR AGED LUTHERANS, WAUWATOSA, WIS., AND CHAIRMAN, ACCREDITATION COMMITTEE OF AMERICAN ASSOCIATION OF HOMES FOR THE AGED

Reverend EGGERS. Permit me, first of all, to identify myself. I am William T. Eggers, the administrator of the Home for Aged Lutherans, Wauwatosa, Wis., a suburb of Milwaukee, and the home that I administer is a 270-bed facility, designed primarily to care for older people afflicted with long-term illnesses.

I also serve as secretary of the American Association of Homes for the Aging and the chairman of its committee on accreditation. This association represents the nonprofit homes in this country, that is, those homes sponsored by civic, community, church, fraternal, and other groups, and these homes are governed by board responsible to the community or their respective sponsoring groups.

Without elaborating the historical reasons for this decision, I want to say, to begin with, that the executive committee and the board of our association became convinced in the spring of 1963 that our asso-

ciation should take the initiative in trying to establish in this country a unified multilateral program for the accreditation of nursing homes and homes for the aged. It, therefore, appointed a committee on accreditation to pursue the establishment of such a program.

This committee met repeatedly in the fall of 1963 to prepare for the calling of a meeting at which organizations logically interested in such an endeavor would be represented.

Such a meeting was held on November 7 in Chicago. Invited to this meeting were the following organizations: the American Hospital Association, the American Nursing Home Association, the American Medical Association, the College of Surgeons, the College of Physicians, the American Association of General Practitioners, the American Psychiatric Association, the American Nurses Association, the National League for Nursing, the Federation of Licensed Practical Nurses, the National Association of Social Workers, the Association of Rehabilitation Centers, and the American Dental Association. Nearly all of these groups were represented at this meeting, and all expressed an interest in it.

The American Association of Homes for the Aging proposed that an independent corporation be formed for the purpose of accrediting homes for the aged and nursing homes, that organizations representing these institutions hold slightly less than 50 percent of the voting power in the corporation and that organizations representing professional groups hold the remainder of the voting power. It also proposed that the administrative expenses of the new corporation be borne by the groups forming it in proportion to the voting strength they held, and that the actual cost of surveying homes be borne by the institutions surveyed.

It further proposed a tentative budget. It thereupon suggested that these proposals were open for discussion, modification, and would hopefully be adopted in some form or another.

Throughout these and all subsequent meetings our association pursued the goal of a single, voluntary, multilateral program of accreditation on the national level with adequate standards and adequate provisions for an appeal process.

After a lively and extended discussion of these matters, the representatives of the various associations agreed to meet on February 20, 1964, at the University of Chicago to report back to the group the positions that their respective organizations took in the interval.

Out of the February 20 meeting and its reports there came the formulation of a steering committee composed of one representative of each of interested organizations.

Several organizations had, at this time, expressed their inability to proceed with the project or did not seem especially interested. Several others, although interested, did not have representatives at the meeting. As a result, a steering committee of eight people met on February 20 to pursue the matter of a national accreditation program. This committee was charged to explore three avenues of action.

It organized itself and through a subcommittee did pursue its three charges. It corresponded with the Joint Commission on the Accreditation of Hospitals to determine whether or not the joint commission would at this time reconsider the possibility of accrediting homes for the aged and nursing homes.

As other testimony may disclose, the joint commission, under a special grant, pursued this matter for a year and developed standards and an appropriate program for the carrying out of these standards.

However, in November 1962, the board of trustees of the American Medical Association considered the joint commission program and voted not to support it. The steering committee had been instructed to explore also this avenue, in an attempt to leave no stone unturned in the effort to attain the national unified program of accreditation.

While the commission has, according to my understanding, asked its member bodies to reconsider this matter, at this point there seems little possibility that the American Medical Association will change its position, and we have been advised unofficially to work on the assumption that the joint commission will not proceed with such a program of accreditation.

The subcommittee's second charge was to determine whether or not the National Council on Accreditation, sponsored by the American Medical Association and the American Nursing Home Association, would at this time open its corporation to permit a truly multiprofessional approach to the accreditation of nursing homes and homes for the aged with adequate representation from all groups concerned.

The subcommittee held a special meeting with representatives of the national council, including representatives of the AMA and the American Nursing Home Association. It reported back to the steering committee that the national council at this time apparently does not believe in this approach. This observation must be qualified by the statement that the national council seems to be prepared at present to admit into its membership several concerned groups at its discretion and according to a timetable agreed to by the members of the national council.

For example, the national council may at this time be prepared to grant membership to the American Hospital Association and the American Dental Association, but not to our own American Association of Homes for the Aged, representing the 4,500 church-related or community-sponsored homes for the aged, responsible to some community-based organization or to the community itself.

The American Association of Homes for the Aging finds this selective approach unacceptable, since it has always believed that only a group truly representative of all homes and of all the major professions, concerned in the work of homes, could provide the broad base for the valid accreditation program this country needs.

When the failure of these two approaches, to the joint commission and to the national council, was reported to a subsequent meeting of the steering committee, the steering committee authorized its subcommittee to proceed to explore the possibility of forming a new corporation for accreditation.

The subcommittee is at work on this matter and hopefully will report findings to the steering committee, scheduled to meet in the latter part of this month.

Regrettable as the emergence of a second accreditation body in our field will be, two crucial considerations have prompted the American Association of Homes for the Aging together with other organizations (as seems apparent from various expressions) to pursue the creation of a second accreditation group. I think it is important that your committee fully understand these considerations.

The American Association of Homes for the Aging has never believed that it nor any individual organization should dominate any accreditation program, but it has sought fair and adequate representation for its members and for all the other groups it believes should validly participate in such a program.

Our association is willing to sit as one member equal to other members in a new corporation; it believes that it and every organization vitally concerned in this matter should have the same fair representation.

What concerns our association most deeply in this question of representation is the question of standards. Our association believes that the present standards of the national council are inadequate, and under the present program of the national council or under any proposals by the national council known to our association, it will have no voice in upgrading these standards to the level our association believes necessary.

It is urgent that the American public, public welfare bodies, and insurance companies have an adequate measuring device by which to determine whether a home truly meets the standards necessary to skilled nursing care.

At the present time there seems to be good reason to believe that an adequate accreditation program will be provided the Nation through a truly multilateral corporation. The American Medical Association and the American Nursing Home Association apparently will not choose to be members of this new corporation.

Neither will the American Academy of General Practitioners. No clear indication of their position has been received from other medical groups. However, the American Hospital Association, the American Dental Association, the American Association of Homes for the Aging, the nurses group previously mentioned, the National Association of Social Workers, the Association of Rehabilitation Centers, the National Rehabilitation Association, and the National Association of Sheltered Workshops and Home Programs continue to evince a strong interest in a truly multilateral program.

It is the hope of our association that this program and all programs of accreditation in the health care field will one day be unified under the Joint Commission on the Accreditation of Hospitals.

While it is impossible at this point definitely to predict that this new corporation will be formed, there is strong evidence that this is likely, and I am optimistic about the future.

Thank you for this opportunity to bring you up to date in this field.

Senator Moss. Thank you, Reverend Eggers, we appreciate your testimony. This committee is very much concerned with this problem of accreditation of homes for the aged and nursing homes. We are very glad to have your testimony because it helps us have this picture developed for us as to what occurred.

You say your organization became active in promoting an accreditation program in the spring of 1963.

Reverend Eggers. This is right.

Senator Moss. By that time, as I understand it, the Joint Commission on Hospital Accreditation had already ceased its efforts, and the National Council on Accreditation had announced its program. Is that correct?

Reverend EGGERS. That is right. In fact, it was those two events that prompted us to enter into the field.

Senator MOSS. Did your committee on accreditation, as a first step, approach the national council on the possibility of broadening its program?

Reverend EGGERS. This is correct.

Senator MOSS. And then at your November 7 meeting all of the groups represented expressed interest in establishing a multilateral program. Is that true?

Reverend EGGERS. This is true. Senator, I have with me the minutes of the November 7 and the February 20 meetings which I can give to the committee. We have the complete record there.

Senator MOSS. Very good.

Did the groups present approve those minutes? Did they become the official record of those meetings?

Reverend EGGERS. They did. While there was no official vote, no one objected to them.

(The documents referred to are reproduced as appendix I beginning at p. 179.)

Senator MOSS. Was there any opposition to your proposal in view of the fact that the national council program was already functioning?

Reverend EGGERS. No; the American Medical Association representatives and the American Nursing Home Association both expressed themselves as highly interested in this matter and both expressed themselves as being very hopeful that a united program could be achieved. This occurred both in the November 7 and the February 20 meeting.

Both groups become a part of the steering committee and both have representatives on the steering committee.

Senator MOSS. So, in the beginning at the first, both of these organizations indicated interest in and support of the idea of the multilateral accreditation program. Is that true?

Reverend EGGERS. This is true.

Senator MOSS. When you got to the February 20 meeting, which groups did the eight people represent?

Reverend EGGERS. They represented the American Hospital Association, the American Medical Association, and the American Nursing Home Association, our own association, the National Association of Social Workers, the College of Surgeons, and one of the nursing groups which I cannot identify—either the American Nurses Association or the National League for Nursing. These eight groups.

Senator MOSS. They were still then present on the 20th of February? Now when was it that you found they had decided against this and dropped away from it?

Reverend EGGERS. When the February 20 meeting of the general committee ended, these eight groups met as a steering committee and at that time a subcommittee was appointed to investigate the three possible courses of action. This subcommittee consisted of a representative of the American Hospital Association, the American Dental Association, and our association.

We subsequently had meetings of the subcommittee with members of the national council. At that time Dr. Schwartz, who was representing the American Medical Association and the national council,

stated that he personally believed that just as the American Medical Association was competent to represent all medicine, so the American Nursing Home Association, in his opinion, was probably competent to represent all nursing homes and homes for the aged.

He said that if this were not true, perhaps we should have two programs in the country; we should each go on our way.

Since that time there has been a meeting of the steering committee at which it seemed evident that our association certainly was not going to be invited into the national council. This is now 30, 40, 50 days ago. Since then we have received no official invitation.

To explain the situation a little more clearly, Senator. We approached the national council with the hope that all of the groups which were represented and which we thought were validly interested would be received as a unit into the membership of the national council.

Apparently, and I say apparently, because I certainly do not know what the plans of the national council are, but apparently some groups will be invited into the council in a selective process.

Senator Moss. You say that you predict your group would not be one of those invited in. Is that right?

Reverend Eggers. We have no knowledge that we are going to be invited in and I have indications that other groups have been approached.

I can only speak from the record, I do not know what the intentions of the council are.

Senator Moss. Certainly I realize that, and this is, of course, a rather troublesome and puzzling thing and that is the reason I am trying to follow it by asking questions to see how much we are able to understand from the events that have taken place.

Reverend Eggers. As a further clarification, Senator, may I add that our association is the newest in this field. We were formed in November 1961, I believe. At that time the matter of accreditation was before the joint commission. In our initial meeting with our greater concern about it, we voted to endorse the joint commission program.

It is only because the joint commission did not carry out this program that our association entered this field at all and even today our position is that we think accreditation of homes should be a part of the Joint Commission on Accreditation of Hospitals' work, and we would be very happy to see this program governed by this commission.

Our entrance into the field is a second choice, so far as we are concerned.

Senator Moss. You would be glad to function with the joint commission as the first choice. Is that correct?

Reverend Eggers. This is correct.

Senator Moss. Senator Fong, any questions?

Senator Fong. Yes, Mr. Chairman.

Mr. Eggers, you stated that the Joint Commission for the Accreditation of Hospitals did make a study of nursing homes for about a year. Is that correct?

Reverend Eggers. This is correct.

Senator Fong. Do you know why they gave it up?

Reverend EGGERS. The board of trustees of the American Medical Association voted not to participate in this program of the joint commission. This is my understanding.

Senator FONG. The Joint Commission for the Accreditation of Hospitals, who are the members of that committee?

Reverend EGGERS. There are four member bodies. The American Hospital Association which holds seven votes, the College of Surgeons which holds three votes, the College of Physicians which holds three votes, and the American Medical Association which has seven votes. There are 20 seats in all.

With the American Medical Association not participating, the program could not move ahead. The commission did not officially veto the program, but my understanding is that the commission voted to table the matter indefinitely. For this reason we were able to approach them once more, since it was officially a tabled matter.

I think I have the facts correct, Senator.

Senator FONG. In other words, they did make a study, do you know whether the study was in depth?

Reverend EGGERS. More than a study was made, Senator. Standards were prepared and so forth; complete standards. The program was at a point where it was logically ready to swing into action, if it had the approval of the four member bodies.

Senator FONG. Do you know the reason why?

Reverend EGGERS. The American Medical Association voted not to enter and this is all that I know about it.

Senator FONG. You do not know the reason back of it?

Reverend EGGERS. I think you would have to ask the representatives of the American Medical Association.

Senator FONG. And where do the nurses stand? The American Nurses Association? They also do not participate in that.

Reverend EGGERS. In the steering committee meetings and in the general meetings which our association had called, the nurses groups expressed great interest in the very thing that we have been trying to achieve in this country; a single, multilateral, unified national program.

Senator FONG. Do you have any kind of a body now that accredits nursing homes and homes for the aged?

Reverend EGGERS. Our association has not. The national council is at work in this field; accrediting nursing homes and presumably they would accredit homes for the aged, but we are not satisfied with this.

Senator FONG. You are not satisfied with the body now that is accrediting?

Reverend EGGERS. That is correct.

Senator FONG. What is that body?

Reverend EGGERS. The national council.

Senator FONG. And what is its membership?

Reverend EGGERS. The American Medical Association and the American Nursing Home Association. These are its two members.

Senator FONG. So, the American Medical Association and the Nursing Home Association are members, sole members——

Reverend EGGERS. They are the sole members.

Senator FONG. Of this national commission which is now accrediting nursing homes?

Reverend EGGERS. That is right.

Senator FONG. And you said you are not satisfied with it?

Reverend EGGERS. We are not satisfied with the standards the council has created and we feel that we have a legitimate interest in having a voice in the creation of standards and the administration of the program.

Senator FONG. According to your statement you wanted 50 percent of the voice. Is that correct?

Reverend EGGERS. No; I stated that the institutional groups which would be concerned—this is the American Hospital Association which does have geriatric units, the American Nursing Home Association, and the American Association of Homes for the Aged—these three groups together should have less than 50 percent of the voice, not our association individually.

Senator FONG. And then the professionals would have the other part.

Reverend EGGERS. That is right.

Senator FONG. So it looks like the American Medical Association is not willing to give up 50 percent?

Reverend EGGERS. You have to ask them, Senator.

Senator FONG. Do you have anybody within the State that accredits nursing homes and homes for the aged?

Reverend EGGERS. In some States the program is rather far advanced. In my own State it is quite advanced. We have the standards, we have the organization set up, and we are looking for financing. In view of the fact that no national program has come forth as yet, we are proceeding with our State program. We would abandon it if we had a national program that we felt was adequate.

Senator FONG. Are there any laws in the various States that set up standards for nursing homes and homes for the aged?

Reverend EGGERS. Yes, Senator, there are. I think practically every State today has licensing laws, but about 2 years ago I made a survey of all the States, the State boards of health, and I received replies from some 40 of the State boards. The unanimous opinion was that licensing laws have to be kept to a minimum and that a voluntary program of accreditation to lift the level of the field was very desirable.

Senator FONG. So, the laws are very minimal?

Reverend EGGERS. That is right.

Senator FONG. And you desire a better standard?

Reverend EGGERS. That is right.

Senator FONG. You stated that there are 4,500 church-related or community-sponsored homes for the aged?

Reverend EGGERS. That is correct.

Senator FONG. That is taking in all of the religious organizations?

Reverend EGGERS. That is correct.

Senator FONG. And how large are those homes, average size?

Reverend EGGERS. I do not know, but we conclude from some surveys that our association has made that over 200,000 beds in this field are in the nonprofit homes. This would mean that, on the average, our homes are larger than the for-profit homes. I think this is generally true.

Senator FONG. Are you able to give this committee the average cost per individual? Mother Bernadette gave us some idea of her cost. Could you give us the average cost per individual?

Reverend EGGERS. May I just refer to our charges because they reflect our costs within a few dollars and I know our charges and I do not have the exact figures concerning our costs.

Our charges for those people in our home who are able to pay for themselves run on a varying scale from $155 a month to $300 a month, maximum. Our charges to county patients are based on what the county will pay us.

For Milkaukee clients, whom we serve, we get $140 to a maximum of $225, compared with $155 and $300 from our own clients. So you see that we have to, at least a small extent, supplement these payments with some charitable moneys which we are perfectly happy to do.

From other counties in the State of Wisconsin we receive smaller amounts of money. In some instances the maximum money received is $125, especially from some of the rural counties whose clients we serve.

Senator FONG. How much is paid by the returns that you receive, excluding charity?

Reverend EGGERS. Pardon me?

Senator FONG. I said how much are the expenses met by the income.

Reverend EGGERS. This would meet all of our expenses.

Senator FONG. You are able to?

Reverend EGGERS. Yes, but we do supplement this with charity.

Senator FONG. Do you have a lot of volunteer workers?

Reverend EGGERS. We have a volunteer organization in our home of about 125 members who are working as volunteers. This organization is doing bedside service directly to the patients, within the limitations of a volunteer group, these women are also assisting as clerical helpers, receptionists, and so on. Without this group, again our charges——

Senator MORSE. Senator Fong, would you yield for clarification?

Senator FONG. Yes.

Senator MORSE. I am not sure the witness understood your question a moment ago, the one that asked the witness to tell you how much of the expenses of their home are covered by the collections they made from patients that can pay their own way, and I understood him to answer "all."

Reverend EGGERS. From the patients who pay their own way, all, Senator.

Senator FONG. I am still in doubt. You have a group of patients that pay their own way from $150 to $300?

Reverend EGGERS. That is right.

Senator FONG. Now, does the income from those patients pay the expenses of the entire home for those patients and for your charity patients as well, plus what you get from Government assistance for the charity patients, or does it just pay the way for that part of your operation that serves the patients that can pay their own way?

Reverend EGGERS. The individual patient, this is our principle, who can afford to pay his way, pays his way, and nobody else's . Does this clarify it?

Senator FONG. That is the only part of your home operation that that patient pays for?

Reverend EGGERS. That is right.

Senator FONG. But the charitable part of your operation would put you in the red if it were not for the fact that you have assistance from various welfare funds or Government agencies?

Reverend EGGERS. That is right. And what I said, Senator, in addition, was that the assistance through old-age assistance and all the rest, is not sufficient. We still have to add charity to that.

Senator MORSE. I am sorry, Senator. I wanted to get that cleared up.

Senator FONG. The charity you allude to, in what form and from whom?

Reverend EGGERS. We get that from our constituent bodies, the several Lutheran synods who support us and their congregations.

Senator FONG. Could you give us a percentage of the total expenses that are involved in the carrying on of a home like your home, the percentage of contribution made by your board?

Reverend EGGERS. Anything I say is going to be unfair, because ours is a complicated picture, but we have a budget of about $650,000, and we rely at the present time for about $50,000 to $60,000 on charity.

Senator FONG. $50,000 to $60,000 on charity, so, therefore, you rely about 8 percent, 9 percent on charity?

Reverend EGGERS. Nine percent.

Senator FONG. Now, would you say that would be a fair description of the 4,500 church-connected, community-connected, old-age homes and nursing homes in the country?

Reverend EGGERS. I would not know, Senator.

Senator FONG. You have no idea?

Reverend EGGERS. I have no idea.

Senator FONG. Now, as far as you know, are most of these church-connected and community-connected aging homes or nursing homes, are they being helped voluntarily by a lot of volunteers?

Reverend EGGERS. A good many of them are, and I do know that nearly all of them need the charitable contributions, as we need them in our home.

Senator FONG. Now, Mr. Eggers, there have been, for a while, quite a number of these homes that were constructed and all of a sudden they stopped. Would that be a fair statement?

Reverend EGGERS. That is correct.

Senator FONG. Could you tell the committee why there was such a stoppage of the building of these homes?

Reverend EGGERS. May I put it in terms of our own home very concretely?

Our home is owned by a nonprofit corporation of concerned individual members of the Lutheran Church. This corporation elects a board, and so on, and administers the home. According to my understanding of the changes which were made in the law, the decision as to whether to build or not would no longer depend on my corporation but would depend on my official church body—the south Wisconsin district of the Lutheran Church, Missouri synod, specifically in this case.

The Government apparently is no longer accepting the security that my corporation can give to such a program and is requesting that the official church body give additional security. It is one thing to get a

corporation to move and it is quite another thing to get an official church body like mine to move.

Senator FONG. So, the Government is asking for a better guarantor?

Reverend EGGERS. That is correct, and I do not see why it is necessary, because there have been few, if any, failures, to my knowledge, in this program.

Senator FONG. In your experience, there have been very few failures?

Reverend EGGERS. None.

Senator FONG. Would you recommend to the committee that we recommend that the FHA standards be not so stringent?

Reverend EGGERS. Senator, I really do.

Senator FONG. Now, if we were to relax these strict provisions concerning guarantee, do you feel that there will be more of these homes that will be built by church-affiliated groups?

Reverend EGGERS. Absolutely.

Senator FONG. Thank you.

Senator MOSS. Senator Morse, do you have any questions at this point?

Senator MORSE. On page 7, Reverend Eggers, you say in point 2:

> What concerns our association most deeply in this question of representation is the question of standards. Our association believes that the present standards of the national council are inadequate, and under the present program of the national council or under any proposals by the national council known to our association, it will have no voice in upgrading these standards to the level our association believes necessary.

What are your specific criticisms of the standards of the national council at the present time?

Reverend EGGERS. I think, Senator, that the criticisms would apply to almost every section of the standards that have been created. On the plane last night I reviewed the accreditation standards which we had established in the State of Wisconsin and made some comparisons with the national council material. And in every instance where I made the comparison I found that our Wisconsin standards were far superior.

For example, in the amount of professional nursing care required, in establishing a ratio between the number of patients and the number of registered nurses and licensed professional, practical nurses this is evident.

In provisions—just to stay in the nursing area—in provisions for orientation and specifically requiring a very definite inservice training program. Some of the standards of the national council make references to these things but my comparison showed that the Wisconsin standards were far more specific and concrete and required the home to carry out a very definite kind of a program which, in my opinion, would guarantee in a far more substantial manner the kind of care that I think we should have.

I could go over practically every section of the code as they have it and as we have it in Wisconsin with you and I think I could show you this.

Senator MORSE. Mr. Chairman, may I ask the counsel for the staff if the record of this hearing thus far contains a list of the standards of the national council?

Senator Moss. No. It does not at this time, Senator.

Senator Morse. Could you, Reverend Eggers, supply us with an official list of the standards of the national council?

Reverend Eggers. I have the book, but I am sure that the representatives of the national council present here can also furnish it.

Senator Morse. We will get them one way or the other.

Reverend Eggers. Yes.

Senator Morse. Mr. Chairman, I think you are touching a very vital matter here in this hearing. I want to apologize to the chairman and my colleagues on the committee for not being able to be here prior to this session, although I was briefed on what has been going on.

As you know, I have been fighting McNamara's war on the floor of the Senate and that is a one-man job. So, I have not until now been able to get into this matter, but I am going to ask, Mr. Chairman, that an official request be made by counsel of this committee to whoever counsel decides is the appropriate body, I think the witness is probably right, the national council, as to their standards. I want it made an official part of this hearing.

And then I want to say, Mr. Chairman, that I would like to have a ruling from you that this witness be requested to supplement this written statement of his by filing a memo setting forth in detail his specific criticisms of those standards.

And I assume that he speaks for his group and I want to know what is wrong with these standards and I do not know where you can get a better witness after this testimony he has given us to supply us with that informaion.

He is obviously a very fair witness and cannot give us any information as to what the motivations of anyone else may be or the reasons that the national council might have. I do not buy that. I think this witness has an obligation to this committee to advise us as to what he knows and, therefore, I would like to have a supplemental memorandum from this witness. I would like to have it also bear on another interesting point that he makes in this statement—if you will give me a moment, I will find it. Maybe you can help me, Reverend Eggers. It is the point in which you stated you sought admission to the national council but were turned down. Counsel suggests page 5.

The subcommittee held a special meeting with representatives of the national council, including representatives of the AMA and the American Nursing Home Association.

It reported back to the steering committee that the national council at this time apparently does not believe in this approach. This observation must be qualified by the statement that the national council seems to be prepared at present to admit into its membership several concerned groups at its discretion and according to a timetable agreed to by the members of the national council.

For example, the national council may at this time be prepared to grant membership to the American Hospital Association and the American Dental Association, but not to our own American Association of Homes for the Aged, representing the 4,500 church-related or community-sponsored homes for the aged, responsible to some community-based organization or to the community itself.

The American Association of Homes for the Aging finds this selective approach unacceptable, since it has always believed that only a group truly representative of all homes and of all the major professions, concerned in the work of homes, could provide the broad base for the valid accreditation program this country needs.

I fully appreciate, Reverend Eggers, your inclination not to comment upon the information that might have been given to you by the national council. I admit we ought to seek the information from them, but I do not try lawsuits that way.

I would like to know what you will say for the record as to what the national council gave to you as its reasons for not giving you membership in that association or council.

Reverend EGGERS. Senator, it did not give any reasons.

Senator MORSE. They did not give you any reasons?

Reverend EGGERS. The only thing which was stated at that time, to my knowledge, was the remark that Dr. Schwartz made in the meeting of the subcommittee with the national council representatives, in which he stated that just as he felt that the American Medical Association could adequately represent all medicine, so he thought that the American Nursing Home Association could adequately represent our field.

When I said that I did not think this is true and I did not think that at this point there would be a marriage between the American Nursing Home Association and the American Association of Homes for the Aging, Dr. Schwartz said, "Well, perhaps we had better go our own ways then, each of us."

This is the only comment I have ever heard.

Subsequent to that meeting, at the meeting of the steering committee, which I think was held on March 23, no invitation was extended to the whole group by the national council and this is the thing that we were after—not necessarily that our association be individually invited, but that the whole concerned group sit down with the national council and as a group enter into some kind of an arrangement so that we could have this one unified program—no overtures of that kind have ever been made.

Senator MORSE. Reverend Eggers, am I correct in interpreting your prepared testimony as saying in effect that your group sought to join the national council and was rejected by the national council?

Reverend EGGERS. I would not put this quite that way, Senator. I would say—again I go back, that this whole group of organizations—we believe and apparently other organizations believe the same thing with us—should sit down with the national council and all of us become part of the same mechanism to do this job.

So, I would not single our association out especially as being different from the rest of the group.

I know that my testimony may have put it in a somewhat misleading form, which I did not intend, and I apologize for that. I mentioned our association especially as distinct from others.

But, we want the group approach to accreditation and we still believe that the group approach is the valid approach.

Senator MORSE. I interpreted this language on page 5 of your statement—take a look at it—to mean that the American Association of Homes for the Aged, representing 4,500 church-related or community-sponsored homes for the aged, responsible to some community-based organization as well as itself—the American Association of Homes for the Aging finds this selective approach unacceptable since it has always believed that only a group truly representative of all homes and all of the major professions concerned in the work of homes could pro-

vide the broad base for the valid accreditation program this country needs.

I interpret that to mean you could not get into the national council if you wanted to.

Reverend EGGERS. I do not believe we could at this time.

Senator MORSE. When you say that you "do not believe," have you ever sought to and been turned down?

Reverend EGGERS. Well, the group has approached—I go back to this—we called together in Chicago the nurses groups, the social workers, the medical societies, and so on, and we thought that as a group we should cooperate and work with each other, and it was representatives of this group which approached the national council, and the national council apparently has made no statements inviting the group in.

It has apparently invited one group or another individually, and we feel this is the unacceptable approach.

Senator MORSE. Am I accurate in my conclusion from your testimony in which you relate your conversation with Dr. Schwartz, I think you said, that you interpreted your conversation with Dr. Schwartz, representing the American Medical Association, as meaning that he thought the two groups should go their individual and independent ways?

Reverend EGGERS. I think this is what he directly said. It was not a question of interpretation.

(The statement requested follows:)

SUPPLEMENTARY STATEMENT OF REV. WILLIAM T. EGGERS

It seems to me that the national council does not believe in a multilateral approach to the problem of the accreditation of homes for the aged and nursing homes for these reasons:

1. The AMA and ANHA in a bilateral agreement created the National Council on Accredited Nursing Homes. At that time they did not consider including other organizations and they did not discuss a multilateral approach until AAHA took the initiative and called a series of meetings to try to work out a multilateral approach.

2. In spite of the many meetings that were held to discuss the multilateral approach and the many opportunities that the National Council has had since November 7, 1963, to indicate its interest in a multilateral arrangement, no concrete evidence of this interest has been forthcoming. To my knowledge the National Council has not extended an invitation to the group that was invited to the Chicago meetings as a group.

3. This is not the conclusion only of AAHA or its representatives. On the basis of the evidence they had, all the members of the steering committee, except the AMA and ANHA representatives arrived at the same conclusion at the last meeting of the steering committee and authorized a subcommittee to proceed with plans for a new corporation in view of the apparent position of the National Council on this matter.

Senator MORSE. I think, Mr. Chairman, that this witness' testimony needs to be supplemented, too, because we must not take our eyes off of the aged people that we are seeking to help.

I do not intend to take my eyes off of them. The procedural problems and organizational problems and financial problems, the material—institutions called nursing homes—that are set up under various jurisdictions to be of service to these old people, but the responsibility of this committee, and I am sure my colleagues on the committee will not disagree with me there, will never take our eyes off of the welfare of these old people.

I think this witness ought to be asked to submit voluntarily a supplement to this statement—I think it is a very important statement—as to the advantages that he and his colleagues in his group think would accrue by way of better service to the old people if there were a setup that complied with his recommendation on the top of page 6 where he says:

The American Association of Homes for the Aging finds this selective approach unacceptable since it has always believed that only a group truly representative of all homes and of all of the professions concerned in the work of homes can provide the broad base for the valid accreditation program this country needs.

I assume that we are in agreement that standards are necessary and we ought to reach at least a minimum standard of quality and I interpret that testimony to mean that without having the kind of a setup that he recommends for accreditation the loss is borne by the old people and I think this witness is so important, Mr. Chairman, that he does not have to do it, but the record will speak for itself if he does not; I am going to formally, through you, Mr. Chairman, make a request that he supplement his statement with the two voluntary statements covering the points I have raised.

I want to tell the witness why. I think this committee has to dig in and find out why the American Medical Association and the Nursing Home Association feel that it is in the public interest to give, if they have it, the policies that you outline here which, for want of a better descriptive term, I would call sort of a monopolistic control of accreditation in this country.

Senator Moss. We expect to hear testimony on that from some of the witnesses we have scheduled; but I will ask Mr. Eggers if he could supply us for inclusion in the record, supplemental to your testimony, the instances in which you think the standards now published by the national council are deficient and could be improved, and also this further information if you can, in as much detail as possible, indicating what advantages you think it would have for the recipients of care, the older people, if we could have this more broadly representative group setting standards and doing accreditation.

I will ask our staff to see that this supplementary material is printed as part of this record as well as the standards that are now in effect issued by the national council.[1]

(The supplementary material referred to follows:)

COMMENTS ON THE ACCREDITATION STANDARDS OF THE NATIONAL COUNCIL FOR ACCREDITATION OF NURSING HOMES

The Wisconsin standards are submitted as a sample of the high quality accreditation standards which can be achieved both on a State and a National level.[2] Throughout the many committee meetings of the Wisconsin Committee on Accreditation, committee members constantly considered the tensions between ideals and reality and consistently weighed the standards in terms of ideals to be reached. Although the Wisconsin accreditation plan is not yet in operation, it has had many beneficial results in this State, because administrators and boards, as they became familiar with the goals of the Wisconsin plan, began to shape their homes in terms of the ideals the plan sets forth.

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[1] "Standards for Accreditation" issued by the National Council for Accreditation of Nursing Homes is reproduced as app. II, at p. 190.

[2] The Wisconsin standards are included as app. III at p. 223.

The standards developed under the program of the Joint Commission on Accreditation of Hospitals have a similar high quality, and it is the hope of AAHA that the best in these two and in any other similar plans which may exist in the country may be unified in a single national accreditation program.

A comparison of the Wisconsin standards with those of the National Council will reveal that in all aspects of accreditation and in all phases of a home's work, the Wisconsin standards are specific, concrete, and far more demanding of a home.

You will also notice on page 1 of the Wisconsin standards the delicate balance achieved in the distribution of points in each department. Points are granted in such a manner that neither the mere presence of professional personnel in a department nor the existence of an adequate program in the department enable the department to achieve recognition. Program and personnel, together with other features, are balanced out against each other in such a manner that recognition can be gained only if the department has adequate personnel, program, and the other necessary features.

These generalizations can be verified by a comparison of page after page of the two plans. Nursing, one of the most important features of long-term care, will illustrate this. On page 19 of the Wisconsin standards specific ratios of professional and other personnel to numbers of patients are required. In addition, specific requirements concerning procedure manuals, observation of these procedures in the home, orientation, in-service training, conferences, space and equipment, etc., are made. In comparison, the requirements of the National Council are minimal and inadequate. Some of Wisconsin's requirements take the form of suggestions in the National Council's explanatory material. Except for the requirement of a registered nurse, 40 hours a week, and "one licensed nurse on duty at all times," no concrete requests for professional nursing personnel are made of a skilled nursing home.

A similar observation can be made by comparing the physical therapy requirements of both plans. On page 25 of its plan Wisconsin demands specific ratios of physical therapy personnel to patients, requires concrete evidence of an adequate physical therapy program, etc. The parallel National Council requirements are vague and the supplementary material is also vague.

These same observations can be made also with a department like housekeeping. In its standards Wisconsin on page 14 again requires a definite ratio of housekeeping personnel to patients, has specific program tests and allots specific points for meeting the test. In comparison the National Council's material is very general.

Similar observations can be made of the standards in all departments. Even a casual perusal of these documents will bear this out. Whether the point system is used or not, the ratios of personnel to clients are highly significant. Our Wisconsin ratios were worked out on the basis of the needs of patients, a realistic appraisal of the availability of professional personnel, and also took into consideration the fact that smaller homes in isolated rural communities would, of necessity, have to make a different approach to that problem than larger homes in metropolitan areas, in which a more adequate supply of professional personnel exists.

I am sorry that the pages of the copy of the standards of the National Council, which I have in my possession, are not numbered and that, therefore, I was unable to give you specific page references to the council's material in this comparison. However, a perusal of the council's document will enable the committee to find the appropriate references to which I called attention.

ADVANTAGES OF A MULTILATERAL ACCREDITATION PROGRAM

AAHA has always believed that a single multilateral accreditation mechanism would serve the interests of older people and the country best. Insurance companies, public welfare agencies, the public, older people, and others interested would have a single set of standards by which to judge the degree and quality of care a nursing home or home for the aged affords its clients. A single, reliable mechanism to do this would set a pattern for the entire Nation, eliminate the confusion which might result from the existence of several accrediting mechanisms, and offer all third-party payors a simple and efficient test for payments.

This mechanism also should be truly multilateral. It seems to me that the participation of the concerned professional disciplines in such a program would have a number of beneficial results. It would lend to the mechanism a stature, which it would lack without the participation of the disciplines. It would fur-

thermore guarantee the impartiality of the accreditation mechanism, since in the proposals of AAHA no group, including AAHA, AHA, and ANHA, would have a predominant voice. The multilateral approach would also help guarantee that the concerns of each discipline for the proper care of residents and patients would not be overlooked and would receive adequate attention. It was considerations of this nature which prompted AAHA to extend its original invitation to 13 national associations to attend the November 7, 1963, meeting in Chicago.

While the inclusion of additional disciplines, not represented in the meetings, is still an open question, it has been the opinion of many participants in these meetings that to include these disciplines in the governing board of the accreditation mechanism might make the governing board too large and unwieldy a group. It has apparently been the consensus of all who attended these meetings that, if these other disciplines did not participate as members of the governing board, they should certainly participate in a consultative capacity and have a strong voice in matters pertaining to their respective fields.

We appreciate this, Reverend Eggers. I think we have a quorum call on now. The bells do not ring very loud in here, but I can hear them, and there is a quorum call on now.

Now, would the Senator like to come back now or go over until 2 o'clock? I would ask Senator Morse, as I must leave and be absent now for about 30 minutes, if he would take the chair.

Senator MORSE. I can finish with this witness and I will come back. We will go over and he can be thinking about my last question until I can get back. I would like to have him be prepared to discuss this question.

Am I to understand this statement taken from its four corners that in his opinion the standards of care in the homes of the American Association of Homes for the Aging are by and large higher and of better quality because of the higher standards of his association than the care in the homes that come under the jurisdiction of the national council?

Senator MOSS. We will be in recess for 10 minutes and then Senator Morse will preside until the noon recess.

(Brief recess.)

Senator MORSE (presiding). Please come to order.

Reverend Eggers, will you proceed to answer the last question?

Reverend EGGERS. Senator, if I understand the question correctly, did you assume that the American Association of Homes for the Aging had a set of standards at the present time? Is that assumption in the question?

Senator MORSE. I assumed it.

Reverend EGGERS. This is not true.

Senator MORSE. Each home operates independently of all the others as far as standards are concerned?

Reverend EGGERS. That is right.

Senator MORSE. The homes would be divided up then into homes with high quality service, medium quality service and poor quality service?

Reverend EGGERS. I would say to that, Senator, that I think that the bulk of our homes by far have high quality standards. We may have some exceptions where the standards are not what we would like them to be and what we are after is the creation of a set of standards by which all of us could be guided.

Senator MORSE. Did you have in mind a set of standards that you would characterize as high quality standards but standards that ought to be standards of accreditation?

Reverend EGGERS. That is correct. And may I add to that that I would like to submit to the committee as a part of the evidence the standards that we propose for Wisconsin. I think they would illustrate that.

Senator MORSE. I would ask the next question: Will you submit to this committee another supplemental statement setting forth the standards that you think ought to prevail and then advise us percentagewise how many of the homes in your association meet those standards?

Reverend EGGERS. I would be happy to, Senator.

Senator MORSE. I would like to have Reverend Eggers expand on his testimony in regard to policies of FHA and I would also request the counsel of the subcommittee to make a formal request, on my behalf, of FHA for a detailed memorandum from them in regard to their policies in making loans to nursing homes, and I want to know to what extent and if any at all when they changed any of their rules in regard to loaning money to nursing homes affecting, if any, homes that were already under construction.

I think we have to find out whether there is any basis for this criticism, and Reverend Eggers is not the only one I have heard making this criticism, that FHA has a bad habit of changing its rules in the middle of the game after people have gone out and obtained commitments for the building of a home. I want to know if they have changed, for example, in any instances the percentage of insured loan that they guarantee and we ought to get this into the record as ancillary to Reverend Eggers' testimony.

Mr. NYE. Senator, may I interrupt?

While some of these elderly housing projects under section 231 assume the nature in one degree or another of a nursing home, changed regulations are not affecting the section 232 nursing home program, only the elderly housing programs under section 231.

Senator MORSE. Thank you very much.

Mr. NYE. And I hope you get that information that has been asked for.

Senator MORSE. We will get it, do not worry about it.

(The information to be furnished follows:)

FEDERAL HOUSING ADMINISTRATION,
OFFICE OF THE COMMISSIONER,
Washington, D.C., June 5, 1964.

Hon. FRANK E. MOSS,
Chairman, Joint Subcommittee on Long-Term Care,
U.S. Senate, Washington, D.C.

DEAR SENATOR MOSS: I am pleased to have the opportunity to set forth the FHA policy concerning the guarantee of the subsidy differential in a subsidized section 231 nonprofit housing for the elderly project.

The subsidy differential is the difference between the maximum insurable mortgage allowed by statute and the economic mortgage which the FHA underwriting processing determines can be paid off from the estimated net income. In computing net income available for payment of the mortgage, there is deducted from obtainable rents the operating expenses, taxes, a reserve for replacement of structural items, and a reasonable allowance for vacancies.

For example, if the maximum insurable mortgage allowed by statute is $1 million, and the economic mortgage is computed to be $800,000, the $200,000 difference is the subsidy differential. If the sponsoring organization desires in-

surance of the higher mortgage amount, it must guarantee to the mortgage and FHA that if there is a default in mortgage payments by the mortgagor corporation, the sponsor will immediately pay the $200,000 differential in reduction of the mortgage.

The effect of this requirement is to assure that in the event of a default and foreclosure, the amount of loss to the insurance fund will be no greater than if the insurable mortgage had been determined, in the first instance, on an economic basis. The guarantor must be legally and financially able to guarantee the subsidy differential. The mortgagor corporation, which is created by the sponsoring organization to own and operate the project, does not normally have any other assets. Therefore, the subsidy differential must be guaranteed by the sponsoring organization.

This policy applies to all sponsors with projects on which FHA has not issued a commitment for insurance. If FHA processing determines that the insurable economic mortgage amount equals or exceeds the statutory maximum, there is no subsidy differential, and no guarantee is required.

Sincerely yours,

P. N. BROWNSTEIN, *Commissioner.*

Senator MORSE. Thank you very much. That is all.

The next witness will be Father Humensky of the American Hospital Association.

I would now call to the attention of counsel; I wish you would try to get another Senator to take over at 12:30 because I have another official engagement, an official conference luncheon I must attend, and I understand that these witnesses from the American Hospital Association have to catch a 3 o'clock flight. We ought to keep this hearing going until we hear them all.

Father Humensky, we are pleased to have you. You may proceed in your own way.

STATEMENT OF FATHER JOHN J. HUMENSKY, DIRECTOR OF CATHOLIC HOSPITALS, DIOCESE OF CLEVELAND, AND MEMBER OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY FREDERICK N. ELLIOTT, M.D., ASSOCIATE EXECUTIVE DIRECTOR, CEDARS-SINAI HOSPITAL AND MEDICAL CENTER, LOS ANGELES, CALIF.; AND KENNETH WILLIAMSON, ASSOCIATE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Father HUMENSKY. Thank you, Mr. Chairman.

Mr. Chairman, I am Father John J. Humensky. I am the director of Catholic hospitals, diocese of Cleveland, in Cleveland, Ohio. I am a former member of the board of trustees of the American Hospital Association and presently a representative of the association on the board of commissioners of the Joint Commission on Accreditation of Hospitals.

With me is Frederick N. Elliott, M.D., associate executive director, Cedars-Sinai Hospital and Medical Center, Los Angeles, Calif., who is on my left.

Dr. Elliott has had extensive experience in the detailed operations of the program of accreditation. He will be pleased to participate in any questioning which may follow the presentation of this statement. We are accompanied by Mr. Kenneth Williamson, associate director of the American Hospital Association who is on my right.

The American Hospital Association is a voluntary nonprofit mem-

bership organization with over 7,000 members including the great majority of all types of hospitals.

Among these are over 90 percent of the Nation's general hospital beds. Long-term care facilities are included in the membership of the association, and 1,221 nursing homes and other long-term care institutions other than hospitals are covered by the association's program of registration which we will discuss later.

Throughout this century—truly the golden age of American medicine—we have kept our eyes and minds on the general hospital. This has been understandable. It was in the general hospital that science strode from the laboratory to the bedside.

As our energies were directed toward meeting the needs of the acutely ill, we have generally paid too little attention to the long-term patient. If he were mentally ill, we shuttled him to an out-of-the-way mental hospital on an "out of sight, out of mind" basis.

The tubercular we sequestered in a public sanatorium. Wonderful things were done for the patient within the walls of the general hospital. But only too often, its interest which began at the time of admission ended as the patient left the premises.

No longer can we afford this narrow focus on the general hospital. No longer can we look at the short-term hospital as the beginning and the end of patient care. The only way we can provide proper health services to our people is to concentrate on continuity of care or, as it has been put, not several islands but a continent of care.

The general hospital as we know it will always be an important, probably the most important, band in this spectrum. There is now beginning a public demand that nursing-home type of care be provided in or under the auspices of the general hospital.

There are other elements—the home, the health center, the rehabilitation center, the postacute facility. We must provide services at all levels of illness designed for the most rapid, effectual, and economical restoration of health.

Many forces have produced this change in the total picture of community health services. We all know of the remarkable increase in the average life expectancy in our country. This has led to an increase in the degenerative diseases which most generally have both acute and subacute phases.

The general hospital is the proper place for the management of the acute phases. Some other facility is preferable for the subacute stages. Changes in our social fabric have had an important effect on our changing health service picture.

No longer is there sufficient room in most homes for long-term nursing of a sick member of the family. Neither are the members of the family qualified to provide the care that is needed. The very improvement in hospital care has increased public confidence in, and therefore dependence on, the hospital and related facilities.

It is more than ever essential that we provide institutional care to those who need it so that the right person is getting the right care in the right place.

The need for continuity of care requires that community hospitals must become even more comprehensive or general, either by extending the range and depth of their services to include short-term psychiatric care, social services, and effective rehabilitation programs, or by close affiliation with already existing programs.

33-257—64—pt. 2——3

The need for outpatient clinics, day care programs, coordinated home care, chronic illness units, and long-term nursing care units is great; and we believe these are best provided either directly under the auspices of, or in closer affiliation with, a general hospital.

A 1961 inventory of nursing homes in the Nation revealed that of 23,000 such institutions 9,700 were classed as skilled. The accuracy of the term "skilled" applied in this inventory is, we believe, open to serious question since some 45 percent of these homes had no registered nurse available.

We recognize that there are gaps and deficiencies not only as to the number of nursing home beds available but as to their quality because of inadequacies of physical plant, inadequacies as to medical supervision, essential trained personnel, maintenance of adequate records, and other deficiencies.

The Federal Government is providing major stimulation to improve the whole nursing home situation; 803 nursing homes with 43,000 beds have been established through the Hospital Survey and Construction Act.

We are very pleased that the Congress is now considering a substantial increase in the funds to be made available under this program.

Also, through the Federal Housing Administration, insured mortgage loans are available on a long-term basis to assist in the development of proprietary nursing homes. Through this program 224 nursing homes have secured loans providing 19,964 beds.

Senator MORSE. Father, may I interrupt you for just a moment? I do not have a desire to interrupt you much. There has been some testimony about the dissatisfaction with FHA in connection with loans to nursing homes, and you comment here on the number of homes that have received some help.

Is it true that the FHA in some instances has sort of changed the rules in the middle of the game in that they started out guaranteeing 100 percent of the loan and homes were started and then they dropped back to a smaller percentage in some instances, 75 percent? Do you have any knowledge of that?

Father HUMENSKY. I do not have any specific knowledge, Senator, on this particular point. I have heard the testimony of the previous speaker that it did bring about some cutbacks just because of this.

Now, more than that I could not verify nor can I give the percentage of buildings that were discontinued or did not proceed or were not started as a result of the change in these regulations.

Senator MORSE. Go ahead, Father.

Father HUMENSKY. Thank you.

In addition, the Small Business Administration has provided some stimulation. However, the short-term nature of the loans have not proved to provide any major incentive to the provision of nursing home facilities.

We believe of greatest significance is that through all of these programs the Federal Government is stimulating substantial improvement in the physical facilities constructed and toward the improved operation of such facilities.

As we consider the need for nursing home beds we know that there are now more than 23,000 nursing homes with nearly 600,000 beds. The major number of the individuals in nursing homes are over 65 years of age.

At the present time there are estimated to be 18 million persons over the age of 65 in this country. Estimates indicate that this figure will increase to 20 million by 1970. As age increases so does chronic illness and we can anticipate an increased need for nursing home facilities at least in proportion to growth in the aged population.

About 1,000 individuals in the population move into this aged group each day. By 1970 in relationship to existing utilization of such facilities we should, therefore, need around 700,000 nursing home beds. It should be remembered too, that a great many of the existing beds are now in substandard homes which will have to be replaced in the near future.

The nursing home has developed largely as an independent unit. A relatively new development in recent years is to associate the nursing home with the general hospital. The American Hospital Association has been devoting primary effort to developing guiding principles to facilitate agreements between hospitals and nursing homes and other long-term care facilities.

The association believes that such planned programs for the post-acute care of hospital patients and others are urgently needed and that general hospitals and their organized medical staffs should accept responsibility for planning such programs in cooperation with other responsible institutions and agencies.

The American Hospital Association is convinced that sponsorship of nursing home facilities under nonprofit community auspices is in the public's best interest.

It is specifically indicated that such relationships can importantly affect the coordination of facilities and services so as to provide continuity of care and treatment; that unnecessary transfer of patients can be prevented; that there can be a reduction in the total cost for care; that such coordination will encourage promotion of efficiency and economy. It is believed that there are definite advantages both to the general hospital, the nursing home, and the patient.

In light of the above, the association has promulgated a set of guiding principles for agreement between general hospitals and nursing home and other long-term-care facilities. We wish to submit a copy of these guiding principles for the record. I have a copy here, sir.

Senator MORSE. They will be received in the record and printed at the conclusion of your testimony.[1]

Father HUMENSKY. Fine.

It is our belief that nursing home care can be improved by efforts in two directions primarily. The first of these is in respect to the provision of adequate physical facilities.

We have already mentioned the effort underway in this direction. The second primary effort is in improving the quality of care provided. We believe basically this will be accomplished by placing nursing home patients under responsible medical authority, by providing for at least the supervision and direction of nursing services by a graduate professional nurse by requiring essential patient care records.

Also, of course, involved in this general area is the provision of adequate diets and food service, the extension of physiotherapy and

[1] The document referred to appears at p. 118.

other rehabilitation services, and especially a ready means of admission to the nursing home from the hospital and readmission to the hospital when necessary.

The third major approach we see as essential is that of appropriate organization. The key to this we believe is the association of the nursing home with a general hospital.

This is a primary means of bringing the nursing home into the mainstream of health care. This will have important ramifications for insuring medical supervision, improve the care and improve the overall economic situation in respect to the care of aged persons.

Also, the association has supported strongly the need for establishing a program of accreditation which would assist in developing and maintaining necessary standards. We believe that this can best be done through an organization with multilateral representation of health agencies.

Senator MORSE. Father, I would like to interrupt for one question that is in my mind. This is very helpful testimony.

The suggestion that nursing homes ought to be associated with the general hospital for the medical reasons that you set out earlier in your statement would not in any way, would it, impair the programs of church groups, such as the church group in whose behalf Reverend Eggers testified, who maintain a series of church nursing homes not connected with a hospital? Is there any reason why you could not work out an affiliation program that would make it possible for them to be associated with that hospital and still maintain reasonable autonomy as a church home?

Father HUMENSKY. Senator, there should not be any great conflict. The difficulty is there and we must recognize it; namely, that we are dealing with two separate autonomous corporations—one that has the purpose of caring for the convalescent and for the chronically ill, and the other is the acute hospital.

Now, it may be that the same religious community will not own both of these institutions, but a working agreement could be managed and there would be nothing as far as I know in the religious setup and ownership of these two types of institutions that would preclude the good that will accrue to the patient through such an affiliation with the hospital.

Now, these affiliations are more or less arrangements, working arrangements, to take care of the patient in whom both the nursing home as well as the hospitals are interested at certain given times, as the need arises.

But I know it is difficult since we have tried it in my own diocese but those things that can be worked out; I think with good will a practical solution as to some of the obstacles that do exist can be worked out and that it will redound to the patient's benefit eventually.

Senator MORSE. Can we not stop the difficulties, as I said earlier this morning, so that the aged get the care they ought to receive? Can we not work out the administrative difficulties?

Many of our communities in this country—your general hospitals are not church-affiliated hospitals. There are many church-affiliated general hospitals, but many general hospitals are city hospitals, run by the city.

I do not see any great administrative difficulty in working out an arrangement between so-called private nursing homes—be they Catholic, or Protestant, or Jewish, or nondenominational—and a governmentally owned general hospital operated under a municipal corporate setup, do you?

Father HUMENSKY. I do not. And I do not want to get in on the question of areawide planning, because I do not think it is germane at this point; but to prove your point here, we do have the metropolitan housing development of apartments for the aging, the high-rise type, which were specifically built in three instances close to general hospitals.

Now, that was done for the purpose of facilitating the transfer of these patients; many of these patients or aged require ambulatory services which they can receive in the hospital, which is close by, so that we can arrange for the transfer and for the care of these aged patients from these homes built close to voluntary nonprofit hospitals.

We have three such apartments in Cleveland. One is served by St. Vincent Charity Hospital; another is served by Mount Sinai Hospital; and the third which has been opened up just recently, is being served by Lutheran Hospital.

So, I think that if there is a nursing home that is owned privately, even by a religious group, that it could be served; that is, its inmates could be served by a community-owned hospital.

Senator MORSE. I think this is a very important point you are making, Father. You know, I have worked on this committee for some years and conducted some hearings across the country. We have some great nursing homes in this country; we have some problems with others, as you know. In some there is State assistance provided. I know, for example, of the Mount Angel Home in Oregon, which is really a teaching nursing home. They started a teaching program there some years ago that is outstanding, but they also recognize the importance of bringing in the medical care that hospitalization will provide.

Counsel has handed me a question and he thinks this is the appropriate place in this record to ask it of you.

The question reads as follows:

The American Nursing Home Association testified yesterday that the American Hospital Association is backing away from its position on nursing home-hospital affiliation and referred to this set of principles which you have mentioned as very much watered down from your association's earlier views.

Would you care to comment on that?

Father HUMENSKY. That is the first idea I have about that statement and it is a pretty broad one. I am not aware of our position being watered down. I am concerned and vitally concerned with the testimony which I am giving and assure you that we are more than casually interested in this matter.

Senator MORSE. I am glad I asked the question; it gave you a chance to deny it.

[Laughter.]

Senator MORSE. You may proceed.

Father HUMENSKY. Thank you.

Before discussing the matter of accreditation, we wish to review the activities of the association in developing a program of registration of nursing homes and other long-term care institutions which will have, we feel, considerable continuing values and is of particular importance in readying such facilities for a national program of accreditation.

The following are the requirements established by the association for registration of inpatient care institutions other than hospitals, which means for the most part nursing homes, and 1,221, such institutions have now been registered:

1. The institution shall have beds for the care of patients who require continuing planned medical and nursing care and supervision, and who stay on the average in excess of 24 hours per admission.
2. The facility shall be licensed or approved by the legally authorized agency or agencies.
3. Each patient shall be under the care of a duly licensed doctor of medicine or doctor of osteopathy, and shall be seen by a physician as the need indicates, and there shall be evidence of general supervision of the clinical work by doctors of medicine.
4. There shall be one or more duly licensed doctors of medicine who shall advise on medical administrative problems, review the institution's plan for patient care, and handle emergencies if the patient's personal physician is unavailable.
5. There shall be a medical record maintained for each patient, which shall include at least (*a*) medical history, (*b*) report of physical examination, (*c*) diagnosis, (*d*) physician's orders, (*e*) progress notes (medical and nursing), and (*f*) medications and treatments given.
6. There shall be arrangements to provide diagnostic services, such as clinical laboratory and X-ray procedures, which shall be regularly and conveniently available.
7. The nursing service shall be under the supervision of a registered nurse and there shall be such other nursing personnel as are necessary to provide adequate care of patients 24 hours a day.
8. There shall be evidence that food served to patients meets their nutritional and dietary requirements, as reflected in menus that are planned in advance and kept on file for at least 1 month.
9. The physical plant shall be safe and sanitary and the number of patients accepted shall not overtax the facility.
10. There shall be proper storage and control of narcotics and other medications, and there shall be procedures for proper issuance of narcotics and other medications in accordance with physicians orders.
11. There shall be arrangements with at least one acute short-term hospital where patients whose condition requires it will be admitted with a minimum of delay.

The accreditation of hospitals has been carried on for a number of years by the Joint Commission on Accreditation of Hospitals.

Senator MORSE. Father, I apologize for interrupting again. The Senator from West Virginia, Senator Randolph, will preside. He is one of the most dedicated men on this committee to the cause to which you, too, are dedicated and I want to thank you, Senator, for proceeding.

This is Father Humensky, a member of the Joint Commission on Accreditation of Hospitals.

Please accept my apologies for having to leave.

Father HUMENSKY. Thank you.

Senator RANDOLPH (presiding). Father Humensky, you understand the slight delay in the continuance of your testimony. We are delighted to have you testify and following your statement I know that members of our staff and perhaps the Senator now occupying the chair will want to question you on matters that you have discussed.

Will you proceed, sir?

Father HUMENSKY. Thank you.

The accreditation of hospitals has been carried on for a number of years by the Joint Commission on Accreditation of Hospitals. The joint commission is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons.

There are now 4,024 hospitals which are accredited. Personal surveys are made of each facility by a staff physician of the commission. Though the surveys cover a number of matters pertaining to the physical plant and to the organization and administration of the hospital, the surveys are primarily directed toward appraising the quality of medical care.

It is our belief that a similar program is essential to insure good quality of care in nursing homes. The initial efforts of the American Hospital Association in this direction were started in 1957.

The American Hospital Association firmly believes that an accreditation program on a State-by-State basis with each State acting in a completely autonomous manner is not likely to be successful, and that a national program of accreditation is necessary.

The association continued through 1958 to develop criteria for the registration program already referred to. During this period meetings were held with representatives of the American Nursing Home Association and with others.

Agreement was reached by the American Hospital Association, the American Medical Association, and the American Nursing Home Association in October of 1959 as to the desirability of all three groups publicizing the American Hospital Association's registration program—then referred to as a listing program.

During the year 1960, the association worked on the development of the philosophy of a sound accreditation program for nursing homes and other long-term care facilities; and this philosophy was widely discussed throughout the country.

In May of 1961, the association's board of trustees officially recommended to the Joint Commission on Accreditation of Hospitals:

> That it accept responsibility for administering an accreditation program for inpatient care institutions other than hospitals, including nursing homes with skilled nursing services.

In December of 1961, the board of commissioners of the Joint Commission on Accreditation voted to proceed on a program of accreditation and to seek financial assistance for the development of the program.

The effort to secure financial support was successful and a foundation grant was made in the amount of $49,500 to the Hospital Research and Educational Trust of the American Hospital Association. Staff was assigned to develop the project and discussions proceeded with interested organizations.

However, in November of 1962, the board of trustees of the American Medical Association instructed its representatives to the board of commissioners of the Joint Commission on Accreditation of Hospitals to oppose the accreditation of nursing homes by the joint commission.

Thus, the American Medical Association by its action prevented the development of a nationwide program of accreditation by the joint commission.

The American Hospital Association deplored this action as not being in the best interest of the American people. The American Medical Association, thereafter, opened negotiations with the American Nursing Home Association to develop the National Council for Accreditation of Nursing Homes under these two organizations and entirely separate from the joint commission.

Though there have been numerous discussions and meetings to the point of the possible development of one national accreditation program for nursing homes involving all the major organizations concerned, these efforts have not been successful as yet.

The American Medical Association and the American Nursing Home Association have embarked upon their own program of accreditation and the American Hospital Association has continued to develop its program of registration.

The American Hospital Association continues to believe that one nationally directed accreditation program for both hospitals and nursing homes is essential to the quality of care in nursing homes and other long-term care facilities, and we will continue to direct our efforts to this end.

Therefore, though we continue to hope that a full-fledged accreditation program under multilateral auspices will eventually be developed, we believe it highly essential that time not be lost.

Therefore, every effort should be made now to establish a program of adequate standards for nursing home care. For this reason, the association's program of registration has been strengthened; and we are making a major effort to provide for the inspection of nursing homes in order to develop a list of recognized nursing homes which meet basic standards as established by the American Hospital Association.

We appreciate the opportunity of discussing this important matter with this committee.

(Pamphlet follows:)

Guiding Principles for Agreements Between General Hospitals and Long-Term Care Facilities [1]

These principles refer to formal cooperative relationships between institutions having separate corporate structures and distinct governing boards or authorities, not to those situations in which a hospital and a long-term care facility operate under a single board and legal structure.

NEED FOR AGREEMENTS

The American Hospital Association believes that planned programs for post-acute care of long-term patients are urgently needed to assure adequate care of the chronically ill. The association further believes that general hospitals and their organized medical staffs should accept responsibility for planning such

[1] The Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities strongly endorse these guiding principles and recommended that the States give the principles careful consideration in their programing of health facilities.

programs in cooperation with other responsible and interested institutions and community service agencies.

Where postacute care is provided by institutions whose corporate structures are separate and distinct from that of the general hospital, cooperative relationships should be developed between the general hospital and the chronic or long-term care facilities, in order to provide continuity of care. These relationships are best established by written agreements that clearly reflect the specific operating situations. Such agreements can achieve the following purposes:

Coordination of a broad range of services

Organization of facilities and services to provide continuity of care and treatment appropriate and specific to the need of each patient is more than just a long-range goal. It is increasingly a matter of public concern that there be "a broad range of coordinated facilities and services to assure each patient adequate care in the right place, at the right time, and at a cost the Nation, each community, and its citizens can afford."[2] A broad spectrum of care is more likely to be provided when institutions and other community resource agencies work together as partners, rather than independently within the limited scope of their individual resources and services.

Prevention of unnecessary patient transfers

Chronically ill persons have widely varying needs; and their conditions, and consequently their needs, change with unpredictable frequency and rapidity. When, through cooperative arrangements, special services can be bought to the patient in the long-term care facility during brief periods of need for them, undesirable transfer of the patient can be avoided.

Reduction in cost to the patient

Cooperative arrangements and coordination of services permit prompt transfer, when appropriate, from the acute-care hospital to the long-term care facility, with a resultant reduction in total cost to the payer.

Promotion of efficiency and economy

In view of the constantly rising costs of health care, institutions engaged in providing care have an urgent and continuing responsibility to assure the most efficient and economical use of their resources in manpower and facilities.

Opportunity for comprehensive appraisal of health care

Constant review and appraisal are essential to maintaining and raising standards of health care. A coordinated and comprehensive review of the whole range of preventive, diagnostic, acute, rehabilitative, and long-term supportive care is likely to lead to more effective appraisal than review limited to a single phase of care.

Means to end isolation of long-term-care institutions

In general, the quality of care for long-term illness has lagged behind that for acute illness, even by minimum standards. The isolation of many long-term-care institutions from the mainstream of medicine, and the lack of interest of some general hospitals in long-term care, are major factors contributing to this lag. One objective of cooperative relationships between general hospitals and long-term-care institutions is to end this isolation. Coordinated professional direction can improve the services provided by both cooperating institutions.

A formal agreement provides a focus on the shared goal of community service. The planning incident to establishing a relationship necessarily directs the attention of both institutions to the effect of the relationship in meeting patients' needs, which is the common goal. It is essential, when a relationship is being developed, that there be a mutual understanding as to what is to be accomplished. The process of arriving at a formal agreement can aid in clarifying the purpose of the relationship. Development of cooperative arrangements hinges on recognition by all health care institutions that the compelling nature of these considerations transcends the parochial interests of the individual institutions.

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[2] Background statement on role of hospitals in long-term care, American Hospital Association, September 1962.

ADVANTAGES FOR THE GENERAL HOSPITAL

The general hospital may find, after reviewing the availability of beds for care of long-term patients, that the interests of the community will be best served by making optimum use of facilities in an existing long-term-care institution, rather than by constructing additional general hospital beds. In the circumstances, the development of cooperative agreements with long-term-care institutions offers advantages to the hospital. For example:

Prompt transfer of patients to the long-term-care institution for postacute care assures optimum use of the hospital's beds for acute care. Construction of additional beds may thus be avoided.

Adequate postacute care prevents unnecessary rehospitalization of patients.

Employment of the hospital's diagnostic facilities and services for patients in the long-term-care institution makes optimum use of the facilities and prevents unnecessary duplication of these services outside of the hospital.

The special knowledge and skills gained by the staff of the long-term-care facility in providing nursing care to chronically ill and aged patients can be shared with the staff of the general hospital and can thus improve the care of such patients during hospitalization in acute illness.

Evidence is provided to the community that the hospital is concerned not only with the care of the acutely ill but also with all phases of health care needed in the community.

The hospital's desire to see that the best use is made of the community's health care dollars is demonstrated.

ADVANTAGES FOR THE LONG-TERM-CARE FACILITY

Physical facilities and services provided by long-term-care institutions have undergone tremendous changes in the past 5 years. However, the public has not always been aware of these changes. Many of these institutions are striving to improve their services to patients and to gain better understanding of their function in the community. Often they cannot independently add desirable services without increasing costs beyond the reach of their patients. Even if the expense of adding new services can be minimized, higher costs will inevitably result from improvements in the scope and quality of health care of long-term patients. Development of working relationships with general hospitals offers these advantages to the long-term-care institution:

Prompt hospitalization of patients when it is needed.

Improved services to patients without unrealistic increases in cost, through sharing of the hospital's consultants, personnel, and inservice training programs.

Better utilization of facilities through early referrals from the general hospital.

Likelihood of better medical supervision of patient care.

Improved public understanding of the long-term-care institution and its services and of the need for financial support of the inevitably higher costs of improving standards.

Recognition of the institution as a part of the total health resource of the community.

ESSENTIAL ELEMENTS OF A WRITTEN AGREEMENT

No standard or model agreement can be entirely applicable to every situation. It is possible, however, to identify certain elements of such agreements that are essential in all situations. Legal counsel of both institutions should participate in the planning, negotiation, drafting, and review of any agreement, not only to see that all technical legal requirements are satisfied and to insure that the integrity and separate identity of each institution are maintained, but, more important, to be ceratin that the intent and purposes of the agreement are accurately and clearly stated. Essential elements of a written agreement are the following:

1. Identification of each institution and of the officers legally authorized to sign the agreement.
2. A statement of the general and specific purposes of the agreement.
3. Designation of a committee composed of representatives of each institution, who will facilitate the implementation of the agreement and conduct periodic review and revision.
4. A procedure for settling disputes arising under the agreement.

5. A statement that the agreement may be terminated by either party if certain qualifications are not maintained by either institution. These might include: licensure, registration, accreditation, and participating of approval status with respect to third-party reimbursements, governmental or nongovernmental.

6. A procedure for alteration or termination of the agreement.

ADDITIONAL ELEMENTS TO BE CONSIDERED

While all written agreements should contain these essential elements, the precise nature of the agreement and the extent of the areas of cooperation and joint service for which it provides will necessarily vary from one situation to another.

A number of points that should be considered in developing agreements are discussed below. Not all of these will be appropriate or applicable in every situation, but each merits careful consideration for inclusion in the agreement.

Transfer of patients

Development of specific procedures for prompt and efficient transfer of patients between institutions is a most important element in a cooperative relationship. Such procedures should include a determination of—

(1) The priority given by each institution to admission of patients from the other, and to holding beds for readmission of transferred patients;

(2) The sociological and medical information that must accompany a patient transferred from one institution to the other to assure continuity of care; and

(3) The responsibility of the institution in which the patient is resident for billing and collecting patient charges.

Medical staff

Early involvement of the medical and staff leadership of each institution in the process of developing a relationship is most important because of the essential role of the medical staff in implementing any agreement that is reached. While actual medical staff arrangements must depend on the provisions of each particular agreement, the following points should be considered:

1. The clinical privileges to be given staff physicians of each institution by the other institution.

2. The assignment of responsibility for emergency care of patients in the long-term care facility in the absence of an attending physician.

3. The extent of reciprocal participation in medical staff meetings.

4. In the case of the long-term care institution with a medical director but no organized medical staff, the relationship of the medical director to the hospital and its medical staff, including his staff privileges.

5. The responsibility for maintaining adequate medical records in the long-term care facility.

6. The availability of hospital staff physicians for consultation in the long-term care facility, and procedures for arranging consultations.

7. Procedures to guarantee review and appraisal of the quality and appropriateness of professional care in the long-term care facility, including the frequency with which patients are to be seen by their physicians. Such review is an important element in any meaningful relationship. It should be conducted on a routine and continuing basis by a medical staff committee composed of medical and nursing staff representatives of both institutions. Reports and recommendations of this committee should be submitted to the designated medical staff(s), medical staff committee(s), or medical director(s), and to the governing boards or authorities of both institutions.

Sharing of facilities and services

Depending on the situation, cooperative use of facilities and services can be an important element of a relationship. A relationship may involve contractual use of laboratory, pharmacy, X-ray, laundry, and sterilization of supplies and equipment. It may also involve loan and rental of equipment, and joint purchasing of equipment and supplies. The mechanics of such cooperative endeavors, including the method of payment by each institution and the method by which the cost is ultimately charged to the patient, must be carefully worked out and described in the agreement.

When joint purchasing is undertaken, the procedures, including arrangements for delivery and storage and payment for both, and the financial relationships should be described precisely.

Personnel

Cooperative arrangements regarding recruitment, policies on hiring and discharging, wage and salary administration, job classifications, promotion, retirement, and inservice training can form elements of a relationship. The purpose of joint recruitment is to realize the optimum potential of recruitment efforts and, by sharing information concerning vacancies and job requirements, to assist both institutions in securing qualified personnel. Some applicants may be better suited for employment in the cooperating institution than in the one to which they have applied. Uniform wage and salary policies for comparable positions will avoid undesirable competition.

Benefits from sharing certain inservice training programs (e.g., training of personnel in techniques of rehabilitation nursing), will accrue to both institutions. In many instances, the long-term care facility has much to offer the short-term general hospital in the way of special techniques of caring for chronically ill and aged patients. On the other hand, the special knowledge and skills of hospital personnel can often improve services of the long-term care institution in such areas as engineering, housekeeping, inventory control, medical records management, purchasing, and safety programs.

The sharing of knowledge may be achieved through consultation between personnel of the two facilities, through jointly conducted training programs, or through a simple informal exchange of information. Depending on the circumstances, the method of exchanging consultation, training, information, or service can be formalized in the agreement, and provision made for payment for benefits received by each institution through the exchange.

In some circumstances, the two institutions jointly can effectively utilize the services of a specialized employee, whereas neither one separately could do so. This is especially true of professional personnel in short supply, such as dietitians, pharmacists, social workers, and the various specialized therapists. Successful sharing of personnel requires careful delineation of terms of employment, administrative lines of authority, and individual responsibilities and compensation, in order to protect the best interests of both employee and employer.

Methods of financial operation

A meaningful relationship will involve the provision of services by one institution to another. Consequently, a method of determining the cost of such services and, equally important, definite provision for payment should be a part of the agreement. It therefore becomes important to establish, as an initial element in the relationship, standard methods of accounting (including uniform classification of accounts), establishing charges, approval of charges, payment for services and rentals, and meaningful financial audit and reporting. An annual outside audit of any financial transactions under the agreement is good practice, and this should be provided for in the agreement.

Internship, residency, and paramedical educational programs

Formal educational programs for medical, nursing, or other paramedical personnel conducted by either institution may include the other institution in some part of the program. The nature and extent of participation of the other institution should be specified either in the overall agreement between the two institutions or in a separate agreement.

Disaster planning

It may be desirable to do coordinated planning for joint use of personnel or facilities in disaster situations. The operating agreement should cover the intent to effect such arrangements.

PROTECTION OF LEGAL STATUS

The spirit of the working relationship is more important than the letter of a formal agreement; however, there are significant benefits to be derived from formalizing the agreement. The drafting of a formal written agreement demands careful study, prior to the beginning of the relationship, of all operating aspects of the cooperative relationship, of methods of implementation, and of the financial arrangements involved.

It should be noted that the relationship between a hospital and a long-term care facility can be the subject of more than one agreement, and that additional agreements may be necessary during the course of the relationship to cover new or changed circumstances. Further, unless specifically stated otherwise, each

institution is free to enter into separate cooperative agreements with other institutions.

A formal written agreement should have the effect of protecting the legal and tax status of both parties. It can, within limits, clarify and serve as a reference in questions involving the possible liability of either institution when services are provided by an institution other than the one in which the patient is resident. Both parties to agreements should be certain that their malpractice and liability insurance covers acts of employees incident to discharging the terms of the relationship.

Agreements between institutions of different corporate classifications—voluntary nonprofit, governmental, and proprietary—should safeguard the charitable and tax-exempt status of nonprofit institutions and should take into consideration any legislative prerequisites or limitations applicable to governmental institutions. A formal agreement will memorialize the fact that the relationship is not intended to affect the legal status of the parties.

When the contemplated relationship is between either a nonprofit or a governmental institution as one party and a proprietary institution as the other party, the agreement should specify that the nonprofit or governmental institution will not perform services at less than cost. If a member of the board, the administration, or the medical staff of the nonprofit or governmental institution should have a financial interest in the proprietary institution, this would not necessarily be illegal, immoral, or unwise. Nevertheless, in such cases legal involvement to the disadvantage of the individuals and the institutions can occur, under certain circumstances, which may endanger the tax status of the nonprofit institution or may constitute a criminal act if a governmental institution is involved.

DEVELOPING WORKING RELATIONSHIPS

The variety and scope of joint services that may be developed cooperatively between health care facilities have been described. Achievement of a comprehensive coordinated working relationship often begins with a simple agreement concerning a single element, such as transfer of patients.

Successful experience in developing and working with a single element promotes better mutual understanding and confidence, which in turn, lead to consideration of additional exchange or sharing of services. Thus the long-range objectives may often be best achieved by working toward a series of attainable goals. Conversely, overambitious attempts to initiate formal working relationships that are too broad in scope and for which the governing bodies and staff are not prepared may result in failure of the entire effort.

Some of the steps involved in arriving at an agreement are suggested below. Local situations, of course, may demand a different sequence of events.

A logical first step is an informal discussion between the administrators of the two institutions during which the possible scope of an initial agreement is explored.

After tentative agreement is reached on this score, each administrator will want to discuss the proposal with the governing body of his institution to obtain its reactions to pursuing the matter further.

The proposed arrangements should also be discussed with appropriate representatives of the medical staff and/or medical adviser of each institution, unless the particular subject of the agreement is one that does not involve the physicians (such as laundry, purchasing, etc.).

In situations involving the medical staff, consideration must be given to the desirability of seeking formal action by it to establish a clear understanding of physician responsibilities and relationships.

If the subject under consideration involves department heads of either or both institutions, such as the chief admitting officers or directors of nursing, they should be brought into the discussion at this point.

Appointment of a joint committee to implement the agreement, review its effeciveness, propose changes or additions, and serve as an advisory group to administration can precede the actual completion of the formal agreement. In some circumstances, this is a desirable mechanism, especially when several elements of reciprocal relationships are involved.

Joint meetings of the governing bodies of both institutions can also be an effective method of exploring cooperative arrangements and of reviewing the effectiveness of existing arrangements.

Advice of legal counsel is essential before any actual commitments are made, either verbally or in writing. The drafting of the written agreement requires legal assistance for the several reasons that have already been stated. In addition, legal considerations vary from State to State and from community to community. It would be unwise simply to copy agreements developed between institutions in other areas.

Once an initial agreement (however limited in scope) has been successfully negotiated, and a mutually satisfactory relationship established, the possibility of developing additional elements of agreement may be explored. Amendments or new agreements should be developed in the same manner as the initial agreement.

Senator RANDOLPH. Thank you, Father Humensky.

Sitting with you at the table is Dr. Frederick N. Elliott, associate director, Cedars-Sinai Hospital and Medical Center, Los Angeles, Calif. It is our feeling that your comments might be helpful at this point, Dr. Elliott, because of your varied and intensive experience in the matter of accreditation. You have surveyed, of course, many institutions. I wonder how the process works to upgrade quality in ways which cannot, frankly, be accomplished by licensing authorities.

Would you discuss that?

Dr. ELLIOTT. Well, I think it is well accepted, Senator, that in its 12 years of existence the Joint Commission on Accreditation of Hospitals has been successful in upgrading the level of hospital and professional care in this country through its system of surveys and resurveys.

There are two important elements in a program of accreditation.

The first revolves around the question of its motivation. The first and most obvious motive, which is one of self-interest, is to create an image which will invite public confidence but which may or may not actually deserve it.

The second is a rather practical consideration. Increasingly accreditation has been used as a criterion of merit by third party payers and is, therefore, a very desirable acquisition on the part of a health care facility.

The final and really relevant one is that it is a voluntary, self-initiated activity to meet the moral and ethical and professional obligations for the care of the people that are entrusted to the institution.

Two particular and essential ingredients of the accreditation procedure are:

That there be an onsite visit by a person who is qualified by training and experience to give a subjective and a qualitative evaluation of the standards of care achieved.

There is also a basic principle which has been well proved through the years and is accepted everywhere; and that is that the quality of professional care varies directly with the scrutiny to which it is subject. It is well established that medical care provided by a physician is best where it is under general medical supervision and subject to the scrutiny of his professional colleagues and peers.

Now, these features are essentials of the program for the Joint Commission on Accreditation of Hospitals and they are essential for any accreditation program of nursing home facilities which will be acceptable to the American Hospital Association.

Without these features we feel that the American Hospital Association could not accept or lend its support to such a program. Without these features, such a program might achieve the first or the second

objective; an invitation to public confidence and to participation by third party payers, but not necessarily or even possibly achieving the third objective; meeting moral, ethical, and professional responsibilities for adequate patient care.

Senator RANDOLPH. Are you critical of the American Medical Association in this area?

Dr. ELLIOTT. Do you mean critical in a negative sense, Senator? [Laughter.]

Senator RANDOLPH. Well, of course, if you do not like negative, use another word. Are you critical?

Dr. ELLIOTT. I think all of us who are concerned about any question, Senator, are critical inasmuch as we attempt to apply some standards of judgment.

Let us say that——

Senator RANDOLPH. You may not understand. I am talking about the accreditation program, the stand taken by the AMA.

Dr. ELLIOTT. Well, may I answer the question in two ways, first generally, Senator?

As I said, one of the problems of the professions, if they are going to remain as professions, that is as groups of individuals marked out from the general class of people and endowed with special prerogatives, perquisites, and privileges, is that these must be earned and retained by performance. And the requirements of performance for a profession are self-evaluation, self-judgment, and self-discipline.

These are very difficult things for humans to do, and there has always been an element in all the professions, and the medical profession is no exception, which has rejected these responsibilities while willingly accepting and in fact claiming the prerogatives and the privileges.

There has not been an annual meeting in the last 10 years of the American Medical Association in which there has not been vigorous criticism of the Joint Commission on Accreditation of Hospitals because of the standards of performance and self-evaluation which it requires of the organized physicians of our hospitals.

It would be most unrealistic if the American Medical Association was not sensitive to this point of view so vociferously expressed by a portion of its membership. It would be unrealistic to say that the AMA's all-out effort in favor of a full acceptance of professional responsibility by all its members would not be somewhat lessened by this internal revolt.

Now, to specifically answer your question, Senator. The requirements for registration of a nursing home by the American Hospital Association—and this is merely registration, a more or less quantitative thing, without the survey that I was telling you about—are already in excess of those required for accreditation by the National Council for the Accreditation of Nursing Homes which do not require in all instances even qualified nursing observation of the patients in their care.

Nor do they require an organized activity on the part of the medical staff to review and appraise the quality of care given to the patients. And so long as this program lacks those elements it will not be acceptable to those who are really concerned with the third and valid objective of a program of accreditation.

Senator RANDOLPH. Dr. Elliott, it is our understanding that you have reviewed the standards used by the National Council on Accreditation. Would you tell us whether you feel these are adequate?

Dr. ELLIOTT. I think that is the very basis of our stand, Senator, is that we do not feel that they are adequate. A copy of these accreditation standards is available and has been submitted to your committee, and on comparison with the registration standards of the American Hospital Association which Father Humensky has outlined in our submission, there is a qualitative discrepancy apparent to anybody.

Senator RANDOLPH. Thank you, Doctor.

Mr. MILLER. Mr. Chairman, may I pursue this?

Senator RANDOLPH. Yes, indeed.

Mr. MILLER. The testimony this morning has revolved essentially around this whole matter of accreditation. The question, Mr. Chairman, that I want to raise, may be a minor aspect of the matter, but it seems appropriate to have some clarification, with reference to certain areas. Certainly no group is better qualified to comment on these areas than the representatives of the American Hospital Association.

Referring to your statement on page 10 you point out that there are now 4,020 hospitals that are accredited. Could you tell us how many hospitals are not accredited?

Father HUMENSKY. I imagine there would be about 3,000 that are not accredited. A large number of these hospitals could not be accredited since they are hospitals with fewer than 25 beds. The joint commission will accept for accreditation only hospitals with 25 beds and up. And others which do not meet the standards, dare not even ask for a survey to be made of their institution. So, that actually, the majority of the beds, I think, are in the accredited hospitals at the present time, but—and that is only a rough number of the beds in the 4,020 accredited hospitals.

Mr. MILLER. Are there any hospitals in your opinion that probably could qualify for accreditation which have made no application for accreditation?

Father HUMENSKY. I have not heard of any. Fred, would you know?

Dr. ELLIOTT. That would be a matter of opinion, sir. But I think it is highly unlikely and on the basis of my own personal experience, that a hospital which is both eligible and could achieve accreditation would fail to ask for it. It is widely accepted as something desirable, most hospitals desire to have it.

I am not aware of an institution which could qualify both in a quantitative way and in the quality of its operation which has failed to avail itself of accreditation.

Mr. MILLER. Might I ask if Mr. Williamson has any further comment on that?

Mr. WILLIAMSON. No. I think that the answer Dr. Elliott has given is right. I think that there are various compulsions, call them, going on now that will increase the likelihood of hospitals seeking accreditation. In the gray area, when you get down into smaller hospitals, because of the requirements that are increasingly being imposed by the third party payment organizations now indicating that they will only in the future pay for care in accredited hospitals, the pressures, I

think, will increase in this direction and any that can possibly become accredited will apply.

I think within the group of smaller hospitals, the 25 or less, the joint commission has at various times considered the possibility of moving into this area. It has not done so as yet, but two or three States have started State programs to try to get at these smaller—the 25 and less bed hospitals—to at least help them improve their operations.

Mr. MILLER. Does Blue Cross in its contracts generally make payments only to accredited hospitals?

Mr. WILLIAMSON. Not generally; not as yet.

Mr. MILLER. Another question along this line relates to the purpose of accreditation both current and historically.

Again on page 10 the statement is made the surveys for accreditation cover a number of matters pertaining to the physical plant, to the organization and administration of the hospital.

The surveys are primarily directed toward appraising the quality of medical care.

I would like to ask if that was the initial primary purpose of accreditation by the Joint Commission on Accreditation.

Dr. ELLIOTT. The program of the Joint Commission on Accreditation grew out of the program originally established by the American College of Surgeons in 1918. At that time, fellowship in the college was based upon clinical experience and depended upon the record which a surgeon could produce to substantiate it. It was found that few hospitals had the facilities or the records to which a man could turn to support his application for a fellowship.

The program of hospital standardization requiring certain minimum standards of performance and records in hospitals was initiated and carried on by the college from 1918 to 1952. At that time its size and the cost involved, and so on, indicated that it would have to be discontinued and at that time the Joint Commission on Accreditation of Hospitals involving now in addition to the surgeons, the College of Physicians, the American Medical Association, the American Hospital Association, was incorporated. Its genesis was the surgeons—a professional concern for the standard of care.

The joint commission has always been professionally oriented; it has always had its emphasis on professional excellence, and it has continued in that tradition.

It represents a very fine example of a profession meeting the obligations that are inherent.

Mr. MILLER. Are there any differences in types of accreditation such as accreditation for teaching purposes?

Dr. ELLIOTT. There are other programs, sir.

The American Medical Association has a council on medical education and hospitals which approve educational programs, and there are others.

The joint commission has only one program applied to institutions large and small, which is based primarily on some elementary things like patients' safety, because a patient is in great jeopardy just because he is a patient and then more particularly on the quality of care as represented by the quality of review and appraisal and evidence of concern on the part of the organized medical staff to maintain it.

Mr. MILLER. How is the cost of the survey of a hospital met?

Dr. ELLIOTT. Until recently this has been met by the underwriting institutions in proportion to their representation on the 20-man board of the corporation.

Recently there has been a change. A policy of charging for the survey, according to the amount of time required on a more or less arbitrary basis, has been instituted.

Mr. MILLER. This charge is payable by the hospital itself?

Dr. ELLIOTT. It is payable by the hospital. This is a recent development.

Mr. MILLER. No further questions, Mr. Chairman.

Senator RANDOLPH. Thank you, very much.

Father Humensky, on page 12, I have noted that you speak of the action of the board of trustees of the American Medical Association in November of 1962 in effect instructing its representatives to oppose accreditation by the joint commission.

I wonder if you would provide for the record the date of the meeting of the joint commission at which the change in the bylaws was voted down.

Father HUMENSKY. I was not on the commission at that time, Senator. I would not have the exact date. I have stated that November of 1962 was the time that action was taken by the American Medical Association and shortly thereafter was referred to the joint commission. Since the joint commission can pass on any such matters by three-fourths majority vote and the American Medical Association, having 7 members out of 20, their action precluded, since they did not approve, the sponsorship of this accreditation program of nursing homes.

It was impossible and still is impossible unless the representatives of the American Medical Association change their minds and their vote to pass the desired and the originally sponsored and approved program.

Since you are asking so many questions on this one point, and they have been asked here this morning, Senator, there seems to be a little confusion on what is the actual value of the standards of the council, the standards of registration the American Hospital Association has, and then the desired and agreed upon standards of accreditation that were originally acceptable and then rejected in November of 1962.

I would like to submit this as a part of our testimony here if you would please accept that. This is the original philosophy and the report that was made to the Joint Commission on the Accreditation of Hospitals.

It contains all of the standards, the requirements, and it is all in here and can be compared with any document that has been prepared to the present time or will be prepared in the future.

I think it is a very good one. I think it has the value of little less than a Bible, you know.

Senator RANDOLPH. Father, we will receive this. I am not sure it will be published as a part of the printed record. It might well be.

Father HUMENSKY. Senator Morse was quite concerned about what the requirements were in comparing what actually is in existence at the present time and I thought it would be a very useful background material.

Senator RANDOLPH. It may be that we will want it printed as a part of the record, but at least, we will accept it for the record and find it useful.

Father HUMENSKY. Fine.

(The document referred to is reproduced as app. IV at p. 238.)

Senator RANDOLPH. Now, would you hazard the reason or reasons why the representatives of the American Medical Association, the board, opposed the accreditation of nursing homes as recommended by the joint commission?

Father HUMENSKY. That would be a very hazardous guess, Senator. I know of no other reason that the one that was made by representatives of the American Medical Association. I think these reasons have already been accepted, and have been referred to; anything that I might say on this point would be sheer conjecture and to judge the motivation of another organization, and one that I respect very much, certainly would be amiss of me; it is not that I am fearful to make a mistake, but certainly to make an official statement on something I do not know about, I would not hazard even a close guess on that.

It is very difficult and very——

Senator RANDOLPH. It is too hazardous for you to——

Father HUMENSKY. Well, I do not have to worry too much about my——

Senator RANDOLPH. Dr. Elliott, would you address your thinking to this subject?

Dr. ELLIOTT. I think, Senator, that again it would be a matter of opinion, and accurate or otherwise, I feel, Senator, that this is a question which the American Medical Association should answer.

There was one reason, given for publication, and we have a publication which carries that. The official statement was that the program as it had been developed was not acceptable to the American Nursing Home Association.

This was the reason given by the American Medical Association, quoting another association and declining to give any further reason.

Senator RANDOLPH. For the record, I think we should state that the American Medical Association was invited by letter to have a representative or representatives present to testify. We had hoped to discuss this with all of those who are associated with the problem.

Do you know, Father Humensky, if there was substantial opposition to your accreditation program as set down by the joint commission other than that which flowed from the opposition of the American Medical Association?

Father HUMENSKY. No. As far as I know. I was not on the commission at that time but I was a trustee of the American Hospital Association and the report that was given to us by our executive director, Dr. Crosby, was that it seems to have been satisfactory to all.

While there was discussion as to the requirements and the development of the entire philosophy, there did not seem to be any opposition other than the one block that made the presentation that killed the whole project at that level.

Senator RANDOLPH. I hesitate to say this, but I think we can; it is information which has been received; that the College of Surgeons and the College of Physicians did vote in favor of accreditation.

They are groups within, we will say, the medical profession who did feel that the joint commission's national accreditation program had value. This is not improper for me to place in the record. It seems to be information that is correct.

Mr. WILLIAMSON. Excuse me, Senator. I might say it is quite proper, because representatives of those two organizations officially supported a joint commission program of accreditation in 1961.

Senator RANDOLPH. Thank you very much.

Has the American Hospital Association, Father Humensky, been invited to participate in the national accreditation program sponsored by AMA and the Nursing Home Association?

Father HUMENSKY. Has the American Hospital Association been invited?

Senator RANDOLPH. Yes.

Father HUMENSKY. No. I do not think there was any invitation. It was a bilateral agreement between the nursing home association and the American Medical Association that gave forth to the program as it exists now. I do not recall any other organization or any other agency in the field that was invited to join.

Beyond that, I am not aware of any official or even unofficial action.

Senator RANDOLPH. Thank you, Father.

We have had some information, again this is conjecture to a degree, that the American Medical Association might have been in opposition not for a direct reason of the program of accreditation but for certain side issues, if I use that term advisedly. Would you care to comment? [Laughter.]

Father HUMENSKY. You are putting smoke in a hole, Senator.

I have heard that, too. I believe it is a rumor but don't know where it originated. I do not think that the whole medical organization would be that vindictive.

I do not know. It might make interesting comment on how rumors originate and what the content is, but I do not think it would reflect the thinking of the entire organization by any means.

Senator RANDOLPH. Father, off the record.

(Discussion off the record.)

Senator MOSS. Father Humensky, I am sorry I was not here for all of your testimony and I am scanning this rather quickly now. I have had some opportunity to see it before I left earlier this morning, but there is one question here that I would like to ask.

On page 12 you say that the American Medical Association thereafter opened negotiations with the American Nursing Home Association to develop the National Council for Accreditation of Nursing Homes under these two organizations and entirely separate from the joint commission.

Did the AMA take the initiative in attempting to establish this new program?

Father HUMENSKY. I do not know. It may have been spontaneous in the sense that these negotiations were going on in the joint commission and were ready to be approved and then all of a sudden these were discontinued and then this new council cropped up.

Now, there may have been some background activity going on for quite some time that we did not know about. However, I believe that the statement was made here this morning that the nursing home

association did approach the American Medical Association to unite and to sponsor the creation of this new council on accreditation.

So that I would presume these were the prime movers; that is, the nursing home association was the prime mover in organizing this new council.

Senator Moss. It has been suggested that maybe Dr. Elliott may have a comment on that particular point about the sequence and what movement followed which. We are just trying to get that clarified if we can.

Do you have anything you could contribute to us at that point?

Dr. Elliott. We have here, Senator, a chronological outline of the events related to the development of a program for accreditation in nursing homes. However, it contains only the record of meetings and what was accomplished at those meetings and the resolutions that were passed, and I was neither a member of the joint commission nor in any way directly related to these negotiations and I cannot answer the question.[1]

It may be with reference to the general question asked earlier that this question was considered part of or subsidiary to many other things which are going on in the medical and medical-economic and medical-political field.

However, I do not think that it is possible to assume that in an incident such as this, where the welfare of a large segment of our population is concerned and where there is a professional responsibility for that welfare that any other consideration would be allowed to detract or interfere with the merits of the question standing by itself.

Senator Moss. Thank you, sir.

Thank you, then, Father Humensky, Dr. Elliott, and Mr. Williamson. We appreciate your coming here representing the American Hospital Association and helping us to make the record and trying to find some answers in this most important field.

Father Humensky. Thank you, Senator.

Senator Moss. I understand our reporter and members of the staff have not had a chance for any lunch. I am going to recess now long enough for that to take place.

We will return at 1:45 and continue with our hearing.

We will stand in recess until then.

(Whereupon, at 1:15 p.m., the committee was recessed, to reconvene at 1:45 p.m., the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:45 p.m., Senator Frank E. Moss, chairman of the subcommittee, presiding.)

Senator Moss. The committee will resume.

We will hear now from the National Council for Accreditation of Nursing Homes. Dr. H. Close Hesseltine, chairman of the National Council for Accreditation of Nursing Homes and member of the Joint Commission on Accreditation of Hospitals, will be our next witness.

I understand he will be accompanied by Mr. Alfred Ercolano, executive director of the American Nursing Home Association.

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[1] The document referred to is included as app. V at p. 257.

Will you gentlemen come forward, please?

We are glad to have you, Dr. Hesseltine, and to have you back at the table, Mr. Ercolano.

Will you introduce your other associate?

STATEMENT OF DR. H. CLOSE HESSELTINE, CHAIRMAN, NATIONAL COUNCIL FOR ACCREDITATION OF NURSING HOMES; ACCOMPANIED BY ALTON BARLOW, PAST PRESIDENT, ANHA, AND VICE CHAIRMAN, NATIONAL COUNCIL FOR ACCREDITATION OF NURSING HOMES, AND ALFRED S. ERCOLANO, EXECUTIVE DIRECTOR, AMERICAN NURSING HOME ASSOCIATION

Dr. HESSELTINE. Mr. Chairman and members of the committee, you have stated who I am. I am Dr. H. Close Hesseltine, professor of obstetrics and gynecology at the University of Chicago.

With me on my left is Mr. Alton Barlow, who is past president of the American Nursing Home Association. He is a nursing home owner and administrator and is currently the vice chairman of the National Council on Accreditation of Nursing Homes.

On my right is Mr. Ercolano, executive director of the American Nursing Home Association, and we would like to have him here as a resource person, if we may, please.

Senator MOSS. Thank you.

Dr. HESSELTINE. Mr. Chairman, we would like to offer or submit to you and your committee the statement that we have presented to you, and have you accept this as our testimony, and in the interest of time, and to allow questions, we would like to abbreviate part of this testimony and only talk on certain aspects of it, so that we would perhaps have more time for questions.

Senator MOSS. That certainly may be done. The entire statement will be placed in the record, and we will ask you to emphasize those parts that you care to.

Dr. HESSELTINE. And further, Mr. Chairman, if it pleases you and your committee, if questions do not bring out some points that we feel need to be answered, we would appreciate the privilege of responding to a few questions that were proposed this morning relating to accreditation.

Senator MOSS. Most certainly you may do that.[1]

PROFESSIONAL DEVELOPMENT OF NURSING HOMES

Dr. HESSELTINE. Nursing homes began to spring up throughout the United States during the early 1900's. Many nursing homes had their origin as boarding homes to which people came in good physical and mental condition. However, as these people became older, their health declined and many became chronically ill or disabled.

These people did not need hospitalization, but did require some help in maintaining themselves. Thus, the boarding home owner found himself in the nursing home business.

[1] Supplementary material submitted by the National Council for Accreditation of Nursing Homes appears as app. VI at p. 265.

Most of the older nursing homes came into existence in facilities planned for other purposes. Although the majority of nursing homes may still be operated in improvised facilities, recent years have seen the establishment of facilities specifically designed for use as nursing homes.

Years ago, nursing homes were referred to as homes for incurables, old folks homes, poorhouses, almshouses, or had other names which characterized them as essentially domiciliary in character. Today these names are seldom used.

There frequently was an attitude in nursing home operation that all good patients belonged in bed, but today the recommended philosophy is to help patients live as normally as possible.

Whereas nursing homes usually had only elderly patients who came with terminal illnesses, these facilities are currently used for people of all ages. Today many patients are sufficiently improved so that they are enabled to return to their homes.

In 1941 licensing laws for nursing homes had been enacted in only one State, whereas in 1961, nursing homes were licensed in all States. According to the 1961 inventory of nursing homes conducted by the Public Health Service, about 92 percent of all nursing homes were fully licensed, and these homes had 93 percent of the beds.

We would all agree, I am sure, that the scope of licensing requirements should be expanded so that an even greater percentage of nursing homes are required to meet reasonable standards. We should be sure, moreover, that no public funds are expended for care in unlicensed nursing homes.

The rapid growth of the nursing home industry has intensified the difficulty in obtaining adequate staffing. Recruiting and holding a sufficient number of qualified staff is perhaps the greatest single problem confronting nursing homes. The problem is not limited to professional staff alone. It extends to all classes of nonprofessional help, as well.

It is gratifying to see the heightened public and professional interest in the provision of care for the chronically ill and recognition of the important contribution which nursing homes make.

In comparison with the situation years ago, when deficiencies in the operations of these homes were generally ignored, deficiencies in a small number of homes now are the subject of intense public interest. Occasionally, justified criticisms of a few nursing homes are generalized to cover the vast majority of nursing homes, even though they are effectively operated in the public interest.

Today nursing homes as medical care facilities are becoming more important with the rapid increase in the number of older people in our population and the wider use of these homes for posthospital convalescent care and for the care of the long-term ill.

Other factors contributing to the need for nursing homes are the changes in our social and economic environment. Urban growth and concentration make for smaller homes and apartments, which frequently do not have a spare room for an aged parent. In some homes, all adult family members work, and no one is available to care for an ill or incapacitated relative.

While our social goal should continue to be directed toward maintaining the chronically ill in their own homes, or in those of their children or other relatives, some other type of living arrangement, such as a nursing home, may sometimes be necessary.

GROWTH OF NURSING HOMES

Prior to the 1930's, only a few nursing homes existed in the United States. However, with the enactment of the Social Security Act in 1935, making public assistance funds available to the needy aged, proprietary boarding and nursing homes for elderly people began to flourish and public almshouses subsequently declined.

In 1939, the first known count of nursing homes showed that there were approximately 1,200 nursing, convalescent, and rest homes, having roughly 25,000 beds.

In 1961, the Public Health Service conducted an inventory of nursing homes and related facilities, which showed that there were about 23,000 facilities, or 2,000 less than that shown in a 1954 inventory.

Despite the drop in the number of facilities, the resident capacity of the 23,000 nursing homes now totals 592,800, a 32-percent increase over 1954's total of 450,000. About 85 percent of all nursing homes, with 61 percent of the beds, are proprietary. About 11 percent of the homes are voluntary nonprofit, and 4 percent are publicly owned facilities.

Because such terms as "nursing home" and "homes for the aged" have widely different meanings to different people in different localities, both inventories sought to classify facilities according to the predominant level of care furnished. The U.S. Public Health Service, therefore, classified all nursing home facilities into three groups: skilled nursing, personal care, and residential care homes.

Skilled nursing homes are the largest single category of nursing home facility, and it is expected that their proportion of all nursing home facilities will increase. Skilled nursing homes have increased in number from 7,000 in 1954 to 9,700 in 1961. Their total capacity has nearly doubled—from 180,000 to 338,700 beds.

Practically all of these beds—337,300—were reported as assigned to skilled nursing service. Infirmaries of facilities having personal or residential care as their primary purpose have some skilled nursing beds, and bring the total number available throughout the country to 362,200.

The number of personal care homes has grown from 9,000 with 190,000 beds in 1954 to 11,100 homes with 207,100 beds in 1961. In contrast, the number of residential care facilities has declined from 9,000 homes with 80,000 beds to 2,200 homes with 47,000 beds.

Although accounting for nearly 9 out of 10 homes, the proprietary homes provide little more than 7 out of 10 beds. Nearly 9 out of 10 skilled nursing homes have at least 1 full-time registered professional nurse (R.N.), or licensed practical nurse (L.P.N.). About 18 percent of the homes have both full-time R.N.'s and L.P.N.'s, 29 percent have full-time R.N.'s, and 39 percent have full-time L.P.N.'s.

PUBLIC HEALTH SERVICE STANDARDS

It has long been recognized that a well-defined and universally accepted set of standards would provide a sound basis for evaluating services and facilities. Consequently, when the Public Health Service issued the "Nursing Home Standards Guide" in June 1961, it was greeted with universal acclaim.

These guides were prepared to assist State and local licensing agencies and other regulatory groups in instituting or improving laws, regulations, or other required standards for the establishment, maintenance, and operation of nursing homes.

Although State and local licensing provisions are gradually being strengthened, they do not offer assurance of substantial improvement in standards of care in nursing homes. Licensing regulations usually provide minimum standards of construction and operation, with limited incentive for progressive improvement. They tend to deal primarily with physical requirements, such as fire safety, functional layout, and sanitation.

ACCREDITATION

It has long been recognized that voluntary classification and accreditation of nursing homes have the potential for upgrading standards of care beyond minimum acceptable requirements of licensing programs.

Accreditation is the recognition accorded to an institution that meets the criteria established by a competent agency which considers these criteria as the minimal condition under which good quality care can be rendered. The process of accreditation entails—

(1) Development of standards;

(2) Survey of facilities by individuals particularly qualified to evaluate how well the standards are met;

(3) Awarding of an appropriate symbol of recognition to nursing homes which meet the standards and advising all facilities surveyed whenever they have failed to meet the standards; and

(4) Periodic reinspection of accredited facilities to ascertain whether they continue to meet the standards, and reinspection of facilities which failed to be accredited to determine if sufficient improvement has occurred which would meet accreditation.

Establishment of an accreditation program is evidence of willingness on the part of the nursing homes to set and maintain standards. Conducting an accreditation program indicates willingness on the part of the sponsoring organizations to assume responsibility for good practices.

The need for accreditation of nursing homes was recognized by professional authorities at the National Conference on Nursing Homes and Homes for the Aged, sponsored by the Public Health Service in February 1958.

Subsequently, several State and regional organizations, some of which were affiliates of the American Nursing Home Association—hereafter referred to as ANHA—began to establish accreditation programs of their own.

It was generally believed that these local programs would delay significant improvement in the quality of nursing home care and increased financial participation by third-party payors.

In order to forestall the growth of these programs and prevent confusion in the health field, the ANHA voted in March 1961, to establish a national accreditation program. The ANHA recognized the limitations of its own program and consistently sought additional sponsors.

Meanwhile, the Joint Commission on Accreditation of Hospitals, which is sponsored by the American Medical Association, the American Hospital Association, the American College of Physicians, and the American College of Surgeons, was also considering the establishment of an accreditation program for inpatient care institutions other than hospitals.

The program would have been available to nursing homes, homes for the aged, rehabilitation centers, and similar agencies. After months of discussion and negotiation with several national organizations, the sponsoring organizations of the joint commission decided in March 1963, to discontinue any further action on nursing home accreditation.

NATIONAL COUNCIL FOR THE ACCREDITATION OF NURSING HOMES

Subsequently, in mid-April 1963, the AMA and the ANHA announced a plan for a jointly sponsored national accreditation program for nursing homes. In establishing the National Council for the Accreditation of Nursing Homes, it was recognized that nursing homes were medical care facilities. Therefore, it was decided not to accredit residential or domiciliary care facilities.

At present, the national council consists of nine directors, five of whom are physicians appointed by the American Medical Association, and four nursing home administrators appointed by ANHA. During its first year of existence, the National Council has succeeded in establishing a set of uniform standards for accreditation and has initiated a program of surveying and accrediting nursing homes.

A survey is conditional on the requirement that the nursing home has a State license. The surveyor seeks to determine if the home is medically oriented, the professional staff is qualified, and sufficient for the services the home purports to provide, and the physical facilities, equipment, and supplies are adequate for the care and treatment of the patients.

Under current standards, accreditation is granted at three levels of care:

1. Intensive nursing care.
2. Skilled nursing care.
3. Intermediate care.

The level of the facility is based primarily upon the nursing skill level of the staff in the nursing service. In an intensive care facility, the nursing service is under the supervision of a registered professional nurse, with a registered professional nurse on duty 24 hours a day, 7 days a week.

The nursing service in a skilled nursing care facility is under the supervision of a registered professional nurse, and a registered professional nurse must be in charge of patient care for a minimum of 5 days, 40 hours a week. Moreover, at least one licensed practical nurse must be on duty at all times.

Finally, in the intermediate care facility, the nursing service is under the supervision of a licensed practical nurse. This type of facility requires a licensed practical nurse to be on duty 5 days a week, a mini-

mum of 8 hours each day, and a night attendant to be awake and fully dressed.

As of April 29, 1964, the national council had accredited 287 nursing homes, with 18,208 beds. About 100 applications were in various stages of processing. The number of new applications being received is, indeed, encouraging. The program has received enthusiastic support from the medical profession, including many State medical society committees on aging.

This program does not only recognize those homes which qualify for accreditation, but assists ineligible homes to improve their own standards.

It should be noted that the national council accredits all qualified nursing home facilities, whether they be governmental, nonprofit, or proprietary.

The National Council for Accreditation of Nursing Homes is proud of its program for accrediting nursing homes. Even in its present early stages, it has proved to be a good program. We have set up realistic and attainable standards. We have a single set of standards which nursing homes throughout the country can work toward. In contrast to licensing, accreditation standards will be the same in every State.

As we indicated before, the national council consists of representatives from AMA and ANHA. The bylaws provide for additional sponsors, and the current sponsors are exploring ways of broadening the sponsorship.

The public relies upon accreditation. Accreditation of hospitals has assisted in the general improvement of our hospitals. Accreditation will similarly improve nursing homes. Our program will encourage the establishment and maintenance of such nursing homes.

The nursing homes must meet the challenges of rapid medical, nursing, and social changes. To meet these challenges, the accrediting agency must be aware of, encourage, and prepare itself to pass judgment on experiments and new methods of nursing home care.

Accreditation by the national council will mean that the nursing home has been judged by a recognized professional organization as meeting uniform national standards beyond those required by law.

Accreditation will mean that the professions devoted to meeting the health needs of our society have assessed the physical plant and professional ability of the facility's personnel and found them to be worthy of a certificate of approval.

Accreditation will assure the public that the facility has voluntarily demonstrated a willingness and ability to provide a higher level of care than that required by a licensing program.

In all our deliberations and decisionmaking, the National Council for the Accreditation of Nursing Homes will keep in mind the objective of accreditation to serve and protect the public interest.

Mr. Chairman, on behalf of the national council, and Mr. Barlow and myself, I want to thank you for the invitation and the opportunity of appearing before you and your committee.

And if we can answer your questions, we will be glad to. If we cannot, we will be glad to try to find the answers and send them to you.

Senator Moss. Thank you, Dr. Hesseltine. We are pleased to have

you here today, and we do appreciate your coming and bringing these other gentlemen to appear, also.

Are you the AMA representative on the joint commission?

Dr. HESSELTINE. I am one of the five representatives of the AMA. No. Beg pardon. I misunderstood. I am one of the seven of the AMA representatives on the joint commission.

Senator MOSS. I see. And I understand you are also past president of the Illinois Medical Society. Is that correct?

Dr. HESSELTINE. Yes, sir.

Senator MOSS. And do you hold an office at the present time in the AMA?

Dr. HESSELTINE. I do not.

Senator MOSS. Just as its representative on the joint commission?

Dr. HESSELTINE. Yes, sir, and in the national council.

Senator MOSS. Now, turning to page 5, here, do I interpret correctly that only 29 percent of the skilled nursing homes have a full-time registered nurse in attendance?

Dr. HESSELTINE. This is in the second full paragraph, sir?

Senator MOSS. Yes.

Dr. HESSELTINE. Yes. Twenty-nine have full-time, according to the Public Health Survey of, I think, 1961. It is probably a little higher now, but we were trying to stick to facts.

Senator MOSS. I see. When that survey was made?

Now, is this just proprietary homes, or is this of all nursing homes?

Dr. HESSELTINE. All nursing homes.

Senator MOSS. All nursing homes of all kinds.

You have some figures about the number of nursing homes that the council had accredited. Do you have any figures on the numbers who failed to meet the standards and that have been denied accreditation?

Dr. HESSELTINE. Yes, sir. Seventeen have been denied accreditation; have been surveyed and have been denied.

Senator MOSS. I see. Percentagewise, that would be about 8 percent, perhaps.

Dr. HESSELTINE. Yes.

Senator MOSS. Do you have a central staff of inspectors at the national council to do the accreditation surveys?

Dr. HESSELTINE. On the national council we have 16 surveyors. The office is located at 645 North Michigan Avenue, Chicago. This is where our operating headquarters are, and this is where all of the requests for surveys come, where they are processed, where surveyors are assigned, where reports are sent in from suveyors, and that is from where we operate.

Senator MOSS. I see. An application would come in, then, from a nursing home and be put in this process; and part of the process of accreditation would be inspection by one of these inspectors who would be assigned to go out to the home.

Dr. HESSELTINE. Yes, sir.

Senator MOSS. Do you have any questions?

Mr. FRANTZ. Are these full-time paid staff of the national council?

Dr. HESSELTINE. You mean the inspectors?

Mr. FRANTZ. Yes, sir.

Dr. HESSELTINE. At the present time we do not have full-time paid inspectors. There are some 16 part-time surveyors. They are experienced people who have been doing inspecting in nursing homes for the last 4 or 5 years.

It is in the program to take on full-time surveyors as we can expand them and orient them to do it. We will probably for the time being use part time, too. This is in the evolution of things. To make a sudden change would have slowed up or stopped the progress. These people are qualified. Most of them are nurses. They have been in nursing homes and have had experience.

Mr. FRANTZ. The program is being implemented State by State, is that not correct?

Dr. HESSELTINE. We are operating as a national program. At one time there were a few States that did have State committees. We are trying to operate this at one level, because otherwise, you have slow-up on referrals and clearance.

We will use State committees in nursing homes in an advisory capacity and to obtain information about the integrity of the people, or other information that may be helpful in the public interest.

Mr. FRANTZ. Will the staffing of the inspection process be at the State level?

Dr. HESSELTINE. It will be at the national level.

Senator MOSS. I believe from the information that we received earlier, the Joint Committee on Hospital Accreditation voted unanimously to proceed with a program of accreditation of nursing homes in its meeting of November 20, I believe it was. Is that correct?

The date of the meeting may not be correct.

Dr. HESSELTINE. Did you say the joint commission?

Senator MOSS. The joint commission, yes.

Dr. HESSELTINE. No, I think November 20. If you mean November 20 of 1963, that was the group of some 15 or 14 bodies that were called together to discuss accreditation. I think that was alluded to this morning by Reverend Eggers, in which the American Association of Homes for the Aged I think took the lead to bring the group together. This was a spontaneous group.

I believe that is what you were referring to.

Senator MOSS. Was there not a unanimous expression or vote, then, that this group should proceed to implement the accreditation program?

Dr. HESSELTINE. I do not have with me an exact copy of the minutes. There was general agreement, I think without dissent, that accreditation was valuable, that it was desirable that it should be systematized and not be fragmented, and one program rather than two or three. This is the starting point of it.

At that point, there was one group that was invited that did not appear.

Senator MOSS. I see. But you were there representing the AMA at that point?

Dr. HESSELTINE. That is right.

Senator MOSS. And at that point, were the AMA representatives there in favor of proceeding with this program of accreditation?

Dr. HESSELTINE. We favored accreditation and have favored accreditation. We have a going program. And we would like to have had it coordinated with our program.

Mr. ERCOLANO. Senator, are you referring to the meeting of the Joint Commission on the Accreditation of Hospitals in November of 1961?

Senator MOSS. Apparently December of 1961.

Dr. HESSELTINE. I was talking of November 1963. I am sorry.

Senator MOSS. I gave you the wrong date.

Dr. HESSELTINE. It was my fault. I apologize, sir.

Senator MOSS. At that time, there was agreement, then, that the program should be developed and that there should be accreditation?

Dr. HESSELTINE. Yes. There was agreement, certainly, that it should be developed, because this is needed to grow and develop.

The nursing home field is the most rapidly developing area probably in the medical sciences today, and we feel that for the benefit of the public, accreditation was desirable. This did not mean at that time that the judgment was final. This was exploratory, then, in 1961.

Senator MOSS. But the AMA delegates did express their approval?

Dr. HESSELTINE. On the principle of accreditation.

Senator MOSS. And then there was a subsequent action taken, perhaps coupled with this bylaws change, in which the representatives were instructed to reject this procedure?

Dr. HESSELTINE. Mr. Senator, may I amplify that?

Senator MOSS. I wish you would, please.

Dr. HESSELTINE. I was in the commission when this was discussed at that time. I was a commissioner representing the AMA.

The actual organization for any change in the Joint Commission on Hospital Accreditation, whether it involves a new member on the board or a change in policy, must have unanimous consent of the sponsors, not the commissioners. I mean if it involves a principle or major change, the commissioners can recommend to their parent body. And it was the parent body that made the final decision in this instance.

Senator MOSS. Well, the commissioners in effect recommended one thing, but the parent body decided otherwise?

Dr. HESSELTINE. Yes. I do not recall that that was a unanimous vote at that time. As a matter of fact, I believe that I voted against it for one particular reason, if you would like the reason.

Senator MOSS. Yes.

Dr. HESSELTINE. I do not know why the AMA voted, because this was by their board of trustees, and I have no information on why each man voted as he did.

My own position was that the proposal for accreditation, and taking the nursing home in, was that they would not have a vote at the top level, that they would not be represented on the board. They would be leveled at the secondary level—advisory. There would be no change in the board of trustees on the joint commission.

And if you would like, I would be glad to have Mr. Barlow make a comment on that, because this I think involved the nursing home people more particularly than it did us, and I think he can give you the sequence actually as it took place.

Senator MOSS. I would be glad to have your comments, Mr. Barlow.

Mr. BARLOW. A great many of our members favored the joint commission doing the accreditation, and we did have negotiations with them. But then, when we learned that we would not be represented

on the board, and would have no voice in the decision regarding governing our profession, then we were no longer interested.

Mr. FRANTZ. I am not sure I am understanding the point you make, Dr. Hesseltine.

According to testimony this morning, in December 1961 the board of commissioners of the Joint Commission on Accreditation voted to proceed on the program of accreditation, presumably to go ahead with what they had developed.

Our further understanding, informally, was that this was a unanimous vote. Now, do I understand you correctly to say that you voted against it?

Dr. HESSELTINE. I do not remember. I did not check this date. I have the impression that I missed that meeting. I do not recall specifically.

However, I think at that stage of development they had not gotten down to the specifics. They were talking purely the principle. They had not gotten down to the technique or details of the accreditation and where it would be in the joint commission. This developed at a later time.

Mr. FRANTZ. Some of the chronology is becoming a little more clear. Was there a vote by the joint commission to undertake the accreditation of nursing homes subsequent to this 1961 vote?

Dr. HESSELTINE. I am not sure I understand.

Mr. FRANTZ. At this point, in December 1961, the commissioners were talking about the principle of accreditation, and voted in favor of it. Did they vote again at a later time, after the accreditation program had been developed?

Dr. HESSELTINE. Yes. This was in 1962 or 1963. This is the time that the general working rules had been developed and presented to the commissioners and to the sponsors.

And the point is that when a major body is involved, it seems to me they ought to have a chance at least of expressing themselves and voting, otherwise it would be undemocratic. The Hospital Association is on the top level. The American Medical Association is, and the College of Physicians and College of Surgeons are. I am sure they would be reluctant to be on an accreditation program if it involved them in a major sense, without their having a chance to express themselves at the top level.

I think this is the matter that became involved.

Mr. FRANTZ. Did those representatives who were opposed to it for this reason, then, advocate the expansion of the board for this purpose?

Dr. HESSELTINE. There was no encouragement, and as a matter of fact, for some reason it was never brought before the commission about expanding the board. This was brought up to the parent bodies.

Mr. FRANTZ. One other point. Would you say that the representatives on the joint commission, including those of the American Medical Association, were in favor of the joint commission program, independent of the policies of the parent bodies?

Dr. HESSELTINE. Yes. I think we can talk the principle of unity and accreditation. This was I think the point. But this became involved with matters that we felt were not democracy, and certainly we were influenced by the body that was involved, the American Nursing Home Association, which had a representation of some 4,000 or

5,000 homes, or membership. And this is what we thought was a point of import.

And then subsequent to that, once this position had been taken, the American Medical Association did not take the initiative. They were approached by the American Nursing Home Association in order to try to develop further expansion of accreditation, because they, the American Nursing Home Association, had been doing some accreditation, but they felt it should be broader, and we agreed with this.

And it is our hope that this can be broadened, and at the present time the sponsors are exploring, as I stated here, the avenues of broadening the sponsor members in the organization.

We would like to do this by profession or national level, rather than sublevels.

Now, may I digress to explain this point: In the joint commission we are represented by just fundamentally two groups professionally, the American Hospital Association and the medics. The College of Surgeons and College of Physicians are also members of the AMA, but this came about through an evolution of several years, because the College of Surgeons started the accreditation by themselves some 20 or 30 years ago.

Then they needed help, and then they asked others to join in. So this is why these two bodies happen to be in at this time. And fundamentally, it is a bilateral accreditation, and we have a bilateral in the nursing home accreditation.

We are willing, and the council has recommended to our sponsors, that they explore, and I can assure you that they are exploring, seriously, expanding this to others that have a main interest and a broad interest in care facilities.

Mr. FRANTZ. You reminded me, when you talked about broadening the base of representation within your program; I was wondering how you were proceeding to try to broaden the base, and what groups you have asked to join with you.

Dr. HESSELTINE. If I understood correctly this morning, I heard reference that there was a commitment to approach certain groups. I think the exploration is open. As a matter of fact, as chairman of the national council, I wrote, in behalf of the council, to pave the way for our sponsors, a few months ago, to several groups, asking if they would be interested in considering either a sponsor or an advisory committee capacity to several groups, including the American Nurses Association, the American Psychiatric Association, the groups that met last November, the American Association of Homes for the Aging, and others.

Several of them indicated their interest in an advisory capacity, a few at the level of sponsor, which then would have trustees or board members.

This information, then, was given to our sponsors, the American Nursing Home Association and the American Medical Association, to explore further these groups that have interested themselves, to express themselves either in writing or personally.

Mr. FRANTZ. You referred to this same meeting that Reverend Eggers referred to, but in his statement this morning he said that the results of the meeting indicated the national council does not believe in the broadly representative approach. Was there some misunderstanding on that point?

Dr. HESSELTINE. I am in doubt as to the source of his information. Anyway, this is not the fact. Neither the council nor the sponsors subscribe to his charge nor have they at any time taken this position.

Senator MOSS. Senator Yarborough, do you have any questions at this point?

Senator YARBOROUGH. Dr. Hesseltine, I note from your statement that you point out that the urban concentration and growth make for smaller homes and apartments that frequently do not have a spare room for an aged parent, and that often all of the adult family members work, but with no one there to care for an ill or incapacitated relative, and you point to a growth in nursing homes from 1,200 in 1939 with 25,000 beds to 23,000 homes with 592,000 beds at the present time.

That roughly parallels, the growth of nursing homes parallels, the growth of urban population, does it not?

Dr. HESSELTINE. I presume so.

Senator YARBOROUGH. I know in my own State, in 1940, 40 percent of our people in Texas lived on farms and ranches. Now, just 20 years later, in the 1960 census, that had declined from 40 percent to 13½ percent.

That drop in the rural population fairly well parallels the urban growth in the rest of the Nation. And the change of the way of life of people, it seems to me, has accentuated this problem as much as the increasing longevity of the populace itself.

Do you not find that to be true in your studies, that the change in the way of life, the people moving from a rambling type farm home, where an aged grandparent could be taken care of, to a small apartment in the city, makes it very difficult to take care of an aged grandparent? Is that not one great cause?

Dr. HESSELTINE. I presume so, Senator.

It occurs to us that whether they are aged or not aged, the long-term care in many areas is unsuitable in the usual home environment, because of the lack of facilities, or the means of getting up or down from a second- or third-floor apartment.

Also, we believe the nursing homes had a stimulus in part because they removed these long-term care patients from hospitals. It removes them from the environment of drama of surgery and tension of acute medical cases, and is a halfway house in part between the hospital and the home that is not quite ready to receive them.

Senator YARBOROUGH. Your conclusion is that the nursing homes must meet the challenge of social changes. This is one of the social changes taking place, in the urbanization of our population. That is one of the social changes that have brought this need about.

According to the statements I have seen, of people over 65, there are approximately 5½ million who are chronically ill, of those who are over 65 years of age. So if they were all occupied, the 592,000 beds would take care of about a tenth, roughly a tenth, of the people over 65 who are chronically ill, would they not?

Dr. HESSELTINE. That chronic illness does not mean, of course, they are bed patients. Many of these people are hypertensive but not bed patients. Some have arthritis, or wear glasses, et cetera. This is a health evaluation as to their freedom from either symptoms or medical conditions.

33-257—64—pt. 2——5

Senator YARBOROUGH. Of these 592,000 beds, how many are occupied, on the average? What is the figure, 300,000; 400,000?

Dr. HESSELTINE. Could Mr. Barlow answer this, please?

Senator YARBOROUGH. Yes.

Mr. BARLOW. I would think about 85 percent.

Senator YARBOROUGH. Is the turnover fast, or slow?

Mr. BARLOW. I would say neither. It is sort of in between.

Senator YARBOROUGH. I have no further questions, Mr. Chairman.

Senator MOSS. Thank you.

Senator Fong?

Senator FONG. Dr. Hesseltine, the membership of your National Council for Accreditation is composed of five physicians and four nursing home administrators. Is that right?

Dr. HESSELTINE. Yes, sir.

Senator FONG. And how many physicians comprise the Joint Commission for Accreditation of Hospitals?

Dr. HESSELTINE. Thirteen, and seven hospital administrators.

Senator FONG. So you have doctors in the National Council for Accreditation, and you also have doctors in the Joint Commission for Accreditation. Is that correct?

Dr. HESSELTINE. Yes.

Senator FONG. Now, as I understand from your testimony, you said in 1961 your group, known as the Association for Accreditation, decided to go national?

Dr. HESSELTINE. That was when the American Nursing Home Association voted to establish a national program, and it was started by the American Nursing Home Association.

Mr. ERCOLANO. If I could treat this chronologically, in January of 1962, the American Nursing Home Association had developed its own accreditation program. It was the sole sponsor, and it had incorporated a separate corporation in the District of Columbia for the purpose of accreditation.

Senator FONG. What year was that?

Mr. ERCOLANO. That was in late 1961, early 1962.

At this time, the American Nursing Home Association wrote letters of invitation to the American Hospital Association and the American Medical Association and the American Dental Association and the American Nurses Association, asking them to support and sponsor and join in this program of accreditation.

The American Nurses Association, the American Hospital Association, and the American Dental Association said that they felt the program for the accreditation of nursing homes should be under the jurisdiction of the Joint Commission on the Accreditation of Hospitals. The American Medical Association said neither "yea" nor "nay."

At that time, when the joint commission had started an exploratory study on the possibility of the Joint Commission on the Accreditation of Hospitals involving itself with the accreditation of long-term inpatient care facilities other than hospitals, the American Nursing Home Association backed off from its accreditation program that it had set up.

Then, when the joint commission voted not to accredit, or not to involve itself in accreditation of long-term care facilities, this was in November of 1962, or December of 1962. It was late 1962.

The American Nursing Home Association, early in 1963, approached the American Medical Association and asked the American Medical Association if they would be interested in cosponsoring an accreditation program with nursing homes and with our association.

Senator FONG. Did the organization of the National Council for Accreditation take place prior to the refusal of the AMA to join?

Mr. ERCOLANO. No, sir. Afterward.

Senator FONG. Afterward. I see.

So when they refused to join the association, which would have involved other homes and other organizations having a say in the runnning of their program, they formed this National Council for Accreditation?

Mr. ERCOLANO. Yes, sir.

Senator FONG. So that came as a result of the nonforming of that group, which was proposed?

Mr. ERCOLANO. It came as a result of the Joint Commission on the Accreditation of Hospitals voting not to involve itself in the accreditation of long-term care facilities or inpatient facilities other than hosptals.

Senator FONG. So had the AMA agreed to go along with Reverend Eggers' group's idea, the National Council for Accreditation would not have evolved. Is that right?

Mr. ERCOLANO. No, because the group of which Reverend Eggers spoke this morning did not have its first organizational or investigative meeting until November of 1963. The National Council for the Accreditation of Nursing Homes had been in operation for some months prior to this investigative meeting of November 1963.

Senator FONG. The doctors joined this nursing home group subsequent to turning down Reverend Eggers' proposal?

Mr. ERCOLANO. No, the American Medical Association and the American Nursing Home Association——

Senator FONG. Were already in existence?

Mr. ERCOLANO (continuing). Were already in existence prior to the calling of this meeting.

Senator FONG. Prior to the calling by Reverend Eggers of his group, together with the people who are in the Joint Commission for Acceditation of Hospitals, you were already in existence?

Mr. ERCOLANO. Yes, sir.

Senator FONG. Now, since you were already in existence, did that play a part in the AMA turning down this new group, the formation of this new group?

Dr. HESSELTINE. Senator, it did not get to the point of serious consideration, because this involved some money to be paid by the parent organizations. They had to go back to the organizations after the November meeting, to see whether the organization would be willing to underwrite, because the staff salaries are paid from this.

The survey income pays for the survey part, but there is the central staff that has to be maintained.

This had to be determined—whether they could be truly financially responsible for helping in the program. This had to be done. You cannot throw the structure overboard without disruption of the program.

But we were surveying, we were accrediting nursing homes. The proposal at this time was that we arrest our program, redraft our rules, have a major shift in the board members, and it seemed to us that this was not in the public interest.

We had a program going. We thought that we could do it by evolution, with benefit to the public, rather than to have to arrest the program and then try to start it again.

Senator FONG. In other words, you felt that you already had an accreditation program going that was pretty good?

Dr. HESSELTINE. Yes, sir.

Senator FONG. Now, in your accreditation program, you had three levels of care, known as intensive nursing care, skilled nursing care, and intermediate care. When a nursing home sends its application to you, you will evaluate this nursing care, and then will place that nursing home in one of these three categories. Is that right?

Dr. HESSELTINE. No, this is just at the start. They make an application by filling out a form and supplying information. This is the start. And then we send a surveyor to the home, who actually goes through the home, sees the kitchen, sees the floor, the patients, notes the doctors' records, their notes, how often they are in, how orders are handled, whether they have medical coverage, and all of the other things that we feel are required to be able to be documented to provide the kind of service they purport to offer, that they have enough personnel and that the personnel fills in to one of these schedules. Then the surveyor makes the report back to the board.

The board makes the decisions on whether this in their judgment is intensive nursing care, skilled nursing care, or intermediate care, or is not worthy of any one.

Senator FONG. To go back to the previous question I asked you, if your Commission for the Accreditation of Hospitals had acceded to the request of Mr. Eggers and his group and those who were with him, would that have entailed the dissolving of your National Council of Accreditation?

Dr. HESSELTINE. I do not think so.

Senator FONG. Could the two have worked together, or worked separately?

Dr. HESSELTINE. One would of course have to surmise. This is a hypothetical question.

The national council is operating and will continue. It is surveying. It has the respect of the nursing home people, the great bulk of them. It is respected by the medical profession. And I would certainly anticipate that it would continue to thrive.

Certainly competition might muddy the waters a little bit, and I would certainly like to see one rather than two or three accreditations.

Senator FONG. Then you would have two accreditation groups if one did not dissolve?

Dr. HESSELTINE. Well, we might in that event, yes.

Senator FONG. Or if the National Council for Accreditation were willing to join the Joint Commission for Accreditation, then probably you would form one group?

Dr. HESSELTINE. Senator, our position is that we are interested in securing and protecting the public's interest. We are not interested in an organization per se. We are not interested in rules.

We feel that we have a dedication to the public, as I have had in my whole life, in teaching and in research, and I intend to continue in this direction, and I am sure the other members of the board are dedicated.

We are more concerned over the care of the people than we are with a particular organization. And I am sure that our structure can be amended, and we have bylaws to provide this.

We would rather see the growth within an organizational function than a new growth that has to start. This always adds confusion.

Senator FONG. After the application has been received from a nursing home, and after the evaluation and investigation, then these nursing homes are placed in one of three categories by the association. Is that correct?

Dr. HESSELTINE. Yes.

Senator FONG. What is the average cost per patient in an intensive nursing care home?

Mr. BARLOW. This of course would vary according to the facility. Some facilities cater to a different class of clientele, and others to, shall we say, the people that have assistance.

I would say that rates run anywhere from $8 to $12 per day.

Senator FONG. And what would your other levels be? Skilled nursing care and intermediate care?

Mr. BARLOW. The skilled care I would say would run anywhere from $6 to $10.

Senator FONG. And your intermediate?

Mr. BARLOW. Around $4 to $6. Maybe a little lower in some areas.

Senator FONG. And in your surveys of the various nursing homes, which predominated? The intermediate skilled?

Mr. BARLOW. The skilled. I think the percentage, Senator, is around 49-something skilled, 36 intensive, and 16 intermediate.

Senator MOSS. I think maybe we ought to clarify this, about where the large percentage of nursing homes fit. We had some testimony this morning indicating that there would be a much larger group in the lowest category. Do you have those figures there?

Mr. BARLOW. These are the percentages, Senator, according to the homes we have now surveyed. This is the actual percentage of the homes that we have granted certification to.

Mr. FRANTZ. I believe the statement this morning was that only 45 percent of the skilled nursing homes have a registered nurse available. So, the remaining 55 percent would necessarily be in the intermediate category, according to your definition.

Mr. BARLOW. This is true, but this is the percentage of the homes that we have actually surveyed.

Senator MOSS. Dr. Hesseltine, when I asked you before, you said of course you would not know the reason that the board of trustees did not accept the recommendation of the representatives of the joint commission, but that they did take the other view, and rejected your

recommendation for going forward with this joint endeavor of the many organizations.

We on the committee have been aware that there has been a deep-seated difference between the American Hospital Association and the American Medical Association on the subject of hospital insurance for the aged, and we have heard that the AMA's board had reasons for possibly blocking the joint commission's accreditation program, and this was related somewhat to this disagreement over the bill.

Dr. HESSELTINE. If I understand your question, Senator, I do not think there was any thought of differences in legislation on their attitude about accreditation.

Senator MOSS. Not between the Hospital Association and the American Medical Association?

Dr. HESSELTINE. I have not heard it in any way implied or voiced.

Senator MOSS. And, of course, you are not on the board of trustees.

Do you know whether there was ever any indication given to the American Hospital Association representatives that a change in their attitude would change the attitude of the American Medical Association toward this accreditation program?

Dr. HESSELTINE. Mr. Chairman, may I approach the answer in this light: I think by and large, the American Hospital Association and the American Medical Association have excellent relations; both boards are composed of gentlemen. I do not know of any two groups of organizations that are intimately related but that they may differ from time to time.

But on the total picture, they have good relations in common, and good relationships, and I think differences here and there would not be an occasion for discord on either side.

Senator MOSS. And your testimony would be, then, that you have not heard of any of this discussion between these representatives centering around the so-called medicare bill?

Dr. HESSELTINE. Not having anything to do with decisions.

I have heard discussions on the pro and con of the so-called medicare, but not anything that would affect decision with respect to accreditation or education, such as accreditation of internships, or accreditation of residencies, or any other accreditations.

Senator MOSS. Do either of you other gentlemen have any comment on that?

Mr. MILLER. Mr. Chairman?

One simple question, Dr. Hesseltine. To your knowledge, has the American Hospital Association expressed itself as favoring the King-Anderson bill?

Dr. HESSELTINE. I cannot answer this, Mr. Chairman, specifically, because I have not read the detail. I just cannot give an answer to this with definitiveness. I am not aware that they have taken an inflexible position.

Mr. MILLER. Perhaps some of the other gentlemen at the table may want to volunteer.

Senator MOSS. If either of you do, you may.

Well, if not thank you very much, Dr. Hesseltine and Mr. Barlow and Mr. Ercolano. We appreciate your coming and making this presentation to us.

Dr. HESSELTINE. Thank you very much.

Senator MOSS. Dr. Herbert Notkin, member of the medical care section of the APHA, and medical director, county welfare department, Syracuse, N.Y.

We will be very glad to hear from you, Dr. Notkin.

STATEMENT OF DR. HERBERT NOTKIN, MEMBER, MEDICAL CARE SECTION, AMERICAN PUBLIC HEALTH ASSOCIATION, AND MEDICAL DIRECTOR, ONONDAGA COUNTY WELFARE DEPARTMENT, SYRACUSE, N.Y.

Dr. NOTKIN. The first part of my statement, I will just speak from. I will just identify the American Public Health Association, and then I have about a page and a half of statistics I will not bore you with about nursing homes and their patients.

Senator MOSS. If you like, you may put the entire statement in the record, and then go ahead as you would like.

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ON INSTITUTIONAL CARE OF THE CHRONICALLY ILL AGED, PRESENTED BY HERBERT NOTKIN, M.D.

SUMMARY

1. The American Public Health Association recognizes the medical and social needs of older Americans confined to long-term institutions for the chronically ill.
2. It also recognizes the problems of the institutions themselves, from the point of view of unsafe structures, inadequate staffing, lack of affiliation with general hospitals, and the profitmaking nature of most skilled nursing homes.
3. The association feels that the interests of the people currently in nursing homes demands attention through raising standards and simultaneously increasing payments. This should be recognized as a short-term solution to the problem.
4. The criterion by which nursing homes, in common with other health facilities, should be judged is the quality of medical care they provide.
5. High quality can only be achieved by the affiliation of nonprofit nursing homes with nonprofit general hospitals.
6. The construction and operation of any such institutions must be adequately financed, with a major share of the funds coming from government at all levels.
7. Finally, there remains a great need to develop adequate and widespread hospital and community programs of many types to reduce the need for nursing homes to the essential minimum, by enabling as many chronically ill people as possible to function in the community.

The American Public Health Association, founded in 1872, has 13,000 members plus an additional 23,000 members of State affiliates. These members work in public and voluntary agencies—local, State, and National—devoted to safeguarding the health of the public by measures to promote health, prevent illness, treat the victims of disease, and rehabilitate them to social usefulness. The members of the association represent a wide variety of health disciplines, including physicians, dentists, nurses, engineers, laboratory and social scientists, nutritionists, health educators, social workers, and medical care and hospital administrators—men and women who are daily confronted with the health needs of individuals and the organizational and administrative problems which must be solved if those needs are to be met.

BACKGROUND

The chronically ill aged in the United States are a particularly disadvantaged group, medically, socially, and financially. Out of the 17 million Americans over 65, approximately 5.5 million have chronic diseases or disabilities. More than 300,000 of these people live in nursing homes. Almost 90 percent of nursing home patients are over 65 and more than 25 percent are over 85.

Studies have shown that more than one-half of nursing home patients need help in walking, more than one-half are confused all or part of the time and about one-third are incontinent. About half of all nursing home patients have

lived in facilities for more than 1 year. More than 20 percent of nursing home patients have not seen a doctor in 6 months.

More than one-half of all nursing home patients are partially or entirely financed by public assistance, compared to 13 percent of all Americans over 65.

More than 85 percent of skilled nursing care homes in the United States are operated for profit. More than 13 percent of skilled nursing care homes do not report any full-time professional nursing staff. Out of the almost 10,000 such institutions in the country, less than 500 are affiliated with hospitals. The large majority of existing beds in nursing homes are unacceptable according to Hill-Burton safety standards.

To those of us in the health professions represented in the American Public Health Association, quality of care is the hallmark of a medical program. To meet standards of high quality, a program must provide the broad spectrum of preventive, diagnostic, therapeutic, and rehabilitative services. These services must be provided by skilled personnel working in a closely coordinated manner in adequate facilities. With very few exceptions, nursing homes do not meet these standards.

Clearly, nursing homes and their patients present some serious problems to all of us. The rest of these statements will indicate some ways to attack these problems.

WHAT CAN BE DONE IMMEDIATLY?

For both humane and practical reasons, we cannot abandon the more than 300,000 patients currently living in nursing homes. Therefore, our first consideration must be to do what is possible within existing nursing homes to improve the quality of care for their patients.

The major items here are:

1. Adequately financed and staffed State licensing programs, emphasizing a high quality of care. These should be administered by State health departments and should have a strong legal framework.
2. Education programs should be provided for nursing home administrators and staffs, focused on improving the quality of care. These can be provided by State and local governments, as well as private agencies.
3. Adequate financing of care by third-party payers, governmental or private, always with the proviso that the previous two steps accompany any increase in payments.

In any such program, care should be taken not to encourage the construction of new nursing homes which may have excellent physical plants, but which may suffer from all the other deficiencies in quality which plague so many of our current nursing homes.

WHAT CAN BE DONE IN THE LONG RUN?

Almost every advance that is made in the quality of American medicine today is made within the walls of the nonprofit general hospital, whether under voluntary or governmental auspices. The general hospital is vital to medical practice, teaching, and research. As long as nursing homes remain unaffiliated with general hospitals, there is little hope that there will be any real improvement in their programs. Without the active collaboration between the nursing home and the general hospital, it becomes difficult to get physicians to visit nursing homes. It is even more difficult for the physician to obtain necessary X-rays and laboratory tests, and to work with the ancillary personnel needed for adequate care of patients. In those instances where nursing homes have had a successful affiliation with a hospital, the homes involved have been nonprofit in nature. The services which a good general hospital would insist on developing in an affiliated nursing home, such as special diets, careful diagnostic examinations, extensive therapy, social service, and rehabilitation programs, cannot always be readily translated into profit, and indeed may be costly to the nursing home. This is obviously difficult for the nursing home operator, as conscientious as he may be, since his livelihood depends on the profits of the home.

The first basic step, therefore, in improving quality of care in American nursing homes in the long run is to encourage the development of these homes in close affiliation with general hospitals. A step in this direction has already been taken by requiring that Hill-Burton funds be used only for nonprofit institutions, preferably under general hospital auspicies.

The Federal Government could take further steps in this direction. Some encouragement could be given to channeling the nearly $250 million spent for nursing home care under public assistance to nursing homes affiliated with general hospitals. The Congress might wish to study the laws of the nursing home loan programs of the Housing and Home Finance Agency and the Small Business Administration to see if they are truly contributing to better health care of the elderly. There is no question, whatsoever, of the administrative competency of these agencies. The only question is whether their legal base permits providing funds to the right type of facility. Finally, the American Public Health Association is already on record as supporting those provisions of H.R. 3920 which would limit social security payments to nursing homes affiliated with general hospitals.

FINANCING

High-quality care is not possible without adequate financial support. Nursing home costs cannot be adequately financed in most cases through the usual methods of paying for health services. The long periods of stay and the low incomes of chronically ill old people often make direct private financing unavailable. Children of aged parents are often faced with their own burdens of rising living costs, high taxes, and the rapidly increasing costs of educating their own children. Voluntary health insurance, whether nonprofit or commercial, cannot be expected to pay for long nursing home stays without pricing itself out of the market. Government, therefore, becomes the backbone of nursing home financing.

The major current mechanism for such payment is public assistance, usually old-age assistance or medical assistance for the aged. The level of payments under these programs in many States do not encourage development of high-quality care.

The American Public Health Association supports the previous testimony of the Commissioner of the Welfare Administration of the Department of Health, Education, and Welfare before this committee. This testimony relates to broadening the provision of nursing home care for welfare recipients and to removing unrealistic ceilings on payment to nursing homes. Certainly, any new legislation which would pay for nursing home services should provide payments which would allow insistence on high standards.

EXTRAMURAL PROGRAMS

One of the major ways to encourage adequate nursing home services is to reduce the need for such services. In this way, the county can afford to construct and maintain fewer beds of high quality. There are many ways to help accomplish this end.

Within the general hospital, there are two key programs which can help the need for nursing home care. One of these is a rehabilitation program and the other is an adequate social service staff to assist with discharge planning. All too often, older people are discharged from general hospitals to nursing homes because there is no skilled and interested person available to make a better placement.

In the community, any number of programs can help decrease the need for nursing home care. These are described in no special order of importance:

Home nursing care through official or voluntary public health agencies. About one-third of all cities with more than 25,000 have no such programs.

Homemaker programs.—There are only 200 such programs in this country, serving in a given month less than 5,000 families. Even so, about one-third of these agencies serve only families with children.

Home care programs.—These coordinated programs for care in the home number only 33 and serve less than 4,000 people on an average day.

Meals on wheels.—These number not more than a dozen, bringing adequate meals to only a handful of Americans who are too handicapped to shop or cook.

Day care programs.—Common in European countries, this type of program for caring for old people during the day while families care for them at night are practically unknown in the United States.

Foster care programs.—A few of these programs, caring for a few hundred people, help older people with no families of their own find families with whom to live.

Information and referral centers.—These new and useful centers help old people and the chronically ill locate the services they need.

To summarize in a few words, we must protect the interests of our chronically ill, institutionalized older citizens by improving the standards in existing nursing homes. At the same time, we must develop a new nursing home system, nonprofit in nature, and affiliated with general hospitals. We must finance these homes properly, with a large share of the money coming from governmental sources. Finally, we must develop adequate hospital and community programs to keep nursing home care utilization to a minimum.

Dr. NOTKIN. Briefly I will say that there are many patients in skilled nursing homes that basically are old people, are seriously ill or disabled, and they stay for long periods of time. Their medical services are frequently inadequate, and the patients themselves are poor by definition. The nursing homes mostly are profitmaking in nature, and they often have inadequate staffs, and often have unsafe physical plants.

To those of us in the American Public Health Association, quality of care is the hallmark of a medical program. To meet standards of high quality, the program must provide a broad spectrum of preventive, diagnostic, therapeutic, and rehabilitative services. These services must be provided by skilled personnel, working in a closely coordinated manner in adequate facilities.

With very few exceptions, nursing homes today do not meet these standards. Clearly, nursing homes and their patients present some serious problems to all of us. The rest of this statement will indicate some ways to attack these problems.

Senator YARBOROUGH. Mr. Chairman, may I interrupt Dr. Notkin?

Dr. Notkin, while we were waiting for you to come to the witness stand, I read your statement. I am called away by an emergency, but I think you have a very informative statement here that will be helpful to us on the committee. I have read it in full. I want to commend you on this statement.

Dr. NOTKIN. Thank you, Senator.

With regard to what can be done immediately, for both humane and practical reasons we cannot abandon the more than 300,000 patients currently living in nursing homes. Therefore, our first consideration must be to do what is possible within existing nursing homes to improve the quality of care for their patients.

The major items are:

1. Adequately financed and staffed State licensing programs, emphasizing a high quality of care. These should be administered by State health departments, and should have a strong legal framework.
2. Education programs should be provided for nursing home administrators and staffs, focused on improving the quality of care. These can be provided by State and local governments, as well as private agencies.
3. Adequate financing of care by third-party payers, governmental or private, always with the proviso that the previous two steps accompany any increase in payments.

In any such program, care should be taken not to encourage the construction of new nursing homes which may have excellent physical plants, but which may suffer from all the other deficiencies in quality which plague so many of our current nursing homes.

What can be done in the long run?

Almost every advance that is made in the quality of American medicine today is made within the walls of the nonprofit general hospital,

whether under voluntary or governmental auspices. The general hospital is vital to medical practice, teaching, and research.

As long as nursing homes remain unaffiliated with general hospitals, there is little hope that there will be any real improvement in their programs.

Without active collaboration between the nursing home and the general hospital, it becomes difficult to get physicians to visit nursing homes. It is even more difficult for the physician to obtain necessary X-rays and laboratory tests, and to work with the ancillary personnel needed for adequate care of patients.

In those instances where nursing homes have had a successful affiliation with a hospital, the homes involved have been nonprofit in nature. The services which a good general hospital would insist on developing in an affiliated nursing home, such as special diets, careful diagnostic examinations, extensive therapy, social service, and rehabilitation programs, cannot always be readily translated into profit, and, indeed, may be costly to the nursing home. This is obviously difficult for the nursing home operator, as conscientious as he may be, since his livelihood depends on the profits of the home.

The first basic step, therefore, in improving quality of care in American nursing homes in the long run is to encourage the development of these homes in close affiliation with general hospitals. A step in this direction has already been taken by requiring that Hill-Burton funds be used only for nonprofit institutions, preferably under general hospital auspices.

The Federal Government could take further steps in this direction. Some encouragement could be given to channeling the nearly $250 million spent for nursing home care under public assistance to nursing homes affiliated with general hospitals.

The Congress might wish to study the laws of the nursing home loan programs of the Housing and Home Finance Agency and the Small Business Administration to see if they are truly contributing to better health care of the elderly.

There is no question whatsoever of the administrative competency of these agencies. The only question is whether their legal base permits providing funds to the right type of facility.

Finally, the American Public Health Association is already on record as supporting those provisions of H.R. 3920 which would limit social security payments to nursing homes affiliated with general hospitals.

Financing: High quality care is not possible without adequate financial support. Nursing home costs cannot be adequately financed in most cases through the usual methods of paying for health services.

The long periods of stay and the low incomes of chronically ill old people often make direct private financing unavailable. Children of aged parents are often faced with their own burdens of rising living costs, high taxes, and the rapidly increasing costs of educating their own children.

Voluntary health insurance, whether nonprofit or commercial, cannot be expected to pay for long nursing home stays without pricing itself out of the market. Government, therefore, becomes the backbone of nursing home financing.

The major current mechanism for such payment is public assistance, usually old-age assistance or medical assistance for the aged. The

level of payments under these programs in many States do not encourage development of high-quality care.

The American Public Health Association supports the previous testimony of the Commissioner of the Welfare Administration of the Department of Health, Education, and Welfare before this committee. This testimony relates to broadening the provision of nursing home care for welfare recipients and to removing unrealistic ceilings on payment to nursing homes.

Certainly, any new legislation which would pay for nursing home services should provide payments which would allow insistence on high standards.

Extramural programs: One of the major ways to encourage adequate nursing home services is to reduce the need for such services. In this way, the country can afford to construct and maintain fewer beds of high quality. There are many ways to help accomplish this end.

Within the general hospital, there are two key programs which can help the need for nursing home care. One of these is a rehabilitation program, and the other is an adequate social service staff to assist with discharge planning.

All too often, older people are discharged from general hospitals to nursing homes because there is no skilled and interested person available to make a better placement.

In the community, any number of programs can help decrease the need for nursing home care. These are described in no special order of importance:

Home nursing care through official or voluntary public health agencies. About one-third of all cities with more than 25,000 have no such programs.

Homemaker programs: There are only 200 such programs in this country, serving in a given month less than 5,000 families. Even so, about one-third of these agencies serve only families with children.

Home care programs: These coordinated programs for care in the home number only 33, and serve less than 4,000 people on an average day.

Meals on wheels: These number not more than a dozen, bringing adequate meals to only a handful of Americans who are too handicapped to shop or cook.

Day care programs: Common in European countries, this type of program for caring for old people during the day, while families care for them at night, are practically unknown in the United States.

Foster care programs: A few of these programs, caring for a few hundred people, help older people with no families of their own find families with whom to live.

Information and referral centers: These new and useful centers help old people and the chronically ill locate the services they need.

To summarize in a few words, we must protect the interests of our chronically ill, institutionalized older citizens by improving the standards in existing nursing homes. At the same time, we must develop a new nursing home system, nonprofit in nature and affiliated with general hospitals. We must finance these homes properly, with a large share of the money coming from governmental sources. Finally, we must develop adequate hospital and community programs to keep nursing home care utilization to a minimum.

Thank you, Senator.

Senator Moss. Thank you very much, Dr. Notkin.

That is a very fine statement. I concur with Senator Yarborough that it is an excellent presentation.

Since most nursing homes are operated for a profit, contrasted with hospitals which are mostly nonprofit, do you think that this factor, this profit factor, might operate against high-quality institutional care in nursing homes?

Dr. Notkin. Yes, I do, Senator.

Senator Moss. And am I correct in understanding that you suggest the Federal Government, concurrent with increasing payments for public assistance, establish minimal operating standards for nursing homes?

Dr. Notkin. I did not specifically say. I do not care whether that is done at the Federal or State level, but I think it should be done before increasing payments to nursing homes.

Those of us in the welfare field have frequently seen the problem whereby we are pressured for higher payments, but do not receive better services in return for these higher payments.

Senator Moss. And you would make it a condition of receiving any additional aid that they meet certain standards, whether they be State or Federal?

Dr. Notkin. Yes, I would, Senator.

Senator Moss. We have had testimony before that all of the States now license nursing homes, and they have some inspection apparently with this licensing. Do you have information concerning the effectiveness of the enforcement factors of licensing?

Dr. Notkin. Not a tremendous amount. I only work in one local area. But I think certainly in many areas of the country due to lack of sufficient beds for older chronically ill people, State licensing programs have not always been as strict as they should be, because there is no other place to put the people that are in homes that do not quite meet the standards.

So I do not believe there is any deliberate laxity, but I think that the State health departments that operate this program often face this tremendous dilemma of: what do you do when a home is substandard in many areas, such as fire protection, for example, when there is no other place to put the patients in that home?

This is a problem that we all face every day.

Senator Moss. You think being on the horns of this dilemma is what permits these laxities to exist?

Dr. Notkin. Yes, I do.

Senator Moss. Are there any medical audits in nursing homes comparable to those made in hospitals?

Dr. Notkin. Not that I know of, Senator. I am not familiar with the standards of the National Commission on Nursing Home Accreditation, but I do not personally know of any situation where there are any hospital audits of medical work in a proprietary nursing home.

There are some governmental institutions that are a little difficult to classify as to what is a chronic disease hospital and what is a nursing home, but in some governmental institutions of this kind, there is medical auditing going on.

Senator Moss. Do you think that the health service benefits proposed in the King-Anderson bill would provide the financial incentives

necessary to stimulate an expansion of worthwhile outpatient services?

Dr. NOTKIN. Outpatient?

Senator MOSS. Well, maybe "outpatient" is a specialized term. Of limited care of older people outside of institutions.

Dr. NOTKIN. I must confess that I am not familiar with the latest version of this bill. It changes so rapidly I cannot keep track of it.

I would just say that previous testimony by Dr. Terris of our association before a House committee on H.R. 3920 indicated that it was very important to have in the bill a provision for services to be rendered outside institutions, so that it would not necessarily push older people into nursing homes or chronic disease hospitals or general hospitals, if they could get along on the outside.

And this is what I hoped to indicate in the latter part of my statement, about the development of community programs of various kinds, keeping as many people out of institutions as possible.

I think even the best institutions are not really good.

Senator MOSS. Your testimony strongly advocated nursing home affiliation with a hospital as essential to high-quality care. Most hospitals are short-term institutions, and nursing homes would tend to be long-term-care institutions. Is there sufficient variety and change in long-term care to challenge a hospital's medical staff?

Dr. NOTKIN. Oh, yes. There is no question about that, Senator.

In our own county, we operate a 413-bed institution which is, I suppose, a cross between a nursing home and a chronic disease hospital, which has attracted over the last 10 years a staff of very high caliber, all with medical school appointments. Both on an attending and a consulting basis we have very adequate medical services that are quite challenging to the physicians.

Senator MOSS. Very good.

I do appreciate your testimony, Dr. Notkin, and your help in putting this record in a position where we think we will have spread before us the information we need to arrive at some decisions, and we are very delighted that you came to be before us.

Dr. NOTKIN. On behalf of myself and the American Public Health Association, thank you for inviting me.

Senator MOSS. Thank you, sir.

This will be all for today. The subcommittee will recess until tomorrow morning at 10:15.

(Whereupon, at 3 p.m., the subcommittee was recessed, to reconvene at 10:15 a.m., Thursday, May 7, 1964.)

(The following was submitted for the record:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., May 13, 1964.

Senator FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care,
Senate Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR MOSS: Enclosed for the information of your subcommittee is the statement of the American Medical Association on the subject of long-term care for the aging.

We will appreciate it if you would have the association's statement included in the record of the subcommittee's hearings, recently concluded.

Sincerely,

F. J. L. BLASINGAME, M.D.

Enclosure.

Statement of the American Medical Association on Long-Term Care

Chronic Illness and Long-Term Impairment

At the outset, may we commend the subcommittee for its recognition of the fact that our concern lies not alone with the chronically ill, but more importantly with long-term patients. The presence of a chronic condition is not necessarily synonymous with limitation of activity and the problem is not with the some 75 million Americans who have a chronic condition, which may be anything from hay fever to stroke, but with the much smaller portion in this group, both at home and in institutions, who are significantly impaired in life's activities as a result of this condition. The difference between the two groups is effectively documented by figures from the U.S. National Health Survey for 1959–61, which show that, in a total of 73.8 million persons with a chronic condition in our civilian noninstitutionalized population, 54.5 million had no limitation in activity whatsoever resulting from this chronic condition.

Long-term impairment is not necessarily caused by a chronic condition, for not all long-term-care cases are preceded by long-acting etiologic factors. The sudden, short-acting etiologic factor of an automobile crash can and does present long-term-care problems indistinguishable from those associated with chronic disease. Acute diseases may have complications that lead to the need for long-term care and congenital defects compatible with life also produce their share of long-term problems. Thus, the focus of this subcommittee quite properly is not on disease entities or diagnoses, but on those individuals who are significantly incapacitated or hindered in life's activities over a period of time, whether as a result of acute or chronic disease, accident, or genetic defect.

Age Not a Primary Factor

Finally, we would recommend one additional qualification to completely define the group to which this subcommittee should direct its concern. Just as we not define the long-term patient by diagnosis or disease, we urge that he not be defined by age group. Long-term impairment is not characteristic—is not the exclusive province—of any particular age group. While there is an increased incidence of long-term impairment among older individuals, such impairment is not a part of aging any more than short-term impairment is a part of childhood. We stress this distinction, even though it is perhaps an obvious one, because there has sometimes been a tendency to lump these subjects together in the past—to discuss long-term illness and impairment as the problem of the aging rather than a problem for some older individuals. This is most unfortunate to the extent that it diverts attention from the equally important needs of the many younger persons who are long-term patients. The details of treatment for long-term patients should be dictated solely by their health needs and potentials and not by age. To do otherwise merely increases the danger of isolating care of the long-term patient away from the mainstream of modern medical activity.

Characteristics of Long-Term Patient

While it is neither feasible nor desirable to categorically identify long-term patients by diagnosis, age, or type of impairment, it is possible to identify a number of distinguishing characteristics which pose special implications for all disciplines, facilities, and resources involved in providing care for this group.

(1) By definition, the long-term patient will require supervison and care over a protracted period of time.

(2) During the course of his illness, the long-term patient is likely to require a wide variety of services and facilities. The former National Commission on Chronic Illness lists over 30 specific types of services the long-term patient may require at some time during the course of his illness. These run the gamut from assistance in obtaining adequate housing, to physical and occupational therapy, to sheltered work, to surgery.

(3) Most long-term patients can best be cared for at home during much of their illness, and many prefer care in that setting. Even though a minority of all long-term patients are presently in hospitals of other institutions, many of those who are in such places could, under suitable conditions, be cared for as well or better—and sometimes more economically—at home.

(4) Two major and related financial problems may confront the long-term patient: (*a*) maintenance of income and payment of regular living expenses (which often increase during a period of illness) and (*b*) payment of additional expenses resulting from the illness. The problem of financing long-term illness, for some individuals, can be of a magnitude which exhausts their resources unless suitable mechanisms are available to help cushion such expenses.

These broad characteristics, among others, impose certain needs which should be basic in all efforts and programs on behalf of long-term patients.

COORDINATION OF SERVICE

Perhaps the most obvious need is for maximum coordination—with the patient as the focal point and the attending physician as the coordinator—between the various types of facilities, disciplines, and programs which may be involved in meeting the patient's needs at one time or another.

Such coordination is imperative from two standpoints:

(1) Maximum effectiveness and continuity of care for the individual patient.

(2) Most efficient use of facilities and services now existing, with a consequent reduction in the economic burden of long-term illness to the patient and community.

From the patient's standpoint, such integration can be achieved through (*a*) maximum involvement of participating professional disciplines—both within and between facilities—in a team approach to the patient's needs; (*b*) emphasis on continuity of care for patients transferred from one facility to another through exchange of complete medical and social information; and (*c*) prior arrangements for immediate referral to the appropriate facility as the patient's needs change. Such coordination can be of immediate benefit to the patient in terms of more comprehensive care, often reduced length of dependency, and a lessened drain on his financial resources.

The physician has a special responsibility to assume leadership of the care team involved with his particular patient. This responsibility involves not only providing his own professional services, but developing a detailed restorative plan directed toward returning the patient to health as soon and as far as possible, and for supervising the details of therapy provided by other professional personnel. The physician must be informed on the other services and facilities for long-term care available in his community and know how to use these effectively in achieving the best possible care for his patient.

On a broader scale, facilities and services for long-term care in too many communities are currently operating on a segmented or jurisdictional basis. The result may often be a duplication of some services and an absence of others with a resulting reduction in efficiency and increase in overall cost.

Centralized counseling and referral services for long-term patients, their families, physicians, and others involved in care can play a role in helping to solve this problem. Such services have been established in a number of large cities, and are equally practical for rural or semirural areas. They maintain centralized information on long-term facilities and services in the community, assist patients and others in finding the proper facility, and through educational and factfinding programs, stimulate increased cooperation between different care resources. AMA has published a study of four such information centers, operating in Cleveland, Chicago, Milwaukee, and San Francisco, and has endorsed further development of such referral and information agencies in other areas.

Another approach is offered by voluntary areawide planning committees or councils which can coordinate planning for new hospital facilities and help eliminate both duplication of costly equipment and gaps in service. This concept might well be extended to include all types of facilities, programs, and resources involved in care of the long-term patient.

An example of this approach is the joint program being conducted in Ohio by the Academy of Medicine of Columbus & Franklin County and the local areawide planning agency. Through the combined efforts of these and other community agencies a study of existing chronic illness services and facilities in the community is being conducted as the first step in a plan to develop a comprehensive spectrum of services for the long-term patient. It is anticipated that experience resulting from cooperative ventures such as these will be helpful to other communities in meeting the needs of their long-term patients.

REHABILITATION

A second basic need extending across all types of facilities, resources, and disciplines involved in long-term care is for an increased emphasis on rehabilitation. To a much greater extent than now observed, rehabilitation should be incorporated as an integral part of medical care, with important implications for prevention, rather than viewed as an isolated action to be tacked on at the end of definitive medical care. In many cases, deferring rehabilitation until the acute phase of illness has passed, rather than applying such procedures early in the onset of trouble is, in a sense, creating disabilities which need not exist. Rehabilitation as an integral part of care often prevents further deterioration and cuts down the need for prolonged medical treatment.

Too ofen, the individual with an advanced degree of disability, for whom complete independence is not possible, is "smothered" with attention and personal service rather than being encouraged to regain the ability to walk, sit up, or even feed himself. The improvement in motivation and patient morale resulting from even slight gains in self-care are generally acknowledged. What is not so widely appreciated is that rehabilitation for this group, as much as for those who can return to jobs, can save money. A net saving in costs of care has been demonstrated by restorative efforts with advanced disability groups. Such efforts are amply justified on humanitarian grounds alone—surely a demonstrated saving in costs of care eliminates the last possible impediment to deserved attention for these individuals.

An effective rehabilitation program—whether operated in a hospital, nursing home or other setting—does not necessarily imply a complex range of facilities and equipment. Valuable restorative measures, instituted under medical direction early in the course of illness can be as simple as proper bed positioning, exercise and ambulation, retraining in activities of daily living, and correction of sight, hearing, dental or orthopedic handicaps with proper medical appliances. Arrangements for more complicated procedures can be made with other appropriate community facilities whenever indicated.

HOME-CENTERED CARE

A third need is for greater attention to the development of home-centered patterns of care. Most long-term patients can best be cared for at home during much of their illness if proper supportive services under medical direction are made available, and many prefer care in this setting. The provision of such services through coordinated home-care programs, homemaker services, or visiting nurses can help keep the patient in this psychologically therapeutic environment and, in some cases, effect a cost saving as well.

HOME-CARE PROGRAMS

Coordinated home-care programs can complement medical care of the patient at home through the provision of nursing, social, restorative and related services, coordinated through one central agency. These programs, many of which were originally established as a substitute for unavailable hospital beds, are beginning to emerge in their own right as a first-choice approach for certain patients or a patient in certain phases of his illness. As early as 1956, the AMA surveyed 31 such home-care programs operating in this country. Since that time, AMA has cosponsored a series of national and regional workshops on home care in cooperation with other national concerned organizations, and has assisted State and local medical associations to implement the development of such programs in their areas. In cooperation with other national organizations, we are presently preparing guides for the development and administration of coordinated home-care programs.

Significant progress is being made in expanding such programs. In addition, a considerable number of hospitals, nursing agencies and other groups in this country are providing one or two specific services such as home nursing or physical therapy to homebound patients, on an individual basis rather than under a formally organized home-care program.

However, further study is needed to identify and overcome problems which may be impeding the maximal development of coordinated home-care programs. Some of these problems may include:

(a) Little incorporation of such programs into the traditional voluntary insurance and prepayment financing mechanisms for health services. Many of

the programs today are being financed only by tax funds on a demonstration-grant basis. When the grant expires so does the program. More exact data on the actual cost of home-care programs will permit greater participation by Blue Cross, Blue Shield, and private insurance companies in underwriting such services. Then, too, with the present relatively small number of programs, services cannot be provided on any substantial scale to insured patients. Progress along these lines has been made in such areas as Detroit, Mich., and Rochester, N.Y., where organized home-care services have been included under Blue Cross coverage. More such efforts are needed.

(*b*) Concern by private physicians as to the possible effect such programs might have on the physician-patient relationship. An encouraging trend currently is to organize such programs around the private patient and his physician, with the personal physician prescribing needed home services to be furnished by the home-care team. More information and orientation concerning such programs and their benefit to selected patients needs to be directed to the private practitioner. The attitude of such national organizations as the American Hospital Association, American Medical Association, and the U.S. Public Health Service which endorse the concept of home-care programs, should be made known so that the physician, hospital administrator, and public health officer can work together to develop additional programs where needed.

(*c*) Hesitation or feelings of inadequacy by the patient's family about having him at home. The physical and emotional burden of having an ill person at home over a long period of time must be measured very carefully in terms of the particular family involved. Thorough evaluation and counseling is needed with all potential "home-care families," as well as continuing assistance and guidance once the patient has returned home.

Finally, all the costs of providing organized home care need to be carefully analyzed. Evidence is accumulating that a truly comprehensive home-care program is not cheap. The value of such a program lies in its tailoring of service to the individual patient's needs, not in providing cutrate care.

There seems to be no one type of agency particularly suited to administer a home-care program. To a great degree, it will depend on the resources existing in the individual community. One program may be administered by the community hospital; another by a council organized by the medical society, or by the local visiting nurse association; a third by another sort of organization set up specifically for this purpose.

In general, many of the services which could be coordinated through a home-care program are already being provided on a limited scale in communities of any substantial size. Additional needed services can be initiated or purchased from other sources once the administrative mechanism has been set up. It is the organizational pattern and leadership to crystalize the pattern which is more commonly lacking than the actual physical and service resources.

The importance of establishing close working relationships between the home-care program, hospitals and nursing homes in the community should be emphasized. Such cooperation can facilitate transfer of patients back and forth as their needs change. It can often make possible earlier discharge from institutional care, prevent readmission, or obviate the need for institutionalization in the first place.

HOMEMAKER SERVICES

Community homemaker services provide home help in the areas of household work, meal preparation, shopping, and personal services to families. Although only one part of a comprehensive spectrum of home-centered services, they merit specific mention here because of their value when family unity is temporarily threatened by illness, social maladjustment, death or other crisis. Homemaker programs today can prove of considerable value to four general groups:

(1) Families with young children where the mother is temporarily ill or absent.

(2) Older persons who can remain in their own homes if provided some assistance with housekeeping duties or personal care.

(3) Long-term patients who can be cared for at home with the help of this service.

(4) New and expectant mothers.

Although homemaker services were originally primarily a service for families with young children, they are currently assuming increased importance as a way of enabling the long-term patient to receive the needed home care in his own home. Because of this shift in emphasis and because over 90 percent of

homemaker placements involve illness of one or more of the family members, homemaker services should be considered an integral part of a health care program, as are nursing, social work, physical and occupational therapy and other services. A relatively new application of these programs is the incorporation of homemaker services in a total psychiatric care program. Homemakers help in maintaining the homes of mothers institutionalized for psychiatric care, and help smooth the mother's transition from hospital back to the family setting. They have also been placed in the homes of a sizable number of older patients who had responded well to psychiatric hospitalization, been released, and then readmitted in short order because of social situations at home.

The newly published 1964 Directory of Homemaker Services lists over 300 homemaker programs presently operating in this country. This is a 50-percent increase in the number of programs since the last such directory was issued in 1961. However, there is still room for considerable expansion in such programs, to meet demonstrated community needs. The AMA has actively encouraged the formation of community homemaker programs, through its State and local medical societies, the woman's auxiliary, and other channels. AMA was a cosponsor of the 1959 National Conference on Homemaker Services, has published a bimonthly Homemaker Services Bulletin since 1960, and participated actively in the 1964 National Conference on Homemaker Services held recently in Washington.

Some of the priorities in achieving this needed expansion of homemaker services include:

(*a*) Increased effort by voluntary and public health agencies and organizations at both national and local levels.

(*b*) An increase in well-grounded, comprehensive training programs for homemakers, in such settings as university extension divisions, local public schools or Red Cross chapters.

(*c*) Increased extension of formally organized services on a fee-for-service basis.

(*d*) Increased allocations of funds by voluntary and public agencies for inauguration of programs.

(*e*) Increased casework and counseling services for those families requiring homemaker services over an extended period, in order to foster efficient use of homemaker personnel.

(*f*) A more realistic understanding as to what the homemaker may do in the way of personal care.

FINANCING OF CARE

As noted before, the long-term patient is often faced with a financial problem in terms of (*a*) maintenance of income for regular living expenses; (*b*) payment of additional expenses resulting from the illness.

A variety of devices has been developed through which income is maintained, in whole or in part, for some long-term patients, including voluntary insurance plans, workmen's compensation, nonoccupational disability insurance, old-age and survivors' insurance and public assistance. To these, of course, should be added the very important "device" of personal and family resources. These methods should be continued and their use further developed with particular reference to the long-term patient.

PAYMENT OF MEDICAL AND RELATED EXPENSES

Expenses resulting directly from a long-term illness are currently met in a variety of ways, including direct personal financing, voluntary health insurance, philanthropic agencies and voluntary contributions, workmen's compensation and nonoccupational disability insurance. These methods should be expanded and further developed. Until the time when the needs of all long-term patients are adequately met under plans or programs such as those listed here, there is no alternative to the basic proposition that society as a whole, through taxation, must meet the deficit and fill the gap. Funds for this purpose should be provided at the community, the county, and the State level as far as possible, and only when all these are insufficient, at the Federal level, and then only in conjunction with the other levels of government in the above order. The administration of such funds and programs should be kept as close to the persons being served as is compatible with efficiency and economy and should be on the basis of demonstrated individual need.

HEALTH INSURANCE

For persons who are able and who wish to pay the premiums, either directly or through employer contributions or otherwise, voluntary health insurance has demonstrated its effectiveness in financing better care of long-term illness.

The rapid expansion of health insurance and prepayment protection among all age groups has unquestionably been one of the most interesting phenomena of the past two or three decades. Figures released by the Health Insurance Institute indicate that, as of January 1963, 141 million persons were protected by hospital expense insurance; 131 million were covered by surgical expense insurance; and 98 million had regular medical expense insurance. In addition, 38 million were protected by major medical expense insurance; and 43.5 million were covered by loss-of-income insurance

Too, there has been continued growth in quality as well as quantity of coverage—in scope of benefits and percentage of important expenses covered as well as in number of persons protected. This growth in quality is illustrated by statistics from the U.S. National Health Survey for the years 1958–60 which show that, in cases where health insurance was in effect and utilized, over 60 percent of patients discharged from short-term hospitals after a stay of 31 days or more had more than three-fourths of their total hospital bill paid by insurance.

Improvement in quality is illustrated, too, by the rapid growth in major hospital and medical expense protection, and by the expansion of health insurance protection to cover nursing home and other out-of-hospital services. These two types of coverage are of special significance in the financing of care for long-term patients.

Major hospital-medical expense protection has been one of the fastest growing of all types of coverage. After a deductible amount, these plans provide payment for 75 to 80 percent of virtually all categories of health care expenses incurred as a result of catastrophic illness, up to limits as high as $10,000, $15,000 or even, in some instances, $30,000. Over the last 8 years, the number of persons protected under this type of plan has grown from 2 million to over 38 million as of January 1963. The plans range from the supplementary type of policy, which complements basic hospital, medical, and surgical protection; the comprehensive type plan, combining the elements of both basic and catastrophic protection.

This type of coverage is particularly suited to the needs of the long-term patient, who may require a wide variety of services over a protracted period of time. Further expansion of such catastrophic coverage plans is needed.

Progress is being made and more progress is needed in expanding health insurance protection to cover nursing home and other out-of-hospital services. As of September 1963, 78 insurance companies were making available specific coverage for nursing home care, either on a direct individual or group basis, or in conjunction with the other insurance companies participating in the special "65 plus" insurance pooling plans offered to older persons in Connecticut, Massachusetts, or New York. At least 50 of these programs provided coverage on a group basis; about 20 were written on an individual or family basis; and 7 made it available on both a group and individual basis. The programs cover a range of 30 to 200 days of care per illness or per calendar year, and provide benefits of from $5 to $25 per day or care.

Thus, health insurance to cover the cost of nursing home services is becoming increasingly available. In the early stages of this expansion, most of the coverage was for people age 65 and over. By 1963, however, the majority of the coverages were available to persons of all ages or to persons in younger age groups.

In a majority of the plans providing nursing home coverage, previous confinement in a hospital is required. Perhaps a reappraisal of this requirement is in order, since it may sometimes encourage inappropriate institutionalization, with resulting increase in costs. Other methods can doubtless be utilized to assure the insurance company protection of an adequate diagnosis for a covered illness.

As more administrative and cost experience becomes available on home care programs, hopefully there will be a further expansion of voluntary health insurance protection to cover these and other home-centered patterns of health care.

It goes without saying that the improvement in all types of health insurance protection in no way negates the desirability of the individual continuing to prebudget or set aside funds for his own future health expenses outside of any insurance mechanism. It is this combination of individual budgeting for predictable health expense and insurance "backstopping" for the large, individually unpredictable expense which provides the most effective use of the premium dollar.

PUBLIC ASSISTANCE

Public financing of medial care for long-term indigent and medically indigent patients needs to be improved in many communities, wherether for long- or short-term general hospital care, mental and tuberculosis hospital care, nursing home care, rehabilitation services, or care at home.

More effective administration of funds for health services is one of the most urgently needed improvements in the tax-supported public and general assistance programs, both of which serve a significant number of long-term patients. Perhaps the most important need is to insure that present assistance policies point toward restoring the needy sick to health and independence as soon as possible, rather than being set in patterns which encourage prolonged institutionalization and depnedency, with "rewards" for sickness rather than for progress toward rehabilitation.

The Kerr-Mills MAA program has proved to be an effective mechanism in many States for preventing complete dependency in one group—those individuals over 65 who are faced with a financial problem because of catastrophic illness. This emphasis on prevention of dependency should be applied in all present tax-supported programs, for whatever age group. All public provisions for financing should be such that funds are available for the kind of care best suited to each patient's needs.

IMPLICATIONS FOR THE HEALTH PROFESSIONS

To round out the picture as to needs of the long-term patient, a brief examination of the implications posed for the health disciplines and resources primarily involved in his care is in order.

THE PHYSICIAN

The responsibility of today's physician to his long-term patients is well exemplified in the words of the National Commission on Chronic Illness, to the extent that they bear repeating here:

"In retrospect, the job of the family doctor of 50 years ago seems fairly simple. He had perhaps never heard of a medical social worker and had never seen a therapist. Specialists were few and their consultation resorted to only in exceptional circumstances. He could not look for help to many of the modern diagnostic aids and treatment services, for they had not yet been devised. His duty was not so defined, but nonetheless he could plainly perceive it: to be to his patients medical practitioner, social worker, health educator, and friendly guide. The degree to which he was able to do this is evidenced by the reverence in which he is held. Strengthened by the discoveries of medical science and the development of the paramedical disciplines, medical practice at its best can bring today's patient the service and the solace the family doctor used to provide, but raised to a higher power.

"The private physician's role is to do just that. He is the medium through which this comes about. It is he who must determine the nature, time, and place for the patient's diagnostic workup and therapeutic services. He is the one in best position to keep abreast of the patient's total and changing needs and so to insure that all the possibilities for treatment are being realized. The full exercise of this role is of special importance to the long-term patient, who may need so many different kinds of help over so long a period of time.

"It would, of course, be unrealistic to suggest that the personal physician should maintain primary responsibility for all phases of treatment at all times. His continuing participation may consist of relinquishing responsibility in certain situations, sharing it to varying degrees in others, and assuming complete responsibility for periods of time of phases of treatment.

Medical schools have an important responsibility in care of the long-term patient. There is an increasing need for "complete physicians who are trained to guide the patient and his family through the intricacies of long-term illness; who are oriented toward providing continuous preventive and curative care to the patient in the home as well as in the office and hospital.

The family practice residencies and training programs now underway in a number of hospitals are a positive step toward meeting this need. In programs such as those operated by the Harvard University Medical School and the Hunterdon (N.J.) Medical Center, the student, intern, or resident participates in a continuity of care as it is provided in the hospital, the nursing home, the physician's office, and the patient's home, thus seeing the patient, his illness, and his family environment as an interrelated whole. He learns how arrangements are made to transfer the patient to the nursing home or home care program; he learns to conserve hospital beds by preventing unnecessary admissions; and he is exposed to health insurance and welfare programs. He learns to appreciate the role of the family physician as the central figure coordinating these needed community services on a continuing basis for each patient.

THE DENTIST

Dental care plays a major role in the treatment of many patients with long-term illness in that good mastication and absorption of food is an important condition for adequate nutrition.

Perhaps the major immediate challenge facing the dental profession today is the provision on a larger scale of dental care to long-term patients confined to their home or an institution.

Although dentists will make home calls to relieve painful and infectious conditions, the dental care of any large number of homebound chronically ill persons is limited because of the lack of organized programs, facilities, and sometimes appropriate equipment to provide such care.

Nor can many of these patients expect to receive needed attention during periods of care in an institution. Most large hospitals have dental facilities for their patients, or arrangements for needed dental care, but many institutions which care for primarily long-term patients do not. Many small hospitals, homes for the aging, nursing homes, and similar institutions have no regularly established arrangement for referral of patients for dental care, for continuing dental consultation, or for provisions for visits by dentists when needed.

The dental profession has responded and continues to respond effectively to this challenge. In Connecticut, for example, the State dental association, in conjunction with the U.S. Public Health Service chronic disease program, State health department, State chronic and convalescent hospital association, and other groups initiated a coordinated demonstration program to provide dental care for long-term patients both at home and in institutions in New Haven County. Following a disability evaluation, patients receive a dental evaluation and services in the home or the institution, utilizing portable equipment specially designed for this purpose, or are transported to the outpatient department of the local dental clinic for needed care. Whenever possible, arrangements are made whereby the patient may receive care from his own dentist; otherwise, dental services are provided by participating members of the dental society. One important purpose of the demonstration is to determine accurately the cost of such services.

Similar pilot programs have been conducted in other localities—notably Kansas City and the Jewish Hospital of St. Louis. More efforts along this line are needed. The more uniform cost data hopefully forthcoming from these and other studies will assist greatly in the expansion of insurance and prepayment plans for dental care, where needed, to supplement the excellent bank postpayment plans sponsored by dental societies in most areas of the country today.

The dentist is in an excellent position to appreciate the close interrelationship between one health factor and another. He has seen the effect which poor dental health can have on nutritional adequacy, emotional health, and even social adjustment. Somewhat naturally, then, his work is oriented toward the total needs of his patient.

THE NURSE

The professional nurse has a vital part to play in the long-term-care "team." Next to medical supervision, nursing care is perhaps the service most often needed by long-term patients. In addition, whether she (or he) is providing care in an institution or in the home, it is the nurse, in many cases, who is afforded the most intimate and continuing contact with the long-term patient—in some instances, on a round-the-clock basis. As such, the nurse should ideally constitute the "focal point" in coordinating the various aspects of care ordered by the physician, and seeing that such services are carried out on a day-to-day basis. In filling such a role, the professional nurse will and should become familiar with every aspect of the plan of management within her province.

In addition to providing all nursing procedures ordered to implement medical care, the nurse can serve as the physician's "right arm" in two other important areas.

(*a*) Instruction concerning the specific disease and for general health promotion and maintenance. Both patient and family need to understand the illness and its usual course—and how to avoid preventable complications or recurrence.

(*b*) Emotional support and guidance. The nurse can support the physician in helping the patient and his family understand, accept, and adjust to illness and physical limitations, whether temporary or permanent.

For the nursing profession, perhaps the primary challenge—both in training and practice—is a relearning of established nursing concepts—a shift in emphasis from "doing for" the patient to helping him "do for himself."

Traditionally, nursing has been a service of doing everything for the patient, and patients themselves may expect this.

Experience has proved however, that the patient benefits most when nursing personnel assist him in relearning even elementary personal functions of daily living.

Despite significant advances in medical, surgical, and rehabilitative techniques, the belief that care of long-term patients is uninteresting and unproductive in terms of physical and mental improvement still persists to a degree among the nursing and other health professions, with the result that personnel to work with the long-term ill remain in short supply. The problem of involving more health personnel in work with long-term patients is many faceted, stretching across such areas as increased professional and community recruitment, scholarships, stipends and similar assistance, and more adequate job compensation and working conditions, to name just a few. In itself, it is only part of the broader problem of personnel shortages among all health disciplines. Nonetheless, wider recognition by the health professions that care of the long-term patient can be a professionally rewarding and dramatic service to humanity is of first importance. Here again perhaps the major challenge is to those responsible for professional education.

Young nurses, and those at the student level must be afforded more opportunity to participate in care of the chronically ill and disabled, and to see at firsthand how modern concepts of therapy can radically brighten the outlook for many long-term patients. One promising development along this line is that of contractual arrangements between hospital schools of nursing and nearby nursing homes, whereby student nurses are provided inservice training in care and rehabilitation of chronically ill patients in the nursing home. This idea is just beginning to be explored in a number of localities, and, hopefully, will receive further emphasis in the future.

Mention should be made here of the encouraging trend toward improved utilization of the nursing personnel now available and the upgrading of knowledge and skills of all nursing workers. The increasing number of nurses working on a part-time basis is a promising development in alleviating the shortage of nursing personnel.

NURSING HOMES

Nursing homes today are undergoing somewhat the same evolution in patient care as that experienced by hospitals a few generations ago. Much progress has been made in improving the quality of care in nursing homes. In many instances, nursing homes can now be stepping stones to a patient's return to his home and family. However, as a whole, the potential of nursing homes as a link in the chain of medical facilities caring for the long-term patient has not as yet been fully realized.

Each home should make every effort to help patients achieve their full potential for self-care or independence. Nursing home staff need increased orientation to the needs of the long-term patient and the concept of rehabilitation. Health and welfare agencies should be encouraged to expand their on-the-job training programs for nursing home personnel.

Not all nursing home patients can benefit from rehabilitation, of course. Some older patients come into a nursing home because their physical and emotional condition is so deteriorated that it is impossible for them to live by themselves or with their family. In addition, such patients may often exhibit emotional and behavioral disturbances which complicate chronic physical disability. People who are emotionally normal under ordinary circumstances present problems when they are frustrated by chronic illness and institutional living. For such debilitated older patients, self-sufficiency in walking, washing, eating, dressing, and toilet activities are perhaps the only practical rehabilitation goals. In most such cases, we will do well if we maintain the patient at his present level and prevent further deterioration.

However, limited rehabilitation goals in no way diminish the value and importance of rehabilitation efforts, as long as there remains a possibility of improvement in the level of functioning of the patient. The important thing is that some potential for rehabilitation does exist in the majority of nursing home patients. In some, the potential may be only for a greater degree of self-care. For others, return to complete independence may be a practical goal. But in either case, successful rehabilitation will depend to a large extent on the missionary zeal of staff in instilling within patients the will to achieve more independence.

Good nursing homes may lessen demands upon many communities for additional hospital beds. Various studies have indicated that at least one-third of the patients who remain in hospitals 30 days or more do not require the services of a general hospital. The majority of these patients could receive adequate care in a nursing home, or possibly at home under a program of home care. Each locality, of course, needs to determine its own situation concerning the relative need for hospital and nursing home beds.

There is no doubt that nursing home patients need a substantial amount of active medical treatment. Continuing care and surveillance are essential to maintain the medical and functional status of these patients. Passive care or discontinuous medical management only invite physical and mental deterioration. Whatever else the nursing home offers, it is to be expected that nursing care constitutes its essential and distinctive service. In this connection, professional status of nursing homes is showing improvement. According to a 1961 Public Health Service study, nearly 9 out of 10 skilled nursing homes had at least 1 full-time registered professional nurse or licensed practical nurse.

STANDARDS OF CARE AND JOINT AMA–ANHA ACCREDITATION

As noted previously, many voluntary health insurers are exploring ways of providing coverage for nursing home care of the chronically ill. The present joint development of recognized standards of care and an accreditation program for nursing homes by the AMA and the American Nursing Home Association will, it it hoped, further stimulate insurance coverage for nursing home care, which, in turn, will encourage the use of these less costly facilities in warranted circumstances.

These well-defined standards relating to patient care will provide a sound and realistically flexible basis for evaluating nursing home services. The standards are designed not only to recognize those homes eligible for accreditation, but to provide the incentive and goals for improving patient care in other nursing home facilities. Such a voluntary accreditation plan, which is sponsored and administered with the cooperation of the professional organizations concerned with nursing home care, will encourage and facilitate the establishment and maintenance of good nursing homes.

Physicians and the local medical society in cooperation with dentists, hospitals, nursing homes and other community agencies are assuming responsibility for assisting nursing homes to achieve high standards of care. At the national level, the AMA and the American Nursing Home Association have for some time been working together to encourage better communication between physicians and nursing home administrators. Some of the fruits of this liaison have included a survey of some 4,500 member homes of the ANHA, a guide for medical staff

bylaws in nursing homes; and cosponsorship or participation in a number of institutes on nursing home care in various parts of the country. AMA, in cooperation with the ANHA and the American Hospital Association, has also prepared and widely distributed a pamphlet entitled, "Suggested Guides for Medical Care in Nursing Homes and Related Facilities." A copy of the pamphlet is attached for the information of the subcommittee.

HOSPITALS

The "general" hospital of today is, in a sense, misnamed. The term "general" is appropriate in that patients in such an institution will exhibit a variety of diagnostic entities. It is inappropriate, however, in that the majority of today's "general" hosptals are geared to provide one thing—acute medical care. They may be "general" in that obstetric patients and appendectomy cases are housed within the same institution. Their staffing patterns, facilities, and equipment are "specialized," however, to the extent that they are set up primarily to provide one level of care.

The changing pattern of illness during the past half century, the shift in emphasis from acute illness to the long-term degenerative disorders, make it imperative that today's hospital assume a broader role in assisting the physician to plan for the total care of patients in this latter group.

It is of little long-range value for the physician to meet the patient's needs during an acute flareup of long-term illness and then discharge him without sufficient provision for followup care. The result may well be a loss of any gains made in the hospital, and a need for repeated episodes of hospitalization. Similarly, it is of little benefit to either patient or hospital to maintain the patient in a bed geared to intensive round-the-clock medical care when he requires merely some degree of nursing service under medical supervision, or perhaps a graduated program of restorative therapy. The current in-hospital emphasis on "early ambulation" and discharge can be extended to include "early return to the community," to the extent that the hospital cooperates with the physician to insure the patient's discharge to a setting favorable to his continued progress.

The hospital can broaden its scope of services on two fronts, to assist the physician in meeting the needs of long-term patients. Within the institution there is the opportunity to make possible better, more efficient and more economical care through the development of special units, tailored in terms of hospital staff, equipment, and physical layout to the differing level of care which may be required by a long-term patient who is not medically ready for discharge to a nursing home or similar facility, but who does not need the intensive 24-hour care best provided in a hospital setting.

The majority of today's hospitals could well include special provision for restorative services for those with long-term illness or disability. Restorative procedures can be of greatest value for many long-term patients when they are instituted early in the onset of disease or disability—the period when the patient is often hospitalized.

The same justification can be made for providing psychiatric services in the general hospital. In the general hospital setting, the emotional problems which often accompany long-term illness can often be diagnosed and treated in the stage when they are most responsive to therapy. The institution of such services by the physician in the hospital will help to ameliorate the over-crowding which is practically universal among mental institutions. It will also be another important step in the move to bring mental health resources back into a preventive community setting—a move exemplified by the development of community mental health centers and greater emphasis on the family physician as the "first line of defense" in mental health problems.

The hospital can assist the physician on another front to meet the total needs of his long-term patients, through increased cooperation and exchange of necessary information with other care facilities and services in the community, whether they be nursing homes, rehabilitation centers or homemaker programs. The physician's responsibility should not end when the patient has received maximum benefit from in-hospital services but should extend to seeing that the patient is discharged to a setting which will maintain and improve the gains made during hospitalization. The hospital can greatly assist the physician in achieving this goal, through an extension of social case-work and discharge planning services within the hospital, and a prior knowledge of the community resources most appropriate for the patient's continued progress.

INTEGRATION WITH GENERAL MEDICAL CARE

One final and basic need should be stressed; a need which has been implied throughout this statement but merits reemphasis in its own right. In the words of the Commission on Chronic Illness:

"Care of the chronically ill is inseparable from general medical care. While it presents certain aspects, it cannot be medically isolated without running serious dangers of deterioration of quality of care and medical stagnation."

This need applies to all long-term patients, regardless of whether the condition producing long-term impairment is labeled "chronic," "acute," or "accidental."

More attention to long-term patients is needed, but not as a "special" group for whom the treatment emphasis automatically shifts from therapeutic to palliative. Prevention, care, and rehabilitation of long-term impairment must be woven into the warp and woof of general medical care as a simultaneous or continuing process. "Care of long-term patients" as a special type of medical endeavor, might much better be called "care of patients"—who have a long-term impairment.

Guides for Medical Care in Nursing Homes and Related Facilities

Approved by the Board of Trustees of the American Medical Association, the Governing Council of the American Nursing Home Association, and the Board of Trustees of the American Hospital Association, June 1960

PREFACE

The United States today has over 25,000 in-patient facilities other than general hospitals with an estimated capacity of 450,000 beds. These facilities have been grouped under the category of "nursing homes." More than 20,000 of these facilities are proprietary, or commercially owned, accounting for some 232,000 beds. The remainder are under public or nonprofit ownership, and account for approximately 218,000 beds.

Grouped under this term "nursing homes" are facilities ranging from children's convalescent homes to county poorhouses, from institutions providing every general hospital service except surgery, to boarding homes providing the simplest of supportive services to relatively well older persons.

Primarily, however, these facilities, by whatever name they are called, are caring for people who are old. The average age of patients in all types of facilities is 77. The great majority are over 65.

It is generally recognized that the standards of care in a sizable portion of these facilities can be improved. It is also recognized that the need for such facilities can be expected to increase with the growing number of older persons in our population and the wider use of such facilities for posthospital convalescent care.

As a service to these facilities, their patients, and the physicians caring for these patients, the following guides for medical care in nursing homes and related facilities have been developed. These guides are suggested to assist physicians in making the best use of such facilities, and to aid administrators of these facilities in seeing that their patients receive proper medical attention.

NURSING HOMES WITH SKILLED NURSING CARE AND NURSING HOMES WITH SKILLED NURSING AND PERSONAL CARE

1. Each patient admitted should have a personal physician who knows of the admission arrangements and agrees to assume responsibility.
2. Each patient admitted should come with a complete history and physical examination, or should have such examination immediately upon entering the home, including chest X-ray, necessary laboratory work, an evaluation of his potentialities for rehabilitation, at least to self-care, and full orders for treatment. These orders should be kept up to date by daily nursing notes and periodic progress notes by the physician as well as written directives for care and medication as they are changed.
3. Each patient should have periodic visits by his personal physician. The frequency of these visits should be dictated by the medical needs of the patient.
4. Each patient should be served, in case of emergency, preferably by his own physician.

5. Each skilled nursing home should have a principal staff physician or physicians for consultation in general medical policies of the home. He or they would also be available for emergency calls when the patient's regular physician is unavailable. This physician or physicians would also advise the nursing home administrator in matters pertaining to administrative procedures, nursing care, physical or other restorative therapy, special dietary arrangements, storage, and dispensing of medications, and medical records.

6. Each skilled nursing home should make every effort to help patients to achieve their fullest potential for self-care, through treatments and procedures ordered by the patient's physician. These procedures may be as simple as early and progressive ambulation, the correction of sight, hearing, dental or orthopedic handicaps with proper appliances, retraining in the activities of daily living, the use of heat packs or lamps, and simple, graduated exercises for strengthening of affected parts. For the more complicated procedures, skilled nursing homes could well arrange for the part time or visiting services of a professional therapist to provide (under the direction of the M.D.) direct services and to train the home staff in many simple procedures. The home may even maintain special rehabilitation facilities under the supervision of a professional therapist. Rehabilitaton procedures which are beyond the scope of the home should be provided through cooperative arrangements with other appropriate community facilities and agencies.

7. Each nursing home should have arrangements with a nearby general hospital for the transfer with minimum delay of any patient whose condition requires it.

8. Each nursing home should maintain liaison with physicians of the local medical society for the purpose of obtaining consultation and guidance on all matters affecting medical care.

9. Each nursing home should consider using consultative services in nutrition and diet therapy provided by the State health department, or by other agencies or persons qualified to perform such service and should assure that all dietary regimes ordered by the patient's physician are carried out.

10. Each nursing home should be conscious of the dental needs of its patients. A dental evaluation of the patient should be included in the health record. The patient should be seen as often as necessary by his own dentist, if available, or by a principal dentist selected by the home.

HOMES FOR PERSONAL CARE AND HOMES FOR THE AGED

1. Each patient should have named in his admission record a personal physician who could be called in case of need.

2. Any patient who is under physician care should come to the home with written orders by his personal physician for continuing his program of medical care.

3. Personal care and old-age homes should have arrangements with a physician to serve as a medical adviser for the home as a whole and to provide emergency care whenever the patient's own physician is unavailable. This physician should serve as consultant on medical care and related matters such as restorative therapy, special dietary arrangements, storage and dispensing of medications, and medical records.

In general, the medical activity envisioned as going on in this type of home and this segment of a larger nursing home is equivalent to that type of medical activity provided in an individual's own home.

4. Periodic health examinations are recommended.

5. The maintenance of good mental and physical health is dependent on supervised physical activity and mental exercise and stimulation. Preventive and rehabilitative programs to this end should be the responsibility of the administration in this type of home. If patients are up and about, every effort should be made to keep them ambulatory, through proper diet, preventive exercises, preventing accidents, interesting and stimulating activities, and immediate recognition of any signs of deterioration. Every effort should be made to assist bedbound patients in becoming ambulatory, through progressive bed exercises, and then assistance in getting up for longer periods each day, unless such patients are bedbound by physician's orders.

6. Nutrition and diet information may be obtained through consultants at the State health department or other appropriate agencies, and all necessary special diets should be arranged for by the home.

7. The patient's dentist should be known and consulted as often as necessary.
8. Personal care and old-age homes should have arrangements with a general hospital for immediate transfer of any resident who needs intensive medical care.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., May 20, 1964.

Hon. FRANK MOSS,
Chairman, Joint Subcommittee on Long-Term Care,
Senate Committee on Aging, Washington, D.C.

DEAR SENATOR MOSS: The American Nurses' Association sends the enclosed statement and publications relating to standards of nursing care in nursing homes, to the functions of the licensed practical nurse, and to auxiliary personnel in nursing service and requests that all these be included in the record of the hearings of your subcommittee.

Sincerely yours,

MRS. JUDITH G. WHITAKER, R.N.,
Executive Director.

Enclosure.

STATEMENT OF THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association, the professional organization of registered nurses, wishes to comment on the subject of standards of care in nursing homes, which is under consideration by your Joint Subcommittee on Aging. We will not burden the record with statistics for we know that the Committee on Aging has ample evidence and documentation of the problems arising from the needs of an ever-increasing older population. We are concerned with the kind and quality of care given to our older citizens in the various institutions to which they are admitted.

We believe that one of the gravest concerns in the health care field is the mounting number of older citizens who, because of the nature of their illnesses, generally need a different kind of institutional care than is provided in the general hospital. The changes in the age group in the population and in disease trends have stimulated the growth of the nursing home industry. The Public Health Service has defined the homes serving the aged as (1) skilled nursing homes, which provide skilled nursing care as their primary and predominant functions; (2) personal-care homes which provide domiciliary or personal-care functions but may also provide some skilled nursing care; (3) residential care homes which have primarily residential or sheltered-care functions, but which also provide some skilled nursing care.[1]

Many of these homes have been built with Federal funds without due regard for the services which should be provided in the facilities. Whether they are privately owned and operated for profit or are nonprofit or public facilities, we believe that certain standards of care should prevail. Because the ANA was concerned about the lack of health care standards to guide the mushrooming nursing home industry, the ANA prepared and issued a statement entitled "Statement of Standards for Nursing Care in Nursing Homes" in August 1960. This statement is attached and we request that it be included in the record of the hearings.

The existing shortage of qualified professional personnel has caused institutions and agencies to employ a variety of workers to augment the nursing service. Much confusion exists regarding the nature of the work which the various categories of personnel can or should perform. The ANA has developed the following two statements which identify several of these groups of workers in nursing service and requests that these statements—"Statements of Functions of the Licensed Practical Nurse" and "American Nurses' Association Statement on Auxiliary Personnel in Nursing Service"—also be included in the record.

The ANA has met with other groups interested in developing standards of care in nursing homes, and remains ready to cooperate in any way feasible to establish criteria for the evaluation and accreditation of these institutions. About 90 percent of the nursing homes are proprietary, caring for about 70 percent of the total patients. Quality of services in such institutions are necessarily influenced by the need for realizing a reasonable profit from the enterprise.

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[1] "The Older American." p. 40, 1963 Report of the President's Council on Aging.

This increases the need and urgency for adequate and enforcible standards. If public funds are to be used to pay for care in nursing homes, we believe that such care should be purchased only in those homes which are accredited by recognized approving authorities involving all of the professional and health care groups concerned with patient care.

Thank you for the opportunity to express our views.

Statement of Standards for Nursing Care in Nursing Homes

The American Nurses' Association recognizes the urgent need to meet the major and growing problems of the great number of the aged and chronically ill patients in our country. The U.S. Public Health Service has informed us that 450,000 of these patients are now in 25,000 nursing homes, and that the number of both patients and nursing homes is steadily increasing. A special committee of the American Nurses' Association reviewed the publications of other national organizations that are concerned not only with the availability of nursing care facilities but also with the quality of care being given in these institutions. The American Nurses' Association concurs with the 1960 report of the U.S. Senate Subcommittee on Problems of the Aged and Aging, in which the subcommittee stated the solutions of the problems are the joint responsibility of all organizations and individuals in the United States.

In this statement of standards, therefore, the American Nurses' Association enunciates its policies for nursing care in nursing homes. In so doing, the American Nurses' Association accepts the responsibility of the profession to formulate the standards for nursing care for the patients. The statement is made with the knowledge of the characteristics of the patients in these homes as indications of the nursing services and facilities required.

The statement is made with the understanding that the major function of a nursing home is to provide nursing care. The American Nurses' Association accepts the definition adopted by the U.S. Department of Health, Education, and Welfare for purposes of developing its standards guide for nursing homes:

"The term 'nursing home' means a facility or unit which is designated, staffed, and equipped for the accommodation of individuals who are not in need of hospital care but who are in need of nursing care and related medical services which are prescribed by or performed under the direction of persons licensed to provide such care or services in accordance with the laws of the State in which the facility is located."

The American Nurses' Association, furthermore, believes that nursing homes should be licensed, and periodically evaluated by an official State agency in which the professional knowledge of medical and nursing personnel is available. A qualified registered professional nurse should be assigned by this State agency for the purpose of evaluating the nursing care in the nursing homes.

The quality and quantity of nursing care available to the patients are dependent upon the ability to recruit and retain qualified nursing personnel. A general improvement of employment conditions is essential to improvement of patient care in nursing homes.

The American Nurses' Association recommends that in all instances a registered professional nurse carry the responsibility for nursing care in the nursing home. In many instances in the nursing home, the patient's physician does not provide the degree of medical supervision that would be provided for the patient in the hospital. The registered professional nurse discharges her responsibilities in partnership with the physician. In this respect, the American Nurses' Association agrees with certain statements made in 1958 by the American Hospital Association "Listing Requirements for Inpatient Care Institutions Other Than Hospitals," as follows:

"There shall be a duly licensed physician or physicians who shall advise on medical administrative problems, review the institution's plan for patient care, and handle emergencies if the patient's personal physician is unavailable.

"Each patient shall be under the care of a duly licensed physician, and shall be seen by a physician as the need indicates.

"There shall be a medical record maintained for each patient, which shall include at least (*a*) the medical history, (*b*) report of physical examination, (*c*) diagnosis, (*d*) physician's orders, (*e*) progress note (medical and nursing), (*f*) medications and treatments given."

STANDARDS OF NURSING CARE IN NURSING HOMES

1. Skilled nursing care (including its preventive, curative, and rehabilitative aspects) is a necessity in a nursing home. Therefore, the nursing home should provide direct (preferably on the premises 24 hours a day) supervision of nursing care by a registered professional nurse.
2. The registered professional nurse in charge should preferably have had training beyond her basic nursing education in care of the aged and chronically ill, in patient rehabilitation, and in management and leadership.
3. There should be a registered professional nurse or a licensed practical nurse on duty at all times. The number and type of nursing personnel on duty should depend upon the number and condition of the patient population.
4. The registered professional nurse, who is responsible for the kind and quality of nursing care, has an obligation to protect the public by not delegating to a person less qualified any service which requires the professional competence of a nurse. However, certain aspects of the daily patient care may involve or be delegated to other personnel.
5. The registered professional nurse in charge should participate in the planning and budgeting for nursing personnel, equipment, and facilities.
6. The registered professional nurse in charge should have responsibility for the selection, orientation, supervision, evaluation, and employee development of professional and allied nursing personnel; this responsibility to be discharged in conformity with the functions, standards, and qualifications for practice as established by the American Nurses' Association.
7. The registered professional nurse in charge should coordinate and conduct the total nursing program. This would involve interpretation of medical orders and provision for restoration of the patient to his optimum physical, mental and emotional, and social potential.
8. The registered professional nurse in charge should participate in the screening of prospective patients in terms of kinds of care available in the institution.
9. There should be a nursing care plan established for each patient. In the development of the nursing care plan it is necessary to have a written statement by the physician regarding the nature of the illness. The condition of the patient, and the treatment prescribed.
10. There should be a nursing record for each patient. The registered professional nurse should be responsible for the accuracy of the reporting and recording of the patient's symptoms, reactions, and progress.
11. The registered professional nurse in charge should make rounds with the physician and confer with him concerning the patient's nursing needs.
12. The policies relating to the control of prescribed medicines and treatments should be in writing, defining frequency of medical review, and the recording and renewal of orders. These policies should have the approval of the consulting physician or responsible medical group.
13. All medical orders should be in writing and signed by the physician.
14. There should be written nursing policy and procedure manuals which are kept in line with currently approved nursing practices.
15. There should be written personnel policies, job descriptions, plans for orientation for new staff, and provision for inservice education. Employment standards should be consistent with those recommended by the State nurses associations.
16. The nursing staff should be provided opportunity to attend professional organization and other educational meetings.
17. The registered professional nurse in charge should be responsible for defining the activities of volunteer workers as related to patient care and in guiding the volunteers in carrying out their activities.

RELATED STATEMENTS

ANA statements of functions, standards, and qualifications for practice.
ANA–NFLPN statements of functions of the licensed practical nurse.
ANA definition of nursing practice.
ANA Code for Professional Nurses.

AUXILIARY PERSONNEL IN NURSING SERVICE

The national professional organization for registered nurses continues to support the principle, enunciated in 1950 by the Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services (ANA, NLNE, NOPHN, NACGN,

AAIN, NAPNE), that those entrusted with the nursing care of the sick shall be graduates of an approved school of professional or practical nursing and be licensed to practice.

Nevertheless, the American Nurses' Association recognizes that currently there are augmented demands on nursing service, due primarily to an unprecedented number of people in this country requiring nursing care and to the increasing complexity of functions delegated to the nursing service. And while it is true that there are more registered nurses and licensed practical nurses than ever before, the supply does not begin to meet the nursing service needs.

Experimentation has demonstrated that many time-consuming duties previously performed by the professional nurse and the licensed practical nurse can be efficiently and safely performed by properly trained and supervised auxiliary workers. The association believes, therefore, that the quantity and quality of nursing care rendered by the nurse can be increased by delegation to auxiliary workers tasks related to nursing in the care of the patient.

The position of leadership now requires that the professional nursing organization clarify the responsibility of professional nurses for the auxiliary workers in nursing service. It also demands delineation of the scope and value of the auxiliary workers as assistants to nurses in the care of the patient.

DEFINITION OF NURSING

A review of the definition of nursing practice is necessary in order to view the auxiliary workers in context. The American Nurses' Association recommends that nursing practice be legally defined as follows:

1. The practice of professional nursing means the performance for compensation of any act in the observation, care and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.

2. The practice of practical nursing means the performance for compensation of selected acts in the care of the ill, injured, or infirm under the direction of a registered professional nurse or a licensed physician or a licensed dentist; and not requiring the substantial specialized skill, judgment, and knowledge required in professional nursing.

DEFINITION OF AUXILIARY WORKER IN NURSING

The term "auxiliary personnel" in nursing service is used in this statement to designate auxiliary personnel employed to assist the nurse in hospitals, nursing homes, and other agencies. These workers are employed and trained to perform tasks which involve specified services for patients as delegated by the professional nurse and performed under the direction of professional nurses or licensed practical nurses.

Auxiliary workers in nursing service carry out tasks supportive and complementary to nursing practice. Although the performance of these tasks is essential to patient care, the auxiliary workers are neither professional nurses nor licensed practical nurses, nor do their activities constitute the practice of nursing. Furthermore, it is the belief of the American Nurses' Association that licensing of this group is not consistent with the supportive role of auxiliary personnel in nursing service.[1]

It is pointed out that this definition of auxiliary workers rules out all other trained and untrained personnel, of whom there are many. In this other context are such employees as physical and occupational therapy aids and X-ray and laboratory technicians, as well as posters, diet maids, ward maids, messengers, receptionists, clerks. These are excluded because they relate either to the environmental care of the patient or may be assigned to more than one division of the agency. While in some measure they may be supportive to the

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[1] In some psychiatric facilities, for example, the worker who performs functions within the field of practical nursing is sometimes called a psychiatric aid or technician. Preservice preparation of workers performing these functions should be secured in a State-approved program leading to licensure as a practical nurse.

nursing service, their employment, training, and supervision should not be the responsibility of the nursing service.

This statement is chiefly concerned with the group of auxiliary workers frequently referred to as "nurses' aids." The title of this group differs in various employment situations, where they are designated as nursing assistants, ward attendants, orderlies, nursing aids, et cetera. Because of this lack of uniformity in title, it was thought best, for the purposes of this statement to refer to this group as auxiliary workers in nursing service.

SELECTION

The ultimate responsibility for the selection of auxiliary workers in nursing service should rest with the department most closely associated with their work—that is, the nursing department. In the health agencies where there is a general personnel director responsible for employment, the staffing needs of the nursing service can be met adequately only if there is a close working relationship between the personnel director and the nursing service administrator.

QUALIFICATIONS

The qualifications of auxiliary workers differ widely, but in general, preference should be given to those with at least a grammar school education and an interest in the care of the sick. The workers should be physically and emotionally healthy; mentally competent; maintain good grooming and appearance; speak correctly, quietly, and audibly; exhibit a kind, courteous, and friendly manner; demonstrate willingness to work with others; and understand and practice ethical conduct. While the ages of auxiliary personnel show wide variation, ability to perform the expected tasks and to understand the nature of the supportive role in the care of the patient is more important than chronological age. The auxiliary worker should be employed only after a medical examination which includes appropriate physical and psychological tests.

TRAINING

These auxiliary workers who render services which are supportive to the nursing care given by licensed nurses should be prepared for their duties by a planned program of on-the-job training in contrast to the preservice nursing. Subsequent training and evaluation of the auxiliary personnel in nursing should be an ongoing process, with responsibility for this specifically delegated to the nursing service administration of the institution or agency.

The extent and nature of the training program should be interpreted to all workers in the agency so that they will have an understanding of the role of the auxiliary workers in nursing service. There are two attitudes commonly held by professional personnel which need to be modified—one is that which tends to limit the tasks of auxiliary workers so that they cannot make the contribution to patient care which they should, and the other which allows them to take on more and more responsibility for nursing procedures so that eventually, with little or no preparation, they are actually assigned to nurse patients. It is obvious that the whole purpose of auxiliary workers in nursing service is put in jeopardy when either of these attitudes is present. It is also necessary to bear in mind that the practice of nursing by unlicensed persons is illegal and violators are subject to prosecution. The auxiliary worker should be taught to understand the nature of his personal responsibility and the danger to himself and patients should he attempt to practice nursing. Professional personnel must also realize that nurses have an obligation to protect the public by not delegating to a person less qualified any service which requires the competence of a nurse.

The aim of training of these auxiliary workers therefore should be to develop a program which is both safe for the patient and practical for the nursing service. In order to carry out effective on-the-job training for auxiliary workers in nursing service, a qualified professional nurse instructor should be appointed. In large institutions where the number and turnover of personnel warrant it this should be the sole responsibility; in other situations it may be joined with other duties but it should never be secondary to them.

The training program should be well organized including classroom instruction, demonstration, and supervised practice. Experience in a variety of situations has demonstrated that the length of time required for on-the-job training of the

auxiliary workers varies widely, depending upon the ability of the worker and the characteristics of the nursing unit in which the workers are employed. No content however should be included in the training program which would purport to train the worker for more than simple, uncomplicated tasks to be performed under the direction of nurses.

SUPERVISION

After the initial training period, the direct supervision of these auxiliary workers should be delegated to the nursing unit. These auxiliary workers should then be assigned to work under the immediate direction and supervision of a qualified nurse who selects and delegates the specific tasks to be performed by the worker. The vital point is to assure continuing supervision following the orientation period and that the supervision and evaluation of the auxiliary workers in nursing service should be the responsibility of a nurse so designated and prepared by the nursing service administration. The abilities and work performance of these auxiliary workers should be evaluated on a continuing basis, with written reports for the purpose of record and for indications for additional training and assignment.

EXAMPLES OF TASKS

In order to suggest the potentiality of auxiliary workers in nursing service, examples of tasks have been developed. Thees examples are presented with the acknowledgment that the choice and diversity of tasks assigned to the auxiliary worker will depend on many variables, including but not limited to, the nature of the supporting service, the type of patient, the size and kind of institution or agency, the potentiality of the auxiliary worker, and the currently accepted principles of good patient care.

The important contribution of the supportive assistance rendered by the auxiliary worker in nursing service is in the performance of tasks that assist the nurse in direct patient care. The example of the tasks presented here are to be performed under the direction of a professional nurse or licensed practical nurse and as delegated by the nurse responsible for the nursing service of the unit. This list is not intended as an all-inclusive description of the appropriate tasks which may be assigned to the worker by nurses:

1. Answer patients' signals, providing necessary assistance in conformance with delegated tasks and notifying the appropriate nurse when the situation so indicates.
2. Assist with the admission, transfer, and discharge of patients.
3. Assist with the dressing and undressing of patients.
4. Assist with the patients' baths.
5. Assist with the measuring of fluid intake and output of patients and the recording on appropriate forms.
6. Assist with the feeding of patients.
7. Assist with the collection of urine, stool, and sputum specimens.
8. Assist with the weighing of patients.
9. Assist with the making of patients' beds.
10. Assist with the application and removal of such protective devices as side rails, footboards, bed cradles.

The American Nurses' Association recognizes that there are other categories of tasks that are certainly supportive to nursing but, while related and essential to patient care, are not appropriately the responsibility of nursing service. These other categories are typified by housekeeping tasks (such as maintenance of linen supply), dietary tasks (such as serving of meal trays), and messenger service (such as distribution of mail).

The American Nurses' Association therefore believes that auxiliary personnel in nursing can occupy a significant place in a well-organized and efficient nursing service. Auxiliary personnel in nursing service, while participating only in a limited degree in actual nursing care of patients, render valuable supportive assistance to the professional and practical nurse, and contribute substantially to the patient's comfort and welfare.

33-257 O—64—pt. 2——7

Statement of Functions of the Licensed Practical Nurse

This statement, which is an elaboration of the one adopted in 1957, was approved by the executive board of the National Federation of Licensed Practical Nurses in October 1963, and by the board of directors of the American Nurses' Association in January 1964.

PURPOSE

This statement is intended to serve as a guide to—

1. The utilization of the licensed practical nurse in nursing services.
2. Self-evaluation practice by the licensed practical nurse.
3. Development and evaluation of educational standards in the preparation of the licensed practical nurse.
4. Interpretation of licensing legislation.

EDUCATION AND LICENSURE

The LPN should be prepared and qualified for nursing practice by—

1. Education:

(*a*) Preservice preparation in a program in practical nursing approved by the State board of nursing.

(*b*) Orientation and continuing inservice education.

(*c*) Instruction, within the scope of practical nursing, of the practitioner who qualifies for further training in specialized fields peculiar to the agency.

2. Licensure by State board of nursing.

PERSONAL QUALIFICATIONS

Personal and vocational growth and development should be sustained by—

1. Maintenance of good health practices.
2. Active participation in and the promotion of nursing organizations, inservice education programs, workshops, institutes, other educational and community activities.

ROLE DESCRIPTION

The work of the LPN is an integral part of nursing. The licensed practical nurse gives nursing care under the supervision of the registered professional nurse or physician to patients in simple nursing situations. In more complex situations the licensed practical nurse functions as an assistant to the registered professional nurse.

A simple nursing situation is one that is relatively free of scientific complexity. In a simple nursing situation the clinical state of the patient is relatively stable and the measures of care offered by the physician require abilities based on a comparatively fixed and limited body of scientific facts and can be performed by following a defined procedure step by step. Measures of medical and personal care are not subject to continuously changing and complex modifications because of the clinical or behavioral state of the patient. The nursing that the patient requires is primarily of a physical character and not instructional.

In more complex situations, the licensed practical nurse facilitates patient care by meeting specific nursing requirements of patients as directed, such as preparing equipment, supplies and facilities for patient care, helping the professional nurse to perform nursing measures, and communicating significant observations to the registered professional nurse.

LEGAL STATUS

The legal responsibility of the LPN extends to two areas.

1. Licensure to practice practical nursing according to State law.
2. Performance limited to those acts for which he or she has been prepared.

Although it is true that the LPN's responsibility extends to these two areas, bearing in mind the individual's personal responsibility under the law, it is equally true that the professional nurse has ultimate responsibility for nursing service, including the responsibility for assignment of all nursing personnel.

FUNCTIONS

The selection of the functions or the specific procedures to be performed by the LPN depends upon a realistic appraisal of the elements within the situations, such as the complexity of scientific principles underlying the procedure or function; the ability and skills the LPN has acquired and demonstrated; the amount and character of the supervision required by the LPN to perform the functions; and the patients' needs and the ability of the LPN to provide safe nursing care to meet those needs.

In this context, the LPN performs the following functions:

A. Participates in the planning, implementation, and evaluation of nursing care in complex situations, and in giving nursing care in simple nursing situations by:

1. Providing for the emotional and physical comfort and safety of patients through:

(*a*) Understanding of human relationships between and among patients, families, and personnel.

(*b*) Recognizing and understanding cultural backgrounds, spiritual needs; respecting the religious beliefs of individual patients.

(*c*) Recognizing and understanding the effects of social and economic problems upon patients.

(*d*) Protecting patients from behavior that would damage their self-esteem or relationship with families, other patients, or personnel.

(*e*) Participating in the development, revision, and implementation of policies and procedures designed to insure comfort and safety of patients and personnel.

(*f*) Assisting the patient with activities of daily living and encouraging appropriate self-care.

(*g*) Considering needs of the patient for an attractive, comfortable, and safe environment.

For effective practice the LPN must know and utilize fundamental principles of human behavior and have an appreciation of the effects of stress upon individuals and groups.

A practical understanding of human growth and behavior makes it possible to note signs of change or disturbance in the patient's activity patterns. These may relate to illness, to individual responses to the institutional environment, and to personnel.

Representation and participation on committees and in conferences relevant to personnel and nursing care utilizes staff resources to develop a mutual understanding of the individual's role and responsibility in nursing service; e.g., a committee on infection control.

2. Observing, recording, and reporting to the appropriate person:

(*a*) General physical and mental condition of patients, signs and symptoms which may be indicative of change.

(*b*) Stresses in human relationship between patients and patients' families, visitors, and personnel.

3. Performing nursing procedures for which the preparation of the LPN has provided the necessary degree of skill and judgment, such as:

(*a*) Administration of medications and treatments prescribed for the patient.

(*b*) Preparation and care of patients receiving specialized treatments.

(*c*) Performance of special nursing techniques in caring for patients with communicable diseases.

(*d*) Practice of first-aid measures.

(*e*) Preparation and aftercare of equipment for treatments, including sterilization and observation of aseptic techniques.

4. Assisting with the rehabilitation of patients according to the patient-care plan through:

(*a*) Awareness of and encouraging the interests and special aptitudes of patients.

(*b*) Encouraging patients to help themselves within their own capabilities in performing activities of daily living.

(*c*) Knowledge and application of the principles of prevention of deformities; the normal range of motion; body mechanics and body alinement.

(*d*) Utilizing the community resources and facilities for continuing patient care.

B. Promoting effectiveness of the employing health service agency through:

1. Utilizing opportunities in contacts with patients' relatives to promote better understanding of policies pertaining to the health service.

2. Fostering cooperative effort through understanding the functions of all personnel involved in patient care.

3. Utilizing community resources and relationships for better understanding by the public of health services.

APPENDIX

APPENDIX I

Summary of American Association of Homes for the Aging Meeting To Explore the Establishment of a Program of Accreditation for Homes for Aged, Nursing Homes, and Other Facilities

November 7, 1963

Part I. List of Participants

Rev. William T. Eggers, chairman, Accreditation Committee of AAHA Home for Aged Lutherans, 7500 West North Avenue, Wauwatosa, Wis.

Lester Davis, executive director, American Association of Homes for the Aging, 49 West 45th Street, New York, N.Y.

Jerome Hammerman, Accreditation Committee of AAHA, Drexel Home, Inc., 6140 South Drexel Avenue, Chicago, Ill.

Dr. Frank B. Kelly, M.D., American College of Physicians, 122 South Michigan Avenue, Chicago, Ill.

Dr. Reed M. Nesbit, M.D., American College of Surgeons, University Hospital, Ann Arbor, Mich.

Dr. John Paul North, M.D., American College of Surgeons, 55 East Erie Street, Chicago, Ill.

Dr. Gerard J. Casey, D.D.S., American Dental Association, 222 East Superior Street, Chicago, Ill.

Harold E. Goetsch, American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill.

Mrs. Helen D. McGuire, American Hospital Association, 840 North Shore Drive, Chicago, Ill.

Dr. Charles C. Edwards, M.D., American Medical Association, 535 North Dearborn Street, Chicago, Ill.

Dr. H. Close Hesseltine, M.D., American Medical Association, 5841 South Maryland Avenue, Chicago, Ill.

Miss M. Annie Leitch, R.N., American Nurses' Association, 10 Columbus Circle, New York, N.Y.

Mrs. Eleanor B. Baird, American Nursing Home Association, Twin Pines, R.F.D. 3, New Medford, Conn.

William E. Beaumont, Jr., American Nursing Home Association, 516 Rodney Parham Road, Little Rock, Ark.

Dr. Lest H. Rudy, M.D., American Psychiatric Association, 1601 West Taylor Street, Chicago, Ill.

Charles E. Caniff, Association of Rehabilitation Centers, Inc., 828 Davis Street, Evanston, Ill.

Frederick R. Wolf, Association of Rehabilitation Centers, Inc., 828 Davis Street, Evanston, Ill.

Miss Edna Nicholson, National Association of Social Workers, 86 East Randolph Street, Chicago, Ill.

Mrs. Etta B. Schmidt, National Federation of Licensed Practical Nurses, 1402 West University Avenue, Champaign, Ill.

Miss Helen Dunn, R.N., National League for Nursing, Illinois Research Hospital, 840 South Wood Street, Chicago, Ill.

Unable to attend

American Academy of General Practice, 215 Volker Boulevard, Kansas City, Mo.

PART II. SUMMARY OF DISCUSSION

The meeting was called to order by Reverend Eggers at 9:15 a.m. He expressed the appreciation of the American Association of Homes for the Aging for the excellent attendance by the invited organizations, and stated that the purpose of the meeting was to explore the establishment of a multilateral accreditation program for homes for the aging, nursing homes, and other long-term-care facilities.

He then called upon Lester Davis, executive director of the AAHA, to review the interest and concern of that organization in this matter. Mr. Davis pointed out that the AAHA, from its very inception, at the Arden House Conference held in Harriman, N.Y., in November 1961, unanimously adopted as one of its goals the development and implementation of standards of service. The association is vitally concerned with the development of standards of care and service, the exchange of professional experience, and with quality care in nonprofit homes.

In his discussion, Mr. Davis reviewed the historical development of efforts toward establishing an accreditation program. (See pt. III.) He reported that at its first annual convention in October 1962, the association formally supported the efforts of the Joint Commission on Accreditation of Hospitals to establish such a program. In April 1963, upon the discontinuance by the Joint Commission of these efforts, the executive committee of the AAHA resolved:

"That the executive committee immediately take steps to implement the accreditation resolution of the association, preferably with a multilateral approach to the problem.

"That the chairman appoint a committee on accreditation.

"That this committee present concrete proposals at the next meeting of the executive committee.

"That exploratory conferences be held with the AHA and other appropriate national professional organizations on this matter of accreditation."

The committee was subsequently formed and has functioned throughout the past summer. Its efforts have resulted in the calling of this meeting.

Following Mr. Davis' remarks, Mr. Jerome Hammerman, a member of the AAHA Accreditation Committee, discussed the philosophy of an accreditation program, its objectives and characteristics as they had been adopted by the committee. (See pt. IV.)

It was the committee's view that such a program should—

(1) Be free to concentrate on the development of institutions which set an example of high standards of service;

(2) Promote systematic self-regulation;

(3) Develop a set of standards which uphold the ideals of good medical care and provide incentives for their achievement;

(4) Encourage improvement through education rather than through enforcement;

(5) Be voluntary rather than governmental in order to obviate the intrusion of partisan politics;

(6) Be multilateral in sponsorship and independent of vested interests; and

(7) Be organized and administered at the national level and be based on an actual survey.

Reverend Eggers then discussed a proposal for the formation of an independent corporation for the purpose of conducting an accreditation program based in these principles. (See pt. IV.)

The AAHA's Accreditation Committee proposed that this corporation be governed by a board representative of the organizations holding membership in this corporation, with the three organizations representing the institutions caring for patients—AAHA, ANHA, and AHA—holding slightly less than a majority of the voting rights. He then referred to the proposed budget. (See pt. V.) Reverend Eggers offered the committee's proposal that budget be prorated according to the voting rights and that the costs of the actual survey be borne by the institution being surveyed.

The charman declared a short break for coffee to allow people to discuss the proposal before reconvening for formal discussion.

There was a discussion of the nature of homes and nursing care facilities and of the types of patients or residents they serve. It was emphasized that medical care in many of these facilities is highly professional and very intense.

When the discussion centered around the relative strength of AAHA and the

ANHA in numbers of institutions they represent, it was pointed out that the primary concern of the meeting should not be focused on the organizations, the institutions, or their bed capacity, but rather on the 600,000 patients and residents requiring care in some 23,000 institutions across the Nation.

There was discussion of the present program of accreditation administered through the National Council for Accreditation of Nursing Homes and Related Facilities by the American Medical Association and the American Nursing Home Association. Representatives of these two organizations reviewed the program to date and expressed concern that the proposal being made would result in two national accreditation programs. General discussion of this question indicated that the proposal would result in two programs, and that this would not be advisable. However, it was pointed out that the AMA-ANHA program as it is presently constituted lacks the important ingredient of appropriate representation of the national organizations directly concerned.

The question was raised as to whether the National Council is now so constituted that it could be expanded to include these other national organizations and thus become a truly multilateral program. It was informally suggested by representatives of the American Medical Association and the American Nursing Home Association that this might be possible. Representatives of the AAHA and the AHA then pointed out that an organization should provide from its inception an opportunity for all interested organizations to participate fully in the development of a program of accreditation, including its policies, standards, and procedures. It was further pointed out that there is no reason why the work that has already been done could not be used as a base for developing a sound multilateral program. An opportunity to achieve the common goal of all concerned now exists and should not be missed.

The chairman again emphasized the positives that the AAHA committee found in the past history of accreditation and suggested that the AMA and ANHA representatives might ask their organizations to authorize them to present a concrete proposal to the organizations represented at this meeting, utilizing the National Council. It was again pointed out that, should the National Council and/or its member organizations not see fit to participate in a multilateral program, the AAHA and the AHA are committed and ready to carry out such a program together with other organizations, and that this may result in two national accreditation programs.

At one point in this discussion, representatives of the AHA read into the record the resolution recently adopted by the Council on Long-Term Care of the AHA and recommended to its board of trustees. (See pt. III, October 1963.)

At various points in the meeting, the historical background was discussed, references were made to the importance of timing and also to the positives of the past upon which a program could be built. During the discussion a number of references were also made by concerned organizations to the effect that a multilateral program would prove to be the only acceptable program. During the course of the entire meeting no representative of any organization voiced any objection to the desirability of such a program.

After lunch the chairman summarized briefly the discussions of the morning session, after which he presented details of the kind of organization and program as envisioned by the Accreditation Committee of the AAHA. Various clarifications were made at this point, including the fact that the suggested structure was proposed for purposes of discussion and negotiation on the part of the organizations interested in participating. Questions concerning the size of the governing body were then raised, and it was pointed out that the final membership of the new corporation would determine this size, that actual numbers had not been used and that only a principle had been enunciated; that the groups actually representing the institutions providing care should hold slightly less than half of the voting rights of the governing body.

The proposed budget for this organization was discussed. It was pointed out that the figures as presented were tentative in nature and might represent an understatement or overstatement of actual financial need. The point was made that support was being visualized in relation to representation on the governing board.

On a number of occasions questions or reference to specific standards were raised. The chairman pointed out that the committee felt that it should not concern itself with proposing standards at this time but rather its charge was

to propose an organizational structure which would then be responsible for the development and implementation of policy, standards, and procedures. It was further pointed out again that materials developed in previous accreditation efforts should receive consideration and thus not be lost to the task of the governing body.

A question of the proposed scope of the accreditation program was raised: Would it include rehabilitation centers and other health related institutions, i.e., strictly ambulatory care in facilities providing professional services to people with physical, emotional, and mental inadequacies? The chairman commented that this question had not been specifically considered by the committee. However, he felt that this matter was one which should and would receive serious consideration by the future governing body of an accreditation program.

By common consent, the representatives agreed with the chairman's proposal that a second meeting be held and that its purpose would be to have those organizations represented at this meeting to report the position their organization had taken, in the interval, on the proposal. He also asked that representatives come to this second meeting with any concrete suggestions concerning the proposed structure which their organizations believed it wise to make. By common consent it was agreed to hold this second meeting at the Center for Continuing Education, University of Chicago, February 20, 1964, at 9 a.m., with the same organizations represented at this meeting.

The chairman stated that the Committee on Accreditation of the AAHA hoped that the proposed program might receive consideration by the Joint Commission on Accreditation of Hospitals. Thereupon the chairman thanked all those present and declared the meeting adjourned.

PART III. CHRONOLOGICAL LIST OF EVENTS

October 1959—Tripartite Liaison Committee (AMA, ANHA, AHA)

The American Nursing Home Association reported on its efforts to develop a project of classifying nursing homes, believing that classification would be an incentive to improve standards of care in nursing homes.

February 1960—Tripartite Liaison Committee (AMA, ANHA, AHA)

The American Nursing Home Association reported that the request for a National Institute of Health grant to study the classification of nursing homes had been denied. To provide a basis for a new application for such a grant, the Tripartite Committee asked its staff to develop a plan for the preparation of standards of care with the ultimate objective of developing an accreditation program.

May 1960

The staff of the Tripartite Committee developed a tentative set of minimum eligibility requirements for accreditation of nursing homes and related facilities.

May 1961—Tripartite Liaison Committee (AMA, ANHA, AHA)

The American Hospital Association's board of trustees voted to formulate, in cooperation with other national organizations, criteria and methods for the evaluation and approval of inpatient care institutions other than hospitals including nursing homes with skilled nursing services, and further, to recommend to the Joint Commission on Accreditation of Hospitals that it accept responsibility for administering an accreditation program of inpatient care institutions other than hospitals.

The American Nursing Home Association announced, that although it endorsed the Tripartite Committee study plan, it had also initiated its own accreditation program.

October 1961—Tripartite Liaison Committee (AMA, ANHA, AHA)

RESOLUTION

Whereas the Liaison Committee of the AHA, AMA, and ANHA, on Problems Concerning the Institutional Care of the Chronically Ill and Aged, recognizes the urgent need for an accreditation program for inpatient care institutions other than hospitals; and

Whereas the American Nursing Home Association is now embarking on an accreditation program for nursing homes; and

Whereas the Joint Commission on Accrediation of Hospitals is actually the logical choice for administering accreditation programs for all types of health care facilities: Therefore be it

Resolved, That the Liaison Committee urge the Joint Commission on Accreditation of Hospitals (1) to take early action on the question of assuming responsibility for accreditation of all types of health care facilities, and (2) if this action is favorable, to assure the American Nursing Home Association of adequate representation in the operation of such an accreditation program for nursing homes."

November 1961—American Association of Homes for the Aging

Arden House Conference, Harriman, N.Y. (organizational meeting of AAHA). The association unanimously adopted as one of its goals the development and implementation of standards of service.

December 1961—Joint Commission on Accreditation of Hospitals

Voted:

(1) That the problem of accreditation of inpatient institutions other than hospitals is of grave importance and is a job that should be done.

(2) That this should preferably be done by a nonprofit, national nongovernmental organization of stature equal to the task.

(3 That the Joint Commission on Accreditation of Hospitals, by virtue of its experience, knowledge, and prestige, appears to be the logical organization to supervise this program, though great care should be exercised that the present autonomy of the Joint Commission not be jeopardized. The commissioners of the Joint Commission are of the opinion that it can and should administer the program if financial support is available.

(4) That the commissioners of the Joint Commission on Accreditation of Hospitals seek to acquire funds in order that this program may be developed. The primary work in the program to include the development of acceptable standards and other documents necessary for the instigation of the program, as estimate of initial and projected costs, a projected 1-year budget, and any other pertinent facts.

March 1962—Joint Commission on Accreditation of Hospitals

The Joint Commission secured a grant, $49,500, from the Hartford Foundation to work through the health and education trust of the AHA in developing a program of accreditation of inpatient care institutions other than hospitals, to be administered by the Joint Commission. To review such a program and to recommend that constituent organizations declare an intent to participate in the program.

May 1962—Joint Commission on Accreditation of Hospitals

The proposed program of the Joint Commission discussed in a meeting of 12 of 13 invited national organizations.

August 1962—Joint Commission on Accreditation of Hospitals

Voted to recommend to the member organizations:

To establish a division for accreditation of inpatient care institutions other than hospitals, effective January 1, 1963, which will recommend to the Joint Commission on Accreditation of Hospitals policies and procedures for surveying and accrediting of such institutions, and which will be subject to the ultimate and final authority of the Joint Commission on Accreditation of Hospitals, and which will have a board of not more than fifteen (15) members, one (1) each of whom shall be from each member organization of the Joint Commission on Accreditation of Hospitals and, in addition, the majority of the remaining members shall be representative of inpatient care institutions other than hospitals.

To finance this division for accreditation of inpatient care institutions other than hospitals by budgeting separately for administrative cost and direct costs for surveying; two-thirds of the administrative costs to be paid by the Joint Commission on Accreditation of Hospitals and one-third to be prorated among the other members of the board of the division, the costs of surveying for accreditation to be prorated among the institutions surveyed, effective January 1, 1964.

Voted: To call a meeting of the members of the corporation as soon as possible to consider necessary changes in the bylaws and the budget, so as to establish this new division for accreditation of inpatient care institutions other than hospitals effective January 1, 1963.

Voted: That the eligibility requirements for survey for accreditation of inpatient care institution other than hospitals should be established and administered by the Joint Commission on Accreditation of Hospitals.

Voted: To seek funds from a foundation or other source for continuation and operation of the program of accreditation of inpatient care institutions other than hospitals for the year 1963.

October 1962—American Association of Homes for the Aging

Annual Meeting, New York City.

The association approved in principle the recommendation of its officers and board to participate in the program of accreditation sponsored by the Joint Commission and expressed its intent to become a part of this program.

November 1962—American Medical Association Board of Trustees

Voted: "Negotiations be opened with the American Nursing Home Association with the idea of activating the National Council for Accreditation of Nursing Homes" and that "the AMA representatives to the board of commissioners on the Joint Commission on the Accreditation of Hospitals be instructed to oppose the accreditation of nursing homes by the Joint Commission."

March 1963—Joint Commission on Accreditation of Hospitals

Voted: "To discontinue at this time any further action toward the development and implementation of a program for inpatient care institutions other than hospitals by the Joint Commission on the Accreditation of Hospitals and, further, to remain receptive to any future invitations to undertake such a program."

April 1963—American Medical Association-American Nursing Home Association

Announced a jointly sponsored accreditation program for nursing homes.

April 1963 (approved by Board, May 1963) American Association of Homes for the Aging

RESOLUTION

"That the executive committee immediately take steps to implement the accreditation resolution of the association, preferably with a multilateral approach to the problem.

"That the chairman appoint a committee on accreditation.

"That this committee present concrete proposals at the next meeting of the executive committee.

"That exploratory conferences be held with the AHA and other appropriate national professional organizations on this matter of accreditation."

October 1963—American Hospital Association Council on Long-Term Care

Voted to recommend: "To develop and implement as rapidly as possible, in cooperation with other appropriate national organizations, an accreditation program for long-term-care facilities having acceptable written agreements with general hospitals."

PART IV

PHILOSOPHY OF ACCREDITATION

The purpose of the accreditation of health care institutions is to improve the quality of care of patients to an acceptable minimum level and to encourage institutions to exceed the minimum. The establishment of an accreditation program evidences willingness on the part of the institution to set and maintain standards; the conduct of an accreditation program manifests willingness on the part of the parent groups to assume responsibility for good practices.

OBJECTIVE

A. To conduct a survey and accreditation program which will encourage physicians, nursing homes, homes for the aging, and related facilities voluntarily—

(1) To apply certain basic principles of organization and administration for essential care of the patient;

(2) To promote high quality of care in all its aspects in order to give patients the greatest benefits that medical science has to offer;

(3) To maintain the essential diagnostic and therapeutic services in the institution through the coordinated efforts of the medical staff and the governing board or owner of the institution.

B. To establish standards for the operation of nursing homes, homes for the aging, and related facilities.

C. To recognize compliance with standards by the issuance of certificates of accreditation.

D. To assume such other responsibilities and to conduct such other activities as are compatible with the operation of an accreditation program.

CHARACTERISTICS OF AN EFFECTIVE ACCREDITATION PROGRAM FOR INSTITUTIONS

An effective accreditation program should have the following characteristics:

1. It should be free to concentrate on the development of institutions which set an example of superior service.
2. It should attempt to promote systematic self-regulation by the institutions covered.
3. It should develop a set of standards which uphold the ideals of good medical care and provides incentive for their achievement.
4. It should encourage improvement through education rather than through enforcement.
5. It should be voluntary rather than governmental in order to obviate the intrusion of partisan politics.
6. It should be multilateral in sponsorship and independent of vested interests.
7. It should be organized and administered at the national level to prevent local pressures and to make standards acceptable for national third-party paying agencies.
8. Accreditation should be based on an actual survey of the institution by a qualified surveyor.
9. There should be provision for centralized review and action and an appeal process should be available.

PART V. THE PROPOSAL OF THE AAHA TO THE ORGANIZATIONS INVITED TO THE NOVEMBER 7, 1963, MEETING AT THE UNIVERSITY OF CHICAGO, CHICAGO, ILL.

To carry out the philosophy and objectives of the accreditation program outlined above, it is proposed that an independent corporation be formed for the purpose of conducting such an accreditation program.

1. This corporation would be formed by those national, health, and medical organizations concerned with the objectives outlined.
2. This corporation would be operated and standards would be established by a board of governors, appointed by the participating organizations, with the organizations who are primarily concerned with the care of patients holding slightly less than a majority of the voting rights.
3. The administrative expense of the corporation would be financed through contributions made by the participating organizations on a pro rata basis.

PART VI. BUDGET (PROPOSED)

PROGRAM OF ACCREDITATION OF LONG-TERM PATIENT CARE FACILITIES

Administrative expense: To be shared pro rata by the participating organizations.

Item	Amount
Salaries and wages:	
Director	$17,500
Office staff	12,800
Social security	620
Retirement	1,180
Blue Cross	700
Libel insurance, Travel insurance, Honesty bond	100
Total, salaries and wages	32,900
Office expense:	
Furniture and equipment	3,500
Supplies	1,000
Telephone and telegraph	500
Postage and express	1,200
Utilities	300
Subscriptions and publications	50
Maintenance	250
Total, office expense	6,800
Rent	3,000
Publishing and printing	2,500
Travel:	
Staff	4,000
Board	3,000
Total, travel	7,000
Contingencies	2,500
Total	54,700

Field staff expense: This expense will be met through income from a "fee for survey" charge to be paid by institutions applying for survey. This fee is anticipated to be a minimum of $50 plus $1 per bed, not to exceed a maximum fee of $200.

MEETING OF STEERING COMMITTEE ON ACCREDITATION OF SPECIALIZED HEALTH FACILITIES

University of Chicago Center for Continuing Education, Chicago, Ill., February 20, 1964

ORGANIZATIONS AND REPRESENTATIVES

American Association of Homes for the Aging: William T. Eggers, chairman.
American Dental Association: Gerard J. Casey, D.D.S.
American Hospital Association: Mrs. Helen D. McGuire.
American Medical Association: Charles C. Edwards, M.D.
American Nurses' Association: M. Marian Wood.
American Nursing Home Association: Mrs. Eleanor B. Baird.
Association of Rehabilitation Centers, Inc.: Charles E. Caniff.
National Association of Social Workers: Edna Nicholson.

The meeting of the steering committee convened at 1:30 p.m.

A press release concerning the morning meeting of national organizations was approved. (See app. A.)

It was agreed that the approved statement would be released to the press by the American Association of Homes for the Aging, and that no other information would be given to the press by the organizations represented.

ELECTION OF TEMPORARY OFFICERS

It was agreed that, in view of the fact that some organizational representatives to the steering committee have not yet been designated, it would be unwise to elect officers at this meeting. There is need, however, to designate someone to preside over this meeting and to act for the committee until the next meeting. It was decided to elect a temporary chairman and secretary to serve until the next meeting. The following were elected:

Chairman pro tem: Rev. William T. Eggers.
Secretary pro tem: Mrs. Helen D. McGuire.

CHARGES TO COMMITTEE

The chairman reviewed the charges given to the committee:

1. To request a meeting of representatives of the steering committee with representatives of the National Council for the Accreditation of Nursing Homes prior to the March 16 meeting of the National Council's board of directors, to discuss the possibilities of broadening both its sponsorship and areas of interest and to obtain specific information concerning the conditions under which this might be achieved.

2. To request the Joint Commission on Accreditation of Hospitals to reconsider its earlier action of March 1963 with respect to accreditation of inpatient care institutions other than hospitals and also to consider accreditation of other specialized health facilities.

3. To develop a proposal for a new structure to provide a unified multilaterally sponsored accreditation program for the following specialized health facilities: nursing homes, homes for the aged, and rehabilitation facilities; such proposal to be developed with appropriate recognition that there are other kinds of specialized health care facilities that may be included in such an accreditation program in the future.

SCOPE OF COMMITTEE'S CONCERN

In order to determine its course of action and the extent to which the committee is representative, the following were identified and discussed: (1) The kinds of institutions involved; (2) the national organizations representing these institutions; (3) the professional groups involved; and (4) other influential groups having a special interest in accreditation of specialized health care facilities. (See app. B.)

It was agreed that although there are many kinds of facilities and programs that might ultimately be included in the kind of unified accreditation program we envision, we should concentrate now on those that present immediate and urgent needs. These are nursing homes, homes for the aging, and rehabilitation facilities. These three kinds of facilities exist both as separate, independent entities, as specialized programs within the general hospital complex, and in other combinations of multiple-service institutions.

The committee agreed to the following statements to serve as guides for its activities and establishment of priorities.

(1) To accept as a basic principle that, in the interests of high quality and continuity of care of patients, there should be unity and multilateral sponsorship of accreditation of all health care facilities.

(2) The immediate objective is to achieve a unified multilaterally sponsored accreditation program for the following specialized health facilities: nursing homes, homes for the aged, and rehabilitation centers.

(3) To recognize that there are other kinds of specialized health facilities that may be included in such an accreditation program in the future.

Some arguments were put forth in favor of encouraging separate accrediting agencies for these and other kinds of facilities with the hope that eventually they would merge, but it was the consensus that the preferable course of action is to unify the programs from their inception.

It was recognized that considerable work has already been done in development and testing of standards for these different kinds of facilities and that these standards would be valuable and should be made use of in administering the accreditation program.

REPRESENTATION

It was further agreed that all the national organizations representing the facilities themselves were already included on the steering committee or had been invited, with the possible exception of the National Association of Sheltered Workshops. The associations of major professional groups are also represented or have been invited to appoint representatives.

With respect to other interested groups, it was the consensus that governmental agencies should not be involved in a voluntary accreditation program. There was agreement that the National Rehabilitation Association, and possibly the National Association of Sheltered Workshops, might be invited to meet with the steering committee. The chairman of the Ad Hoc Committee on Accreditation of Rehabilitation Facilities could be invited to attend the next meeting to explore relationships and interests. Prior to this, however, the steering committee will request a meeting with representatives of the ad hoc committee.

APPOINTMENT OF REPRESENTATIVES OF STEERING COMMITTEE

The committee appointed Reverend Eggers, Mrs. McGuire, and Dr. Casey to represent the steering committee in exploratory meetings with the National Council for the Accreditation of Nursing Homes, the Ad Hoc Committee on Accreditation of Rehabilitation Facilities, and the Joint Commission on Accreditation of Hospitals.

TIMETABLE OF ACTIONS TO BE TAKEN

The committee approved a motion authorizing the temporary chairman to immediately request the chairman of the National Council for the Accreditation of Nursing Homes for an opportunity to meet with their representatives prior to its March 16 board of directors' meeting to explore possibilities of broadening its sponsorship and areas of interest.

A motion to request a similar meeting, preferably on March 14, with the Ad Hoc Committee on Accreditation of Rehabilitation Facilities was approved.

There was considerable discussion concerning a motion to immediately request the Joint Commission on Accreditation of Hospitals to reconsider its action of March 1963 on accreditation of inpatient care institutions other than hospitals. Some believed that no action should be taken on this charge pending the outcome of negotiations with the National Council. There was a consensus that since these actions were exploratory, for the purpose of obtaining factual information only, there was no implied lack of good faith in doing both at the same time. It was also commonly agreed that the charges as given to the steering committee were to be undertaken concurrently in order to formulate concrete proposals for consideration of the participating associations. A motion to proceed in this manner was carried, with one negative vote and two abstentions.

NEXT MEETING

The steering committee will meet on March 23, 1964, at 9:30 a.m., at the Drake Hotel, Chicago. The temporary secretary was asked to reserve a meeting room and hotel accommodations for members attending from out of the city.

The meeting adjourned at 3:45 p.m.

MRS. HELEN D. MCGUIRE,
Secretary pro tem.

APPENDIX A

[Press release]

MEETING OF NATIONAL ORGANIZATIONS, FEBRUARY 20, 1964

"Representatives of 10 national organizations met at the University of Chicago Center for Continuing Education, 1307 East 60th Street, Chicago, Ill., on Thursday, February 20, 1964, to discuss a multilateral program for accreditation of specialized health facilities.

"Organizations represented at the meeting included:

"American Association of Homes for the Aging.
"American College of Surgeons.
"American Dental Association.
"American Hospital Association.
"American Medical Association.
"American Nurses' Association.
"American Nursing Home Association.
"American Psychiatric Association.
"Association of Rehabilitation Centers, Inc.
"National Association of Social Workers.

"Not present, but expressing an interest, were:

"American College of Physicians.
"National League for Nursing.

"The representatives agreed that, in order to achieve such a multilateral program of accreditation, a steering committee, composed of one representative from each interested organization, should be formed. This steering committee will continue to explore various avenues to achieve the goal of a single multilateral accreditation program."

APPENDIX B

GROUPS INVOLVED OR INTERESTED IN ACCREDITATION OF SPECIALIZED HEALTH CARE FACILITIES

Institutions and organizations:
- Nursing homes: American Nursing Home Association.
- Homes for the aged: American Association of Home for the Aging.
- Rehabilitation facilities:
  - Association of Rehabilitation Centers.
  - National Association of Sheltered Workshops and Homebound Progress.
- Hospitals: American Hospital Association.

Professional groups:
- Directly in-patient care: Physicians,[1] dentists,[1] nurses,[1] social workers,[1] physical therapists, occupational therapists, rehabilitation counselors, podiatrists, psychologists, clergy, recreation therapists, and speech therapists.
- Indirect: Dietitians and pharmacists.

Other interests:
- National Rehabilitation Association.
- National Association of Sheltered Workshops and Homebound Programs.
- Governmental agencies.
- Insurance and prepayment groups.

---

[1] These have been invited.

APPENDIX II

STANDARDS FOR ACCREDITATION

THE NATIONAL COUNCIL FOR THE ACCREDITATION
OF NURSING HOMES
645 North Michigan Avenue
Chicago, Illinois 60611

FOREWORD

The purposes of the corporation are to establish, conduct and sponsor an accreditation program which will provide for and foster standards of professional care of high quality in the operation and administration of nursing homes and related facilities throughout North America; to establish and promote sound principles of organization and administration in the care of patients and guests of nursing homes and related facilities; and to promote essential services in nursing homes and related facilities.

Experience gained in this fashion will be utilized to improve, expand and broaden the knowledge required for the ultimate benefit of the patient. Revisions of the standards will be made as progress dictates.

It is emphasized again that the Explanatory Supplement together with the Evaluation Form reflect the standards upon which the National Council will base its decisions.

Every effort has been made to provide answers to questions which have arisen during surveys and to anticipate questions which may come up in the future. Definitions of terms have been explained to decrease the chance of misunderstandings and, wherever possible, the underlying reasons for inclusion of specific requirements have been stated.

It is felt that both these documents represent the best effort possible at the time of publication. It is understood, also, that changing concepts in medical service may cause certain portions of both documents to be outmoded within a very short time. In an effort to keep the results of this at a minimum, significant alterations will be made as necessary and will be announced periodically. Revised editions of the evaluation form and the explanatory supplement will be published as the need arises.

Since the National Council is engaged in a dynamic program to foster the best quality of care for individuals in nursing home facilities, administrators and owners are specifically invited to submit comments and suggestions resulting from their use of the evaluation form and the explanatory supplement with the purpose of making the accreditation process a realistic as well as an idealistic force in the care of the chronically ill patient.

DEFINITIONS OF LEVELS OF FACILITIES

INTENSIVE NURSING CARE FACILITY -- Nursing service shall be under the supervision of a Registered Professional Nurse and a Registered Professional Nurse shall be on duty at all times.

SKILLED NURSING CARE FACILITY -- Nursing service shall be under the supervision of a Registered Professional Nurse. A Registered Professional Nurse shall be in charge of patient care for a minimum of five days, 40 hours per week. In addition, at least one Licensed Nurse shall be on duty at all times.

INTERMEDIATE CARE FACILITY -- Nursing service shall be under the supervision of a Licensed Nurse who will be on duty five days per week, with a minimum of 8 hours each day. In addition, there shall be a night attendant awake and fully dressed.

33-257 O - 64 - 9 (Pt. 2)

ACCREDITATION EVALUATION FORM

NATIONAL COUNCIL FOR ACCREDITATION OF NURSING HOMES

		YES	NO
I.	ADMINISTRATION		
	Governing Body		
A.	Physical Plant		
	1. Compliance with individual state licensing laws governing nursing homes?	( )	( )
	Date of license or certificate		
	2. Compliance with State rules and regulations for fire safety?	( )	( )
	Date of certificate if required		
B.	Equipment		
	1. Is the equipment suitable to the needs of patients in the facility being surveyed?	( )	( )
	Check attached equipment list noting types and amount of equipment		
	....		
	2. Do all furnishings and equipment appear to be in a state of good repair and safe for use?	( )	( )
	Comment		
	....		
C.	Administrator		
	1. QUALIFICATIONS AND EDUCATION:		
	a. Four years of high school or its equivalent? Comment (see also supplemental information sheet)	( )	( )
	....		
	b. Is this training sufficient for proper discharge of duties?	( )	( )
	Comment		
	c. Experience in nursing home administration or related field?	( )	( )
	Comment		
	....		
	d. Is this experience sufficient for proper discharge of duties? Comment (note experience which may relate)	( )	( )
	....		
	....		
	2. PROFESSIONAL ADVANCEMENT:		
	a. Does the administrator belong to local, state, national organization representing this profession?	( )	( )
	b. Does the administrator regularly attend organized institutes, workshops, association meetings, etc.?	( )	( )
	Comment		
	....		
	(If administrator sends members of staff to workshops, etc., please note)		
	....		
	....		
	....		

I. ADMINISTRATION (cont.) — YES / NO

D. Personnel Policies

1. Does the facility have written personnel policies? ( ) ( )

   Comment ....

2. Are the personnel policies explained to employees when they are hired? ( ) ( )
   Are written copies readily available? ( ) ( )
3. Are job descriptions available? ( ) ( )
4. Is a written employment application required for all personnel? ( ) ( )

   How are references investigated? ....

   ....

5. Is a pre-employment and annual health examination, including tuberculin test and/or chest x-ray required for all personel? (Underline that which applies) ( ) ( )
6. Are employees trained in the execution of the disaster plan? ( ) ( )
   How? (Drills; fire dept.; staff meetings, etc.)

   ....

7. Is a disaster plan posted conspicuously? ( ) ( )

   Where? ....

8. Is there any formal in-service training program for personnel? ( ) ( )

   Who conducts it? ....

   How often? ....

9. Are staff meetings held regularly? ( ) ( )

   How often? .... Is a written record kept? ( ) ( )

10. Are reference materials readily available to staff? ( ) ( )

    What type and where kept? ....

    ....

Any special comment should be made below:

....

....

E. Office Management

1. Are approved forms available? ( ) ( )
   Are they used? ( ) ( )
2. Does the facility have a brochure or written agreement explaining the policies in regard to admission, discharge, refunds, handling of personal possessions, etc.? ( ) ( )
   Is a copy given to the responsible person? ( ) ( )

   Comment ....

   ....

3. Are facilities available for safekeeping of valuables? ( ) ( )
4. On admission, does the patient or responsible person give permission (written) to summon a doctor other than the patient's own physician in case of emergency? ( ) ( )
5. Are account books and records kept? ( ) ( )
   What type of bookkeeping and recording is used? ....

   ....

I.	ADMINISTRATION (cont.)	YES	NO
F.	Administrator Relationships		
	1. Is the family or some responsible person kept informed of the patient's condition?	( )	( )
	How? (In writing, by phone, etc.)		
	....		
	2. Do relationships among administrator, patient and family appear to be good?	( )	( )
	Comment		
	....		
	3. Does there appear to be good administrator/personnel relationship?	( )	( )
	Comment		
	....		
G.	Insurance		
	1. Does the administrator carry professional liability insurance?	( )	( )
	2. Does the administrator carry premise liability insurance?	( )	( )
	Comment		
	....		
II.	MEDICAL CARE*		
	Personal Physician		
	Is there evidence to show that patients are being examined by licensed physicians at intervals in keeping with the patient's condition? Is there evidence to show that the administrator or nurse in charge has consulted with each responsible physician about his patient's condition at intervals of not less than thirty days?	( )	( )
III.	DENTAL CARE		
A.	Does the nursing home policy include dental examination as a part of patient care?	( )	( )
	By whom?		
	How often?		
B.	Does the local dental society provide services for relief of pain and treatment of infection for the patients? If answer is yes, state name of group and brief comment on utilization	( )	( )
	....		

* Does not apply to supervised living care facilities.

		YES	NO
IV.	**MEDICAL RECORDS***		
A.	Does the individual record for each patient include:		
1.	Identification, such as social security number, race, religion, marital status, name of person, relative, and/or agency responsible for payment of services?	( )	( )
2.	History and physical examination, including diagnosis/diagnoses?	( )	( )
3.	Physicians' progress notes?	( )	( )
4.	Physicians' orders?	( )	( )
5.	Medication records?	( )	( )
6.	Special report records?	( )	( )
7.	Significant nursing notes with identifying signature?	( )	( )

Comment ....

....

....

B. Is patient registry complete and adequate for statistical and licensing requirements? ( ) ( )

Comment ....

....

V. NURSING CARE*

		YES	NO
A.	Intensive Nursing Care Facility		
1.	Is there a registered nurse in charge of patient care on all shifts?	( )	( )
B.	Skilled Nursing Care Facility		
1.	Is there a registered nurse in charge of patient care? (minimum 5 day, 40 hours per week)	( )	( )
2.	Is there at least one licensed nurse on duty at all times?	( )	( )
C.	Intermediate Care Facility		
1.	Is there a licensed nurse in charge of patient care? (minimum 5 day, 40 hours per week)	( )	( )
2.	Is there a night attendant awake and fully dressed?	( )	( )
D.	Are there written policies, procedures and guides available to the nursing staff? (Underline that which applies)	( )	( )

Comment ....

....

VI. RESTORATIVE MEASURES

A. Does the attending physician make a determination of the patient's rehabilitation potential as part of the admission procedure? ( ) ( )

Comment ....

B. Is a periodic re-evaluation made by the physician? ( ) ( )

Comment ....

C. Are restorative procedures maintained in accordance with the determination of the physician? ( ) ( )

Comment ....

* Does not apply to supervised living care facilities.

		YES	NO
VI.	RESTORATIVE MEASURES (cont.)		
D.	Are special restorative programs under the supervision of a professional therapist?	( )	( )
	Name		
	Qualifications		
E.	Has the nursing staff been given instruction in such a program?	( )	( )
	By whom and how?		
F.	Has the nursing staff received special instructions or training in procedures leading to maximum patient self-care?	( )	( )
	By whom and how often are they reoriented?..............................		
	....		
	Comment		
	....		
G.	Are there provisions for restorative services from the appropriate community facilities and agencies when such services are not available at the nursing home?	( )	( )
	Name of community facility or agency		
	....		
VII.	DIVERSIONAL ACTIVITIES		
A.	Is there a recreation room, sun room, patio or porch?	( )	( )
	1. Does recreation area appear adequate for size of facility?	( )	( )
B.	Are there facilities/equipment available for:		
	1. Reading material?	( )	( )
	2. Letter writing?	( )	( )
	3. Religious services?	( )	( )
	4. Games?	( )	( )
	5. Radio?	( )	( )
	6. Television?	( )	( )
	7. Other? (Specify)	( )	( )
D.	Are volunteer services utilized?	( )	( )
	Agency?..		
	Frequency..		
	Duration		
E.	Are there visiting hours?	( )	( )
	Indicate times		
	Special comment/s should be made below:		
	....		
	....		
	....		

VIII. ESSENTIAL SERVICES	YES	NO
A. Medication Control		
1. Are there provisions for the safe storing and proper recording of narcotics?	( )	( )
2. Are other drugs properly safeguarded and recorded?	( )	( )
3. Is there a specific plan for administration of medications?	( )	( )
Comment		
....		
4. Are there any medications or drugs allowed at bedside tables? Under what circumstances?	( )	( )
....		
....		
B. DIETARY		
1. Is there a dining room?	( )	( )
Comment		
2. Is the food prepared and served in a form to suit the individual needs?	( )	( )
On what do you base your answer?		
Comment		
....		
3. Food supplies:		
a. Is there a minimum of one week's supply of staple foods?	( )	( )
b. Is there a minimum of one day's supply of perishable foods?	( )	( )
Comment		
....		
4. Is the kitchen clean and equipment (dishwasher, garbage handling facilities, pots, pans, dishes, food blender, etc.) adequate?	( )	( )
Comment		
5. Are refrigeration and storage adequate?	( )	( )
Comment		
6. Menus:		
a. Are menus planned and on file?	( )	( )
b. Are menus posted in kitchen?	( )	( )
c. Is the menu varied sufficiently?	( )	( )
If cycle menus are used, note space of cycle		
Comment		
....		
7. If required, are food handler's permits current?	( )	( )
Comment		
8. Are problem patients being aided satisfactorily with their eating?	( )	( )
How?		
Comment		
9. Are there provisions for serving special diets?	( )	( )
If so, how is this done?		
....		
10. Is there a maximum of 14 hours between the evening meal and the morning meal?	( )	( )
Meal hours		
Comment		
11. Are 3 supplementary feedings provided?	( )	( )
When?		

VIII. ESSENTIAL SERVICES (cont.)

	YES	NO
B. Dietary (cont.)		
12. Are patients weighed monthly and weight recorded?	( )	( )
Comment		
13. Are work assignments and duty schedules posted for dietary personnel?	( )	( )
Where?		
C. Housekeeping		
1. Is the general housekeeping of nursing home good?	( )	( )
Comment		
....		
2. Is the facility free of objectionable odors?	( )	( )
Comment		
....		
3. Is the general atmosphere suggestive of home and comfort?	( )	( )
Comment		
....		
4. Are work assignments and duty schedules posted for housekeeping personnel?	( )	( )
5. Is all laundry done on premises?	( )	( )
Is patient's laundry done on premises?	( )	( )
Comment		
D. Sanitation		
1. Are there evidences of infestation by rodents and/or insects?	( )	( )
2. Are sanitary food handling procedures practiced?	( )	( )
3. Is soiled laundry kept in area away from kitchen?	( )	( )
Where?		
How is soiled laundry transported from patient area?		
....		
4. Is there a separate area for proper cleaning of soiled utensils and equipment (bedpans, etc.)?	( )	( )
E. Safety Measures		
1. Does the home have ample safeguards such as hand rails, etc?	( )	( )
2. Are there first-aid supplies for emergency care?	( )	( )
3. Are all personnel instructed in household accident prevention?	( )	( )

IX. SUMMARY AND RECOMMENDATIONS

X. OVERALL STAFFING PATTERN FOR FACILITY

	7-3	3-11	11-7
A. Administration			
1. Administrator (if also serving as charge nurse, do not count)	....	....	....
2. Other	....	....	....
B. Nursing Care Personnel			
1. Registered Professional Nurse	....	....	....
2. Licensed Practical (Vocational) Nurse	....	....	....
3. Nurse Aides or Attendants	....	....	....
4. Other (itemize)	....	....	....
....			
....			
C. Domestic Staff			
1. Housekeepers	....	....	....
2. Janitors (if used to replace housekeepers please note)	....	....	....
3. Maintenance Man	....	....	....
4. Other (itemize)	....	....	....
5. Laundry	....	....	....
D. Dietary Staff			
1. Dietician*	....	....	....
2. Cook (note hours of work)	....	....	....
3. Helper (note hours of work)	....	....	....
4. Tray Girls (note hours of work)	....	....	....
5. Other (itemize)	....	....	....
* (note if consultant only)			
E. Ancillary Staff*			
1. Physical Therapist	....	....	....
2. Occupational Therapist	....	....	....
3. Speech Therapist	....	....	....
4. Recreational or Activities Director	....	....	....
5. Beautician/Barber	....	....	....
6. Pharmacist	....	....	....
7. Other	....	....	....
* (note full time or consultant average hours per week or day)			

Name of Facility ______________________ Phone __________

Address ______________________________________

Name of Owner ______________________________________

Name of Administrator ______________________________________

Licensed for __________ beds.

1. The undersigned makes application to The National Council for the Accreditation of Nursing Homes.

2. The undersigned requests The National Council for the Accreditation of Nursing Homes to survey its facilities from time to time as the Council may deem proper and agrees to cooperate with the Council and its agents in making such surveys. The official records of the State Licensing agency may be made available to The National Council in its consideration of this application for accreditation. All accreditation certificates shall remain the property of The National Council.

3. The undersigned agrees that it will not hold The National Council, its members, its boards, or its agents liable, for any cause whatsoever, if the undersigned does not receive a Certificate of Accreditation.

4. The undersigned agrees that if it receives a Certificate of Accreditation, it will not hold the Council, its members, its boards, or its agents liable, for any cause whatsoever, if such Certificate of Accreditation is subsequently revoked.

5. The undersigned agrees that the decision of The National Council with respect to the approval of Accreditation or with respect to the revocation thereof shall be in the sole and absolute discretion of The National Council. Said decision shall be final and the undersigned waives all rights with respect thereto.

6. Cost of survey and accreditation shall be in accordance with the accepted financing plan of The National Council. The survey fee is $75.00 plus $1.00 per bed. A check in the full amount of the fee must accompany application. If refund is requested prior to survey, The National Council may retain $25.00 to cover the administrative costs of processing the application.

7. The undersigned agrees to notify The National Council of any change in the administrator or owner of the facility whenever any such change occurs.

______________ ______________________________
Date Name of Institution

Mail this complete form to:

Signed by ______________________________
Applicant

The National Council for the
Accreditation of Nursing Homes
645 North Michigan Avenue
Chicago, Illinois 60611

SUPPLEMENTAL INFORMATION FOR SURVEYOR

Please complete this form and return with your application for survey. Please PRINT or TYPE all entries. Information in connection with items numbered 1-10 need NOT be mailed but must be available for surveyor's review at time of survey.

1. State license to operate facility. If facility holds dual license, both types must be available.
2. Most recent inspection report by the licensing agency if such is made available to the facility.
3. Written personnel policies.
4. Certificate from fire marshall, if required by licensing agency. Fire and disaster plans.
5. Copy of patient's admittance agreement and brochure.
6. Employment applications and employee health examination reports.
7. Records of staff meetings and in-service training.
8. Nursing procedure manual.
9. Sample of menus for past year.
10. Current patient roster and census or patient register.
11. Report compiled by ______________________________
    Name Title Date
12. Name of Facility ______________________________
13. Date established under present ownership ________ Telephone ______________
    area code number
14. Address of Facility ______________________________
    Number Street/Avenue City,State zone county
15. Type of ownership ______________________________
    (corporation, non-profit agency, church, proprietary,partnership)
16. Name of administrator ______________________________
17. Facility licensed by ______________ Current date ________ Expires
    (agency)
18. Licensed capacity ________ Beds in Use ________ License number ________
19. Type of patients admitted: Chronic, ambulatory, bedridden, mild mental etc.

    ____
20. If facility holds dual license, supply same information on secondary license

    ____
21. Type of building construction (frame, brick, cinder block, etc.) ________

    ____
22. Number of floors ________ Occupied by patients ________ Occupied by staff ______
23. Sprinkler system ________ (wet or dry) Fire detection system ________
    year installed year installed
24. Year building constructed ____________
25. Give brief information on alterations, new construction, additions, changes in ownership ______________________________

    ____

26. Administrator: State briefly education, experience in field, other fields, workshops attended (relating to this field) ____________

____

____

27. Medical and Dental Staff: (a) Physician ____________
Name and Address

(b) Dentist ____________
Name and Address

28. Nursing Care: (a) Charge or supervising nurse ____________
Name

____
Degree Address

(b) Briefly, education/experience in this and related fields ____________

____

(c) Length of employment at this facility ______ In this capacity ______

(d) Total number of nursing care personnel:

		Full Time	Part Time	Equiv. Full Time
(1) Registered Nurse	____	(Hours)	(Hours)	(Hours)
(2) Licensed Practical Nurse	____	____	____	____
(3) Nurses' Aides	____	____	____	____
(4) Orderlies	____	____	____	____

Give Nurse/Patient Ratio [(1) + (2) + (3) + (4) - total full time column] = 1

Is night attendant on duty, awake and fully dressed? YES ______ NO ______

29. Dietary Information: Cooks ______ Full time ____ Part time ____

Helpers ______ Full time ____ Part time ____

30. Housekeepers and Maintenance ______ Full time ____ Part time ____

Remarks: ____________

____

I certify that the answers to the above questions are true and correct to the best of my knowledge and belief.

______
Date

______
Signature of Administrator

______
TYPE or PRINT NAME of Administrator

EQUIPMENT LIST

Facility is not presently required to have all equipment listed. Please note amount in space provided when appropriate. Listed equipment should be that of the facility, not rented or owned by the patient. Make special note of equipment not listed on form.

_____________ Intercommunication system (Nurse call system)

Audio _______ Visual _______ Other type ____________________________

BED

_____________ Hospital, gatch spring
_____________ Hospital, adjustable height
_____________ Other

_____________ Side rails (bed)
_____________ For all beds _____________ Only as needed (number)

EQUIPMENT

_____________ Trapeze frames
_____________ Hydraulic patient lift
_____________ Wheelchairs
_____________ Cubicle curtains
_____________ Portable screens
_____________ Footboards
_____________ Alternating pressure mattress
_____________ Autoclave
_____________ Sterilizer, non pressure (instr.) (Or does facility purchase all disposable sterile supplies?)
_____________ Refrigerator for biologicals
_____________ Sterlizer (bedpan)
_____________ Sphygmomanometer
_____________ Stethoscope
_____________ Tourniquet
_____________ Emergency first aid kit
_____________ Enema equipment (disposable)
_____________ Medicine tray, cards and cups
_____________ Means for measuring liquids
_____________ Oxygen therapy equipment

Nasal _______ Tent _______ Mask _______

_____________ Suction apparatus
_____________ Catheterization equipment (sterile/disposable)
_____________ Bladder irrigation equipment (sterile/disposable)
_____________ Syringes and needles (sterile/disposable)
_____________ Intravenous and sub-cutaneous equipment, including 5% glucose and saline
_____________ Tube feeding equipment

_____________ Rails in corridors
_____________ Grab bars in toilet area ______ bath tub area ______ shower area ______

RECREATION EQUIPMENT

______________ Games (Please note types)

______________ Radio
______________ Television
______________ Crafts
______________ Ceramic kiln
______________ Other

____

____

RESTORATION EQUIPMENT

______________ Therapy room
______________ Bedboards
______________ Parallel bars
______________ Mirror, posture, etc.
______________ Staircase, exercise
______________ Ladder, finger
______________ Hand exerciser
______________ Treatment table
______________ Diathermy
______________ Infra-red lamp
______________ Whirlpool
______________ Hot pack unit
______________ Other

LAUNDRY EQUIPMENT

______________ Washer
______________ Extractor
______________ Dryer
______________ Mangle
______________ (note size and type)

____

____

THE NATIONAL COUNCIL FOR THE ACCREDITATION OF NURSING HOMES

EXPLANATORY SUPPLEMENT TO THE STANDARDS FOR ACCREDITATION OF NURSING HOMES

This explanatory supplement is designed to define terms which may be subject to conflicting interpretations and to outline the principles on which many of the requirements are based. The supplement is not a substitute for the basic standards.

The explanatory supplement is arranged in approximately the same order as the standards.

Board of Directors

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Executive Director

ADMINISTRATION

I. Governing Body

The governing body is the individual, group or corporation in which the ultimate responsibility and authority for the conduct of the facility is vested. Conduct of the facility is meant to include satisfactory compliance with all laws, rules and regulations relating to the operation of the facility. The actual owners must be made known to the Council.

The governing body appoints the administrator, formalizes his responsibilities, and delegates to him the internal operation of the facility. In certain instances, the governing body and the administrator may be the same individual, as in the case of a single administrator/owner. The governing body holds the administrator accountable for operation of the facility in accordance with established policies. The administrator shall be a well-trained executive official who is continuously responsible for the operation of the facility commensurate with the authority conferred by the governing body and consonant with its expressed aims and policies. He is responsible for the control, utilization and conservation of the physical and financial assets of the facility, and for procurement and direction of adequate personnel.

In the discharge of its duties, the governing body must necessarily permit the responsibility for medical care of the patient to rest primarily with the attending physician. The physician, however, must be provided with sufficient materials and personnel to practice effectively in a proper environment. Close liaison between the governing body and the physician is essential to the welfare and safety of the patient. There must be mutual respect for the prerogatives of each other, full acceptance of the individual responsibilities and understanding of one another's problems. This can be accomplished only if there is effective organization, good communication and a willingness to work together.

II. Administrator

Every facility shall have an administrator who is responsible for the total operation of the facility. When the administrator finds it necessary to leave the premises, he shall designate an individual to act for him in his absence. At no time shall a facility be left without adequate supervisory and administrative direction.

The administrator shall be an individual who is in good mental and physical health, capable of making mature judgments, of good moral character and who has the educational and other qualifications necessary to operate and manage a facility. He shall have an understanding of his responsibilities in providing care for the residents. It is desirable for the administrator also to have a broad general education including courses in administration or management.

The progressive administrator/owner who is truly interested in the advancement of his facility will want to take the opportunity to ally himself with people having similar interests in professional associations.

III. Administrative Policy

Prior to admission, every facility shall inform a prospective patient or his representative about rates, and any extra charges that may be made for care and services, and about their obligations regarding payment of such charges. Refund policies of the facility also should be defined. After admission, the administrator should regularly apprise the patient of the amount due for care received and what care this amount covers. The administrator should issue a receipt for any money received for care of the individual.

The Council feels that an admittance agreement is mandatory for each admission in order that the patient, or the responsible persons have a clear understanding of the charges that are being made for the services provided as well as the refund policy. The written agreement should include a statement authorizing the facility to summon a physician in case of an emergency when the personal physician or his alternate cannot be reached.

Each facility shall arrange for at least one licensed physician to be on call to the facility in case of an emergency. The Council does not require that a facility maintain a part-time or full-time physician on staff.

In case of serious illness or accident, medical care shall be secured at once and the nearest of kin or other designated person should be notified immediately. In case of death, both the physician and the nearest of kin or other designated person shall be notified promptly. Procedures to be followed in regard to serious illness, accident or death shall be in writing in the office of the administrator and available to the personnel concerned.

Patients may receive care paid by a third party insurance carrier. In these instances, the administrator/owner shall request the attending physicians to review the continuing need for care at frequent intervals to minimize the danger of over-utilization.

Physical Plant -- The grounds and exterior of the facility shall be kept in a sanitary, safe and presentable condition. They shall be free from refuse and litter and areas around buildings, sidewalks, gardens and patios shall be kept clear of dense undergrowth.

The license of a facility should be conspicuously posted and no facility should have more patients than the number of beds for which licensed, except in case of catastrophic emergency when temporary permission may be granted by the local health officer. At no time should patients be housed in areas which have not been approved by the state licensing agency for housing and which have not been given fire clearance by the State Fire Marshal, except as heretofore provided.

Each facility should be equipped with such equipment and supplies as is necessary for the care and treatment of the patients.

Facilities shall provide for the safekeeping of possessions and valuables of patients if they request this service. In such cases the patient or the person responsible for the patient shall be provided with a receipt for those items placed in safekeeping.

It is important that a bookkeeping system which accurately reflects the details of business be used. Elaborate methods are not necessary, but the system shall permit cost accounting to be carried on, so that the administrator may be aware of the expenses entailed in the several aspects of operation, e.g. salaries, food, materials, insurance, etc. Employment of accountants for this purpose is encouraged. Permission to inspect the system at the time of survey will be requested, not to reveal the profits realized from operation of the facility, but to judge the effectiveness of the accounting process from examination of a number of typical entries. Where the bookkeeping and accounting records are maintained by an outside agency, the Council requires that the agency furnish the administrator of the facility a monthly record of income and expenses. The Council feels this is necessary in order for the administrator to keep abreast of the financial situation and the overall operation of the facility.

An accurate record shall be kept of all funds deposited with the facility for use by a patient. This record should contain a listing of all deposits and all withdrawals made, substantiated by the necessary receipts.

No facility staff member should handle the personal business affairs of patients such as paying bills or making purchases without first being requested by the patient or the responsible party to do so in writing. This provision should not, however, relieve the staff of the facility from keeping the patient's personal allowance record.

Personnel -- Every facility shall maintain adequate and accurate employee records. These records shall contain such information as:

a. Employee's name, address, sex, marital status, state registration number (if applicable), name and address of next of kin, social security number, and other identifying data.

b. Resume of employee's training, experience and previous employment.

c. Results of pre-employment physical examination and subsequent annual physical examinations, to include chest x-ray and physician's reports, for all employees and the administrator. No employee suffering from a serious physical or mental illness or having an active communicable disease shall be employed or permitted to work.

33-257 O - 64 - 8 (Pt. 2)

d. Record of any and all illnesses and accidents incurred while on duty.

e. Attendance and earnings records.

f. Comments concerning employee's work performance, as well as a listing of any institutes or training courses attended, to be completed regularly, not less often than once annually.

Each facility should have written personnel policies available for their employees. These policies should include such items as: Duty hours, sick leave, vacations, holidays, dress, conduct and other items which will help employees perform their duties properly.

Employees should be provided with a dressing room having a toilet, lavatory and lockers. There should also be an employees' bulletin board for the purpose of disseminating information to the employees.

There should be a written statement outlining the general operating procedures of the facility. A copy of this statement shall be available in the office of the administrator. It shall be the responsibility of the licensee to see that the policies and procedures outlined in the statement are carried out in the daily operation of the facility.

Employees who have missed three (3) consecutive work days because of illness or accident should submit a doctor's statement concerning their fitness to work before they are allowed to return to employment. This statement should be made a part of the employee's record.

Administrative policies and procedures should be tailored to meet the needs of each facility and its patients. Standards relating thereto outline only the basic principles necessary to establish a sound management system.

There should be written job descriptions outlining the duties and responsibilities of all employees. Each employee should be thoroughly familiar with his duties and responsibilities as stated in the job description.

Administrative policies and procedures should be tailored to meet the needs of each facility and its patients. Standards relating thereto outline only the basic principles necessary to establish a sound management system.

On-the-job training should be carried on to improve the level of services provided by personnel. This should commence with orientation and indoctrination at the time of employment and progress towards developing maximum proficiency at a pace in keeping with the trainee's ability. An ongoing program, including instruction in interpersonal relationships as well as technical matters, tends to increase the employee's interest in his job, to assure good attitudes towards the patients, relatives and other employees, and to reduce personnel replacements.

There shall be a written procedure posted in each facility to be followed in case of fire, explosion or other emergency. Employees shall be instructed in this procedure. The plan shall include such items as: Whom to notify, alarm signals, fire extinguisher locations, evacuation routes, procedures for evacuating helpless patients and personnel assignments for specific duties and responsibilities. Facilities with doors and hallways not wide enough to permit the movement of patient's beds in an emergency shall also specify the method of evacuation. In addition to the existence of a fire control plan, there must be evidence of drills conducted by all personnel at least two (2) times a year.

A reference library containing current textbooks of basic practices in such subjects as restorative techniques, pharmacology, anatomy and nursing techniques is desirable and should be readily accessible to the staff. The scope of material beyond this minimum would depend on the specific needs of each facility.

Housekeeping -- The general atmosphere of the facility should be suggestive of hominess and comfort. The smaller facility will attempt to duplicate the atmosphere of the well-organized and well-run private home. The larger facilities will in many instances more closely resemble a clean and sanitary small hospital. The general atmosphere should reflect those services which the facility is offering.

Rooms -- Patient rooms should be cleaned, arranged in an orderly fashion and well ventilated. If patients keep their own rooms clean, they should be supervised properly to insure accomplishment of this function. After a patient has vacated a room, the room and all its contents should be thoroughly and completely cleaned, aired and deodorized when necessary. Clean bed linen shall be provided. All utensils should be washed and sanitized.

Odor control should be achieved by cleanliness and proper ventilation wherever possible. Deodorants should not be used to cover up odors caused by unsanitary conditions or poor housekeeping practices.

Storage -- Storage areas should be maintained in a safe and neat manner. Combustibles such as rags, cleaning compounds and fluids should be kept in closed metal containers. The lower edge of the bottom shelf or dunnage should be at least six (6) inches above the floor with space beneath for cleaning.

Attics, cellars and similar areas should be kept free of accumulations of refuse, discarded furniture and old newspapers.

Safety -- General storage space should also be provided sufficient in area to prevent corridors and patient rooms from becoming congested with unused wheelchairs, walkers, etc.

Safety of the lives of patients is a fundamental requirement for accreditation. No matter how excellent a facility is in all other respects, if the building is a fire hazard, it will not be accredited.

In addition to close scrutiny by the surveyor, the Council requires evidence of regular inspection by local fire control agencies. To assess the hazards, the Council requests information about the age of buildings and the percentage of occupancy. Control measures are carefully observed during survey such as the type, placement and renewal dates of fire extinguishers, and the necessary installation of sprinkler systems, especially in laundry, trash chutes and storage rooms.

The use of candles, kerosene oil lanterns, or other open flame methods of lighting shall not be permitted.

Facilities should have available, and in working order, necessary emergency lighting to provide sufficient illumination and maintenance for all required signals, alarms, exit lights and other lights necessary to enable persons to see as they leave the building, and to permit continued function of the facility at a level sufficient for basic care. Also, plans shall be formulated in the event the source of gas or water supplies are impaired.

Smoking should be permitted only under supervision and in those areas authorized by the local fire inspector.

Polishes used on floors shall be of a type which will provide a non-slip finish. Throw or scatter rugs are not permitted. Floors should be maintained in a clean and safe condition.

The facility shall be maintained in a good state of repair, shall be designed for quick evacuation and shall have adequate ramps, rails and other safety features such as grip bars in the vicinity of bathtubs, showers, and toilets used by patients. Objects which act as a hazard to ambulation should be removed.

Sanitation -- An adequate supply of clean laundry shall be on hand. Laundry should be handled, stored and processed so that spread of infection will be controlled. Soiled laundry should not be permitted to accumulate and proper laundering techniques should be used. These practices should also be extended to the commercial laundry when the laundry is on a contract arrangement.

Insurance -- The facility should carry liability insurance including malpractice insurance with an adequate limit of liability. In addition, the facility should carry workmen's compensation insurance for all employees as required by the state.

General Policy -- Proper control of noise level should be enforced to insure that patients are not disturbed. Importance shall be placed on the location of the kitchen, laundry and other noise areas in relation to the patients' rooms. Also, the facility should not be located geographically close to noise and odor-producing activities in the community.

Facilities shall admit or retain only those patients who can be treated safely and adequately, within the limitations of licensing requirements. Individuals whose care requirements exceed the capabilities of the facility create an unnecessary hazard for themselves and for others when admitted or retained inappropriately.

The individual in charge on each work shift shall have access to all areas used in the normal course of his duties. Keys to restricted areas shall be immediately available for emergency purposes.

There shall be adequate segregation of patients according to sex, age, and medical condition. Also, accommodations should be provided for the temporary isolation of patients with communicable diseases and for the privacy of terminal or disoriented patients.

The interior of the facility should be maintained in a clean, sanitary, neat, safe and orderly manner using accepted practices and procedures.

Housekeeping, laundry, food service and maintenance staff should not give direct patient care except in accordance with accepted nursing service policies and procedures.

Diagnostic services, laboratory services, radiology services, etc., are not necessary parts of an establishment recognized as a nursing home. If such additional services are included in the program of the nursing home which the Council is surveying, these should be judged by an agency in the community which is qualified to do so. This will have to be done before full accreditation can be given to a facility having these services.

Medical Care -- All patients admitted shall be under the care of a physician licensed to practice in the state. The attending physician of the patient shall be informed immediately upon admission of his patient. The physician in turn shall be expected to immediately furnish the facility with an admitting diagnosis, diet order and treatment orders. The remainder of the patient's medical record which includes a medical evaluation (complaint, present illness, past history and family history), physical examination, and a treatment of rehabilitation potential should be completed by the attending physician in 48 hours. The name of the alternate physician should also be obtained from the attending physician.

It is anticipated that each of the county medical societies and each of the district dental societies throughout the country will establish a nursing home liaison committee for the purpose of offering consultative service to the administrators of the various facilities. It will not provide direct medical or dental advice in the care of a specific patient. It will, however, when requested, help to establish procedural policy and offer general medical and dental guidance.

The name and telephone number of the patient's personal physician and his alternate shall be recorded in the medical record so that in case of an emergency, if the attending physician is not available, the facility would know whom to contact.

The physician should be called when there is any major change in the patient's physical or mental condition. Immediate examination and appropriate treatment by a physician should be given to any patient who has had an accident or injury. The name, address and telephone number of each patient's attending physician and specific written instructions for the procedures to be followed in case of an emergency should be readily accessible and known to all staff members responsible for the care of the patients. The facility shall arrange for at least one (1) physician to be available in the event of an emergency.

Periodic medical examinations are important for any person, particularly for those who are aged. The medical record should indicate that periodic examinations are performed.

It would be desirable for each facility to have an advisory physician (or medical advisory committee composed of licensed physicians). The advisory physician as such should not be responsible for the care of individual patients, but would be responsible for advising the administrator concerning the overall management of patients in the facility. The advisory physician could also be available for emergency calls.

Dental Care -- Patients admitted to the facility for dental care should be given the same careful medical appraisal as those admitted for a medical condition. This makes the care of the dental patients the dual responsibility of the dentist and the physician, each limited to his respective field; the dentist to the buccal cavity and jaws, and the physician to the medical aspects. Policies concerning the admission and discharge of dental patients shall be mutually agreed upon by the physician and the dentist. The important factor is not the procedure but the assurance that the dental patient is well cared for by both the dentist and the physician.

It would be desirable to have a dental evaluation on each patient at the time of admission so that proper steps can be taken to correct known deficiencies. Each facility should be conscious of the dental needs of its patients. An evaluation of the patient's dental status should be made on admission and periodically thereafter, and included in the medical record. The patient should be seen as often as necessary by his own dentist for therapy or dental restoration.

All dental patients treated in the facility shall be by a dentist licensed to practice in the state. The name and telephone number of the patient's personal dentist and his alternate should be recorded in his medical record so that in case of an emergency, if the attending dentist is not available, the facility would know whom to contact.

It would be advisable for each facility to have an advisory dentist (or dental advisory committee composed of licensed dentists) to advise the administrator concerning dental services and policies. The advisory dentist as such should not be responsible for individual dental services to patients, but should make every effort to see that appropriate dental care is provided.

The advisory dentist would have the responsibility for recommending policies concerning oral hygiene and the hygiene of dental prosthesis. The administrator and other personnel of the facility should be advised concerning oral hygiene procedures and other matters relating to the dental health of patients. The following program of oral hygiene for the day-to-day care of patients is recommended. This regimen of daily care may be starting point of the entire dental care program:

Instructions to the Patient

In order to encourage full cooperation, the patient should be instructed in the following areas of personal hygiene:

a. The role of toothpastes, powders and mouthwashes in proper oral hygiene.

b. The methods of toothbrushing and the type of brush to use.

c. The proper use of dental floss.

d. The care and cleansing of prosthetic appliances.

e. The importance of daily oral hygiene maintenance for the patient's well-being.

The Dentist's Role

Periodic examination, relief of pain and the rendering of necessary professional services are the responsibility of the dentist. The dentist in conjunction with the physician, should indicate the diet for the patient to insure proper nutrition.

The Nurse's Role

One of the most important considerations that a nurse should have for the patient is that of good oral hygiene. Many patients do not have the strength or emotional stability to maintain good oral hygiene. The nurse should aid and instruct the patient in brushing his teeth at proper times. Where this procedure is not possible, the patient's lips, teeth and gingivae should be rubbed lightly with moistened cotton or gauze. All removable prosthesis should be properly cleaned. The nurse should be trained to identify oral lesions, swellings and other irregularities, and to call the dentist when such lesions are noted.

State Licensing Laws

Each patient shall be provided a clean and comfortable bed and mattress, a bedside table, chair and storage space for clothing, toilet articles and other personal belongings. In addition, a supply of clean bed linen, blankets, pillows, wash cloths and towels shall be provided along with such equipment as wash basins, mouthwash cups, bedpans and urinals as indicated. There should also be a nurses' "call system either visible or audible" provided for each patient's bed and in each toilet room, bathroom and shower room used by patients. When side rails are required they will be attached to both sides of the patient's bed. Separate toilet facilities shall be provided for patients. All patient rooms should have an outside exposure, should not be below ground level and should not be used as a thoroughfare to gain entrance to other areas of the facility.

Adequate glare-free lighting shall be provided in all areas of the facility. In addition to general lighting, facilities shall be equipped with night-lights in corridors, toilets, patient rooms and similar areas to provide a lighting level of not less than one (1) foot candle. There shall be individual reading lights at each bed.

In all geographical areas requiring heated structures, a central heating system of sufficient capacity to raise temperatures in all parts of occupied rooms to a minimum of 70 degrees F. during coldest periods should be provided. The heating system should be thermostatically controlled in one or more zones. The necessary heating sources shall be furnished in each room or occupied space for maintenance of a comfortable temperature. Heating fixtures shall be properly shielded for the safety of the patients. Portable room heaters shall be discouraged. Each heating source should be equipped with hand controls except in those facilities where individual room automatic control is provided.

Each facility shall be well ventilated through the use of windows or a forced air system, or a combination of both. Areas which do not have outside windows and are used by personnel, such as utility rooms, toilets, bed pan rooms, baths, sterilizer rooms, food storage rooms, etc., should be provided with forced air or other suitable ventilation.

Every facility shall have at least one non-coin operated telephone which is accessible to all employees at all times for use in emergencies. The names, addresses and telephone numbers of the following individuals and agencies shall be posted conspicuously beside this phone, or immediately available:

a. Administrator
b. Advisory physician
c. Advisory dentist
d. Nurse-in-charge of nursing service
e. Local fire department
f. Local police
g. State police
h. Other key people
i. Local hospital
j. Ambulance service

Patient rooms which are approved only for ambulatory patients should not accommodate nonambulatory patients. Before patients are accommodated in ambulatory sections they shall have demonstrated that they are able to walk without assistance and this shall be noted in the health record. The facility shall transfer patients from the ambulatory section if they become non-ambulatory.

An ambulatory patient is defined as one demonstrating the mental competence and physical ability to leave the building without assistance or supervision by any person in case of emergency.

SERVICES WHICH MUST BE MAINTAINED

1. Dietary Services

The administrator or a person designated by the administrator shall be responsible for the total food service of the facility. Sufficient staff shall be employed to meet the established standards of food services. Provision shall be made for adequate supervision and training of the employees.

It is the opinion of the Council that this service should be under the supervision of a qualified person on a full time basis. There shall be facilities for preparing therapeutic diets, although this does not necessarily require a special diet kitchen. In visiting a facility the surveyor evaluates this service on the basis of cleanliness, proper and adequate refrigeration, dishwashing and garbage disposal facilities, safety practices in the preparation and transportation of food and controls established to insure proper diet therapy. Special attention shall be given to the overall appearance of dietary personnel. For example, hair should be well groomed, fingernails trimmed and clean, etc.

A facility which contracts with an outside food management company for dietary services may be accredited provided the company has a therapeutic dietitian on the staff who acts as a consultant and visits the facility periodically.

Dietary records shall be correlated with the medical records. Diet prescriptions shall be specific and complete, and patients' reaction to diet therapy should be recorded.

Menus shall be planned and written at least one (1) week in advance. The current week's menus shall be in an accessible place in the kitchen for easy use by dietary personnel preparing and serving food. This and other measures shall be taken to avoid routine meals. Records of menus as served shall be filed and maintained for reference by personnel of the facility for a period of four (4) weeks. Cyclic menu planning is acceptable, taking into consideration the season of the year and also the length of the cycle. It is felt that cycling should be of not less than two (2) weeks. Monotony is to be avoided.

At least three (3) meals per day shall be served with not more than a fourteen (14) hour span between a substantial supper meal and breakfast, and not less than ten (10) hours between breakfast and a substantial supper meal. It is desirable to make provisions for serving between meal snacks of a nourishing quality.

A manual of policies and procedures for food service to patients and personnel should be developed in writing and made available to those responsible for all management aspects of the food service program.

Therapeutic diets which are part of medical treatment shall be prescribed in written order by the physician; for example, sodium restricted diets, bland-low residue diets, calorie restricted diets, modifications in carbohydrates, protein or fat, etc. In order to serve therapeutic diets as ordered, a facility shall have an approved diet manual readily available to dietary personnel.

Food service is one of the basic services provided by the facility to its patients. Careful attention to adequate nutrition and prescribed therapeutic diets can contribute appreciably to the health and comfort of the patient and can stimulate his desire to achieve and maintain a higher level of self-care. The facility should endeavor to provide patients their nutritional, social, emotional and therapeutic needs. It would be ideal to have the services of a professionally qualified dietitian, though dietary consultants available through the appropriate licensing agencies can be of tremendous value.

Food and nutrition needs shall be met in accordance with the current Recommended Dietary Allowances of the Food and Nutritional Board of the National Research Council, adjusted for age, sex and activity. These allowances may be achieved by a variety of food combinations adapted to the food habits and preferences of the patients. Nutrient concentrates and supplements shall be given only on the written orders of a physician.

Foods should be prepared by methods which conserve optimum nutritive value, flavor and appearance, acceptable to the individuals served. A file of tested recipes should be maintained to assure uniform quantity and quality of products. Foods should be attractively and neatly served. Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving.

It is not sufficient merely to prepare a variety of good foods at each meal if no consideration is given to individual food preferences and individual abilities to consume the food. Many elderly people, particularly those who are somewhat senile, will prefer to make a meal from one type of food. Personnel who understand this situation can see to it that dietic correction is made at the next meal.

Provisions should be made for an adequate, attractively furnished dining area. When this is not feasible, the living room, day room or recreation area might be used at mealtime. For those who are able to be out of bed, but who do not go to a dining area, sturdy tray stands of proper height shall be provided. For those who are bedfast or infirm, tray service shall be provided in their rooms with the tray resting on a firm support. Provisions shall be made to aid problem patients with their eating.

All trays, tables, utensils and supplies used for meal service such as china, glassware, flatware, linens and paper placemats or tray covers should be appropriate, sufficient in quantity, and in compliance with the applicable sanitation standard.

Supplies of perishable foods for a twenty-four (24) hour period and of nonperishable foods for a one (1) week period shall be on the premises to meet the requirements of the planned menus. The non-perishable food shall consist of the commercial type processed foods.

Personnel and visitors eating meals or snacks on the premises shall be provided with dining facilities separate from and outside of the food preparation, tray service and dishwashing areas.

Medical Records

There shall be a separate medical record for each patient. Such records shall be a chronological history of a patient's stay in the facility and every entry shall be dated and signed. The patient's medical record shall be kept on file in the nursing station until the patient is discharged, then it shall be collated and filed in an accessible place elsewhere in the facility.

Since medical records reflect patient care, the Council evaluates a record on the basis of whether or not it contains sufficient recorded information to justify the diagnosis, to reflect the treatment given and to describe the results obtained.

a. Content -- Medical records shall contain the following information:

(1) Identification data

The admission record shall be completed at the time of admission, or within 48 hours after admission. It shall contain identifying information such as: Patient's name, marital status, age, sex, home address, religious affiliation, name and address of attending physician, and his alternate, name and address of next of kin, physician's diagnosis, the information concerning the referral, if any. It shall also indicate the date the patient was admitted.

(2) Medical evaluation (complaint, present illness, past history and family history). Only physicians are competent to write or dictate medical histories and physical examinations. All pertinent positive and negative findings should be recorded. Nurses, or secretaries, shall not be permitted to take medical histories.

(3) Physical examination

Each patient should undergo a complete medical examination by the attending physician immediately prior to admission to the facility or within 48 hours after admission.

(4) Admitting diagnosis

There shall be an admitting diagnosis made on every patient at the time of admission. If a patient requires hospitalization, the facility may need this information to proceed intelligently.

(5) Diet orders

Prescription of a diet for the patient is necessary at the time of admission to insure the patient is served food consistent with the program of medical care.

(6) Progress Notes by Physicians and Dentists

Progress notes should be entered in the medical record at the end of each visit by a physician or dentist. It is felt that patients who are ill enough to occupy nursing beds should be seen by the attending physician not less often than at monthly intervals and considerably more often should the condition of the patient warrant it. These are important as they give a chronological picture and analysis of the clinical course of the picture.

(7) Nurses Notes

This section of the record should contain observations made by nursing personnel in accordance with the policies of the nursing service. All entries shall be dated and signed. In nursing facilities, nurses notes should be kept daily. The medical records, including vital signs, (pulse, respiration, temperature), shall be recorded sufficiently often to reflect the status of the patient. All medication administered shall be charted.

(8) Medication and Treatment Sheet

Notation of all medications given to the patient shall be made on the medication and treatment portion of the medical record. All entries on this portion of the record shall be dated and signed by the individual giving the medication or treatment.

(9) Laboratory and X-ray Reports

To be maintained in the medical record if examinations and tests are conducted.

(10) Consultations

Consultations include an examination of the patient and the patient's record. The consultation note shall be recorded and signed by the consultant.

(11) Physicians and Dentists Orders

All treatment, medication or other medical and dental procedures relating to the patient shall be recorded in this portion of the medical record. This section should also contain any comments of the physician or dentist regarding the patient care or condition. All entries shall be dated and signed by the attending physician or dentist. Orders shall be reviewed and renewed periodically.

(12) Final diagnosis

A definitive final diagnosis based on the terms specified in the Standard Nomenclature of Diseases and Operation shall be written.

Medical records are an important tool in the practice of medicine. They serve as a basis for planning patient care, they provide a means of communication between the physician and other professional groups contributing to the patient's care, they furnish documentary evidence of the course of the patient's illness and treatment, and they serve as a basis for review, study and evaluation of the medical care rendered to the patient. For these reasons the Council considers the quality of medical records an important indication of the quality of patient care given in a facility.

There should be evidence on the medical record that the diagnosis was made on the basis of information given by the patient in the history, a careful physical examination, and a scientific interpretation of the findings. There should be sufficient data recorded to justify the physician's treatment of the patient and the results.

The attending physician shall separately sign the history and physical examination, progress notes, drug and other orders. Aside from the fact that this is a legal requirement, it is a protection to the individual physician. In all instances a physician shall sign the clinical entries which he himself makes.

A single signature of the physician on the face sheet of the medical record does not suffice to authenticate the entire content of the record.

This Council recommends no specific medical record form. Records are evaluated on the basis of content and whatever forms the facility finds most useful are acceptable. It is felt that check-off lists do not adequately provide sufficient information to substantiate the diagnosis and treatment.

Current medical records should be completed insofar as possible within 48 hours. After discharge, records shall be completed within fifteen (15) days. A system of identification and filing to insure the rapid location of a patient's medical record shall be maintained. The unit number system is suggested; however, a serial number or modification of this is acceptable.

The Council has no standards governing the preservation of medical records. The length of time a record is preserved is a matter which should be determined by local laws. Methods of preservation by microfilming or other means of storage is a decision for the individual facility to make.

The medical record is the property of the facility and is maintained for the benefit of the patient, the physician and the facility. It is the responsibility of the facility to safeguard the information on the record against loss, tampering or use by unauthorized persons.

3. Medication Control

The requirement that policies must be maintained to control the administration of dangerous drugs, with specific reference to the duration of the order and the dosage, is misunderstood frequently by facilities and physicians. The Council has no right to tell physicians what kind and how much medication they shall give to their patients and does not do so. The Council does desire that drugs, especially dangerous drugs, be given properly with reasonable controls. The Council is asking that the facility establish a written policy that all dangerous medications not specifically prescribed as to time and number of doses, be automatically stopped after a reasonable time limit. It is a protection against indiscriminate and indefinite prescribing of an open-ended type which can result in harm to the patient, physician or facility. It especially includes such orders as p.r.n., "as necessary", etc. The classifications ordinarily thought of as dangerous drugs are narcotics, sedatives, anticoagulants and antibiotics.

No medication, therapeutic diet, or treatment shall be given to a patient except on the written order of a physician, except in the case of emergency when the physician may give the order by telephone. In such cases the physician shall write and sign the order on his next visit to the facility.

Nursing Service

Nursing services shall be under the direct supervision of an individual who is a registered professional nurse currently licensed to practice in the state. It is desirable that she have training and/or experience in nursing administration, supervision, and restorative services. She shall function under the general direction of the administrator. The nurse-in-charge shall be designated to be responsible in the supervisor's absence and shall be sufficiently qualified to act in that capacity at those times. Responsibilities of the supervisor should include: Working with administration on --

a. Participation in planning and budgeting for nursing personnel and equipment;
b. Developing and having accessible in writing, clearly defined nursing service objectives which are specific, practical, attainable, yet flexible enough to meet the needs of the patients;

c. Developing written job descriptions for all levels of nursing personnel;
d. Establishing nursing policies and developing nursing practice and procedure manuals to guide the nursing staff. The manuals shall be accessible to the nursing staff and the administrator;
e. Selecting, assigning, and supervising all levels of nursing personnel in the performance of their duties;
f. Developing a continuing inservice educational plan for all nursing personnel. All new nursing personnel shall receive a thorough job induction in addition to the continuing inservice educational program for all nursing personnel;
g. Participation in the screening of prospective patients in terms of service available in the facility;
h. Providing professional nursing care for all who need it,
i. Maintaining a daily census report.

The number and level of all nursing personnel shall be determined by the number of patients and their needs, the physical layout of the facility, the services offered by the facility as well as other factors relating to the provision of good nursing care. Every facility shall have a sufficient number of nursing personnel on duty and working (not just on call) at all times to assure complete, safe and efficient nursing care of patients. These nursing personnel shall be available to respond promptly to patients' requests and shall observe every patient at regular intervals day and night. There shall also be such additional nursing personnel on duty as is necessary to meet the needs of the patients being treated.

Good organization is basic to effective group performance and the nursing service must be organized to carry out its responsibilities. There shall be a plan of administrative authority with a definite outline of responsibilities and duties of the nursing staff. The Council suggests that the nursing staff have regularly scheduled meetings on a monthly basis to review and evaluate nursing care, with thought given to improving service to patients. To illustrate, the nursing staff meetings may appropriately include such topics as nursing care plans for individual patients in the facility, consideration of specific nursing techniques, establishment and interpretation of nursing policies, interpretation of administrative policies and reports of meetings and conventions and the like.

It is expected that there be written nursing care plans for patients. These may be on an individual or group basis. The principle is that thoughtful planning has been done to make sure that the patient receives the nursing care he needs. Every patient should show evidence, at all times, of adequate nursing care. Some criteria for determining adequate nursing care include:

1. Evidence of good personal hygiene, such as clean, neat, well-groomed hair; clean, trimmed fingernails and toenails; clean skin and absence of offensive odors; clean mouth and teeth and absence of dry, cracked lips.

2. Evidence of good feeding practices by use of self-feeding devices, attention given to individual food preferences, knowledge of food intake of individual patients, relaxed mealtime atmosphere, use of dining room facilities by as many patients as are able to go to the dining room.

3. Freedom from decubiti and evidence that a regular program is in effect to prevent them.

4. Evidence of proper bed and chair positioning.

5. Evidence of clean rooms, beds, bed linen and clothing.

6. Evidence that nursing equipment is in sufficient supply, in good condition, is properly cleaned and cared for, well-organized and readily available.

7. Evidence of proper procedure in regard to aseptic technique.

8. Evidence of kind, considerate care.

9. Evidence of continuous effort being made to reduce bedfastness by encouraging activity, self-help and maintenance of range of movement to prevent or reduce deformities.

10. Evidence that a continuous program is in effect to prevent and reduce incontinence.

11. Evidence that patients are encouraged to be up and dressed.

12. Evidence that precautions to assure the safety of patients are continuously in effect.

It is recognized that at the time of the survey visit a specific patient may be awaiting dressing changes, colostomy bag changes, etc. These represent a temporary state rather than any reflection upon the overall nursing care. Recent admission from elsewhere will be given proper consideration in regard to their state of apparent nursing care.

Every precaution should be taken to insure that the correct medication and treatment is administered to the patient intended. To accomplish this, nursing personnel should be instilled with the necessity for patient identification. This may be aided by the use of identification bands.

Every accident (whether resulting in an injury or not) and every unusual incident (such as effects of exposure, adverse reaction to medications or treatments) involving a patient shall be described on an incident report form. One copy of the completed report shall become a part of the patient's health record and a duplicate copy filed in the office of the administrator. Incident reports shall contain information as: name of the patient, witness (if indicated), date, time and extent of the accident or incident, circumstances under which it occurred and action taken. An incident report shall likewise be completed for visitors and employees having accidents and also be filed in the office of the administrator.

Physical restraints shall not be used except when they are necessary to prevent injury to the patient or others, and when alternative measures are not sufficient to accomplish this purpose. These measures should not be employed without a signed order of a physician, except as temporary measure in a clear-cut case of medical emergency. In this event, the signature of a physician shall be obtained within twenty-four (24) hours.

Recreational Services

Recreation services may vary from the simplest (reading material and letter writing) to organized group activities. This will depend upon the size of the facility as well as the interest and skill of the supervisor and nursing staff.

Each facility should provide wholesome and satisfying individual and group activities, recreational and diversional opportunities suited to the needs and interests of its patients. Each facility shall have adequate and suitable indoor and outdoor recreational areas.

Patients shall have free access to these recreational areas and shall not be required to remain in their rooms, unless so ordered by their physicians. Some activities and recreational opportunities should be available for those who, for any reason, are unable to leave their rooms. Such actities need not necessarily be of a supervised nature.

Facilities should be familiar with community social and recreational activities. Patients should be encouraged to participate in such activities both in and outside the home whenever possible. Participation in any activity shall be voluntary unless the physician prescribed the activity for therapeutic reasons. Patients should be encouraged but not forced to participate.

They should be permitted to leave the premises to visit, shop, attend church, or engage in other social activities unless good cause can be shown for refusing such permission. Such denial of privilege shall not be done without the written consent of the attending physician and a written release of responsibility from the patient, his guardian, or a responsible member of his family where indicated.

Opportunities for participation in the following types of activities, in the facility or by utilization of outside resources and services, should make for a well-rounded and satisfying experience for the patients:

1. Social activities of a personal or family type;
2. Recreational activities of such variety so that all of the varied interests of the individual patients may be satisfied, and
3. Opportunities for constructive and useful contributions to the work of the facility, the patient group, or to the community.

In planning and developing the activity program, the following principles should be kept in mind:

a. Planning should start with the patients, with their interests, abilities and wishes and their participation should be encouraged at all stages in planning as well as in the execution of plans. The degree of participation by the patients will depend on their health, mental condition, abilities and experience, and on the experience of the group in working together.

b. The activity program, considered in the broadest sense as including everything that goes on in the daily life of the patients, should make it possible for each individual member to have a feeling of belonging, a feeling of being wanted and needed, a feeling of accomplishment and opportunities for making a constructive contribution to the group.

c. Social and recreational activities should provide for community relationships for both the facility and the patients. They should be encouraged to participate in activities outside of the facility when possible. Activities within the facility should be open when possible to persons from the community.

Facilities planning to enlist the services of volunteers from community service groups should keep in mind the following principles:

1. Careful planning and supervision is essential. Not only must the specific activity be fully organized and planned for in great detail, but there must be over-all planning with the volunteers as to their relationship to the total program. The volunteers should be given at least a general orientation to the facility, its services and limitation, and normal routines, so that there will be no inadvertent interference with the program.

2. Volunteers should be trained for the work they are to do and should also have help in how to work with the aged. If the volunteers have not been carefully selected and screened by the sponsoring organization, the facility should provide at least a minimum of orientation to work with the patients.

   Volunteers who do not have a real liking for aged persons and an ability to feel comfortable with them should not be accepted even though they have valuable technical skills.

3. The patients should be included in the planning. Activity which is imposed from the outside is not likely to be successful.

4. The most effective activities will be those in which the patients are helped to do things for themselves, rather than those in which the patients are recipients or spectators.

Many communities have Volunteer Bureaus in their Council of Social Agencies, Community Welfare Council or Community Chest, which recruit and train volunteers for all types of work with community health and welfare agencies. Such volunteer bureaus should be a valuable resource.

Every facility should avail itself of as many of the various community resources and services (public and voluntary) as needed to provide a well-rounded activity program for its patients.

Among the resources available in every community are the following:

a. Public libraries
b. Public recreation departments
c. American Red Cross (has many different services which may be useful)
d. Adult Education Division of the local school department

e. State Department of Education Services for the Blind
f. Church service groups (individual, conference and inter-denominational)
g. Youth serving agencies (Boy Scouts, Girl Scouts, etc.)
h. Community Service Clubs
i. Hobby groups
j. Employee organizations and labor unions

Person in charge should have a sensitivity and knowledge of the behavior patterns and symptomatology of older people. They should be able to interpret properly their attitudes, to supervise their activities, to encourage continuing self-care and to the extent of their ability, to assist with their care and to speak intelligently to the visiting relatives and the attending physician.

The maintenance of good mental and physical health is dependent upon supervised physical and mental activity. Programs to this end shall be the responsibility of the administrator. Every effort should be made to keep patients ambulatory. Means to this end include proper exercise, accident prevention and interesting and stimulating activities.

It is of paramount importance to keep the patient in contact with his family, his friends and the community. Therefore, each facility should provide a favorable environment to make visiting pleasant for patient and visitor alike. Provisions should be made to insure privacy during visits and for regular intervals when patients may receive visitors.

There are many services given for the patients which cannot be performed properly during visiting hours and for this reason unrestricted visiting may pose problems. However, visiting hours should be adequate. Visiting by friends and relatives should be encouraged.

It is recognized that some patients will be unresponsive and resistant to efforts to interest them in activities of any kind and that it may require persistent individual attention and encouragement to gain their participation. The value of such participation to their general health and well-being will more than compensate for the effort expended.

The older patients, particularly those who are senile, will require considerable encouragement and supervision. There is a tendency of many older people to insulate themselves from the activities which surround them. A skillful nurse or aide can properly motivate the older patient to join in group activities.

It is not anticipated that religious services will be held in the facility. Every facility shall endeavor to meet the religious needs of its patients. The clergy of the community should be consulted in this regard. The administrator and staff shall refrain from imposing their religious beliefs on their patients. They shall be free to attend, or not to attend, religious services, inside or outside the facility. If they wish to attend a religious service and are capable of doing so, the facility should make every effort to make attendance possible. Transportation arrangements may well be made with local churches and synagogues. Members of the clergy shall be permitted to see patients at all reasonable hours and an area shall be provided where they may practice their religious beliefs or consult with clergymen, visitors, attorneys, etc., in privacy.

Patients should be encouraged to maintain contacts within the community. Visiting policies should be as liberal as possible and shall be explained to patients' relatives and friends at the time of admission. A simple brochure may be developed explaining the policy and giving other pertinent information about the facility. Restriction of visiting privileges should be avoided except when imposed by the attending physician for medical reasons. Special consideration shall be given to seriously ill patients. Freedom of communication should not be abridged by intercepting or censoring of mail or telegrams, unless written authorization is given by responsible person for a specific purpose.

Continuing interest by relatives and friends of patients should be fostered by the administrator. If the patient's family does not visit regularly, a responsible relative shall be informed about the current status at intervals, preferably not less often than once monthly. Any unusual change in the condition of the patient shall be reported without delay.

Restorative Services

The primary function of the facility is to provide nursing care and related medical services. However, this is by no means its total function. Of vital importance also is the provision of social, diversional, recreational and spiritual activities and opportunities. The facility has the responsibility for meeting or arranging to meet the total needs of each. The facility should help each patient to: (1) maintain his individual dignity and self-respect, (2) strengthen and maintain facility and community relationships, (3) have opportunities for individual satisfactions, and (4) adjust to the pattern of living in the facility.

With understanding of the physical, mental and psychosocial needs of the patient, he can be encouraged to do more for himself within the limitations of whatever environment in which he finds himself. He can be trained in the activities of daily living, that is, to feed himself, to use adaptive equipment, to move from bed to wheelchair, to become a member of a social group. Concern should be expressed not only about the illness of the patient, but about the person himself. There is a responsibility to show the patient that he can still do many things and be a valuable member of a social group. With physical restoration and rehabilitation nursing procedures directed toward independent living, he can be helped to regain self respect and human dignity.

Each facility should make every effort to help each patient achieve his fullest potential for self care through treatments and procedures ordered by the patient's physician. These may include:

1. Early and progressive ambulation through simple strengthening graduated exercises;
2. Retraining in the activities of daily living;
3. The correction of visual, auditory, dental or orthopedic handicaps with the proper prosthesis.

More and more emphasis is placed on restorative techniques. Knowledge concerning this is available at various workshops and training courses. Attendance at these workshops and/or training courses indicates that the administrator is interested in improving the services offered by his facility.

The medical records should contain a statement of rehabilitation potential of the patient.

It is the responsibility of nursing supervisor to insure that all nursing personnel are trained in rehabilitation procedures and are kept abreast of restorative techniques leading to maximum self-care, and that their training is being applied.

Rehabilitation begins just as soon as the diagnosis has been made, and it continues through the hospital or nursing home or any place where nursing care is provided for the ill or disabled patient. Early prevention is essential to forestall further disability, for the restoration process and often the process of maintaining the person at the same level, is a difficult one. In the practice of rehabilitation, the nurse assists the patient to do for himself and to use his abilities no matter how limited they may be. To do so, the nurse must understand and use certain physical restorative techniques such as:

a. Prevention of Deformity, Contracture and Disuse -- Positioning the patient with various disabilities in and out of bed. Use of adaptive devices such as "monkey bars," overhead frames, footboards, traction appliances, splinting and bracing. Exercising the patient for prevention of deformities;
b. Bowel and Bladder Training -- Teaching the paralytic and non-paralytic patient methods of bowel and bladder elimination and control;
c. Self Care -- Teaching the patient to take care of his daily needs, including use of the various improvised devices in feeding, grooming, bathing, dressing and communicating;
d. Ambulation -- Teaching the patient to move safely in and out of bed, in and out of wheelchair; use of walkers, crutches and cane.

To acquire understanding in these techniques; to develop skills in planning and supervising restorative nursing programs; and to become more aware, not only of medical problems, but also of the social and psychological aspects of patient care are the major objectives. It takes real understanding of human needs and the cooperation of all to help an individual reach as great a functioning level as possible, whatever this may be, and still have something to live for.

Rehabilitation is a rather widely used term which frequently refers to the care of the patient as a "whole." Its goal is to help the patient gain an optimal level of functioning; however, this goal may vary from individual to individual. For one person it may mean correcting an impairment so he can return to competitive work; for another it may be only helping him to do more for himself in order that he can be independent in taking care of some of his own body needs.

Larger facilities with a rehabilitation program will probably employ a professional physical and occupational therapist to manage the department. Smaller facilities may have a visiting physical and occupational therapist or competent volunteers. Provisions should be made by the administrator/owner for the instruction of the nursing staff in rehabilitation procedures. Examples of how this might be accomplished are: visiting physical and occupational therapists, workshops, county medical society liaison committees and personal example. Larger communities will undoubtedly offer rehabilitation services. Adequate use of these should be made wherever possible.

An important aspect of operating this type of facility is to provide individual care services. The facility should make every reasonable effort to help restore the patients to the maximum degree of independence and self-help possible. The facility should promote optimal physical and emotional health and the patient having the potential of restoration should be returned to his home or other residential living arrangement wherever possible, when the potential has been reached.

APPENDIX III

ACCREDITATION PROGRAM

Wisconsin Council of Homes & Hospitals Serving the Aged

PREFACE

The purpose of the Accreditation Committee of the Wisconsin Council of Nursing Homes is to establish a program which will provide for and assure the raising of standards of professional care, operations, and administration of nursing home and related facilities in Wisconsin; to establish and promote priniciples of organization and administration for efficient and selective care of patients' homes and related facilities; to promote the coordination of all health organizations and professions so as to assure our patients of the latest advances in the health sciences.

This committee welcomes your suggestions and criticisms; we recognize the fact that this material will have to be changed as we progress in time. On behalf of the committee, may I thank all of the many organizations who sent representatives and consultants to aid us in our work. A special thanks to Mr. Vincent Otis, State board of health director, hospitals and related services, for the assistance given us by Mrs. Gladys Heise, R.N., and Mrs. Patricia Harrison, R.N., of his staff.

THE COMMITTEE,
Mrs. MILDRED ZIMMERMAN, *Chairman.*
REV. WILLIAM T. EGGERS,
Mr. ROBERT STRZELCZYK.
Mrs. LOIS SLONAKER.
Miss FLORENCE DEMASTERS.

DEFINITIONS

Minimum care.—Meaning the extent of care required for the usual ambulatory patient, not confined to a bed or chair, who requires some personal service, nursing care, or general supervision.

Moderate care.—Meaning the extent of care required for the usual semiambulatory or chairfast patient, largely confined to a chair because of decided limitations in locomotion, or spending a part of the day in bed, who requires a moderate amount of personal services, nursing care, or supervison. This classification would also include the ambulatory patient who requires more than usual care or supervision because of some degree of incontinence or mental confusion or unusual need for nursing care, as daily dressings following an operation. It might include the ambulatory patient with personality difficulties creating some disruption in the rountine of the home. Some bedfast patients requiring less than the usual amount of care for this type of patient might also fall in this classification.

Maximum care.—Meaning the extent of care required for the usual bedfast patient who requires personal services and considerable nursing care. The classification would also include the ambulatory or semiambulatory patient who requires an unusual amount of care or supervision because of extreme incontinence and mental confusion. It might include the ambulatory patient with extreme personality disruptions in the outline of the home.

Exceptional care.—Meaning the extent of care required in those exceptional or very unusual situations in which special services, facilities, or equipment are needed to a demonstrable degree over and above those which come within the services provided in the nursing home within the maximum care classification. Such special needs must be prescribed by the physician and be identified and described in agency records.

33-257 O—64—pt. 2——10

Tentative percentage of points given to the various aspects of a service or department

	Percent
Total	100
1. Personnel	45
2. Program	30
3. Space and equipment	15
4. Library	4
5. Written personnel policies	3
6. Written code of professional ethics in use	3

OBSERVATIONS

1. Points are distributed so that, even if all other requirements were fully met, the department that lacks the proper professional personnel does not have enough points to be accredited. Without these people, it can gain only 55 percent of the available points. This means the professional staff is regarded as the key to the operation of the department.

2. The program was weighted 30 percent, heavy enough to make accreditation impossible without a good program, in order to serve as a countercheck on the activities of the professional staff. Again, a department qualified in every other way, but without a program, could not be accredited under this point system.

3. Space and equipment were allotted 15 percent on the theory that, if professional staff exists and is carrying out a program (able to gain a maximum of 75 percent of the points), there must be space and equipment to do this. Moreover, these two items represent a one-time capital outlay, which does not have to be repeated. Nevertheless, it is probably wise to allot an amount this sizable to space and equipment to encourage the smaller home to provide these items and to give them at least partial credit for doing so.

4. Since the last three items each in a small way merely serve to buttress the professionalism of the staff and since these items appear in various departments with this same percentage of points, it would seem that no more points need be allotted to them.

5. The last four items together total 25 percent and, in view of the observations above, this would seem to be sufficient.

Tentative accrediting schedule

	Total points
1. Administration	100
2. Building	90
3. Dietary	100
4. Drug control	50
5. Housekeeping, maintenance, and repair	35
6. Medical records	50
7. Medical	100
8. Nursing	200
9. Recreation	38
10. Rehabilitation	100
11. Religion	37
12. Social service	100
Total	1,000

In this plan, a home ideal in all other departments could be accredited if it gained some points in the following areas:

Religion and recreation	75
Social service	100
Rehabilitation	100
Total	275

However, every home will probably lose points in building, nursing, and dietary, for a conceivable total of 600–650 without the departments referred to above.

It will probably be relatively easy to pick up some of the 75 points in religion and recreation, but not enough points to make accreditation possible. This will force the home into social service or rehabilitation and social service for accreditation.

Under this accrediting system, points in general are distributed into 3 major categories:

1. Administration and building, the basic necessities for operation	190
2. Everything connected with medical aspects of the home: nursing, medical staff, medical records, rehabilitation, pharmacy	500
3. All other services	310
Total	1,000

Tentative point schedule for accrediting homes

ADMINISTRATIVE STRUCTURE

	Points
I. The governing board	50.0
(a) The method of selecting board members to achieve rotation of personnel and/or broad community representation	12.5
(b) The committee structure: the executive, finance, building, and maintenance, and medical staff conference committees (5 points a committee)	25.0
(c) The attendance of members at meetings; 12.5 if two-thirds or more attended in the last 12 months. For lower average attendance, proportionately smaller point value; with an average attendance of less than half of the board	None

ALTERNATE FOR THE PROPRIETARY HOME

If it has a properly constituted advisory committee (including clergyman, a nurse, a doctor, a representative of the community's public health program, and a representative of the public) which meets regularly with the management of the home, 25 points will be allowed.

II. The executive	50.0
(a) Formal academic training in 1 of the professions associated with a home: social work, ministry, doctor, business administrator, registered nurse, etc	12.5
(b) Experience as administrator of a home: 1st year, 10 points; 2d year, 5 points; 3d to 5th years, 4 points per year; 6th year, 3 points	30.0
(c) Continued education, either in formal courses or at recognized institutes, etc., during the last 12 months	7.5

GROUP NO. 1

(In all groups the parenthetical reference is to the Wisconsin State Code):

Water supply (H 34.025)
Sewage disposal (H 34.035)
Garbage disposal (containers) (H 34.045)
Plumbing (H 34.055)
Heating (H 34.101)
Ventilation (H 34.105)
Lighting (H 34.12, H 34.14):
  Emergency lighting (H 34.13)
  Good repair of electric cords (H 34.15)
Fire-resistive construction (H 34.21)
  Fire equipment (H 34.235)
    Total points allotted ---------- 10

Tentative point schedule for accrediting homes—Continued

GROUP NO 2

General construction (1)

Incineration (proper facilities) (H 34.665)
Laundry (proper facilities) (H 34.67)
Sitting room (suitable size) (H 34.655)
Telephone (at least 1) (H 34.69)
Suitable closet or locker room for employees (H 34.705)
Suitable screening (H 34.75)

	Points
Total points allotted	10

GROUP NO. 2

General construction (2)

1. All non-fire-resistant buildings have approved automatic sprinkler systems, irrespective of the type of patients cared for or the number of floors in the structure (H 34.21)	2
2. All combustible decorative and acoustical material, including textile floor coverings and curtains located in corridors, passageways, or stairway enclosures and in lobbies or other rooms or spaces for use by occupants or visitors, are rendered and maintained flame resistant (H 34.26)	2
3. Corridor widths shall be at least 8 feet in patient areas of all buildings. The corridors referred to herein are those in patient sections and in other areas where patients may be transported by beds, wheeled stretchers, or wheelchairs (H 35.11)	2
4. Corridors shall have handrails (H 35.12)	2
5. At least 1 elevator shall be provided where bed patients are located on 1 or more floors above or below the dining or service floor. The platform size of the elevator shall be at least 5 feet 4 inches by 8 feet and the door opening equal or exceed 3 feet 10 inches. Additional service elevators need not meet the minimum size requirements. 2 elevators shall be provided in homes having 60 to 200 patients above the 1st floor (ground level) and 3 elevators be provided in institutions having 200 to 350 patients above the 1st floor. Properly located service elevators meeting the minimum cab and door size requirements may be substituted for the additional patient elevators (H 35.13)	2
6. Incombustible acoustical ceilings shall be provided in the corridors of the patient areas, nurses' stations, utility rooms, floor pantries, and kitchen (H 35.16)	2
7. Doorways for all bedrooms and treatment rooms shall be at least 3 feet 8 inches in width, preferably 3 feet 10 inches (H 35.22)	2
8. Small private toilet rooms adjoining patient bedrooms shall have the door opening into the bedrooms (H 35.24)	2
9. The outlet for general illumination and night lights shall be switches at the door in patient rooms and such switches be of an approved mercury or quiet operating type (H 35.37)	2
10. Facilities for washing containers are provided. Electric garbage grinders are installed when not in conflict with local regulations (H 35.44)	2
Total this section	20

Tentative point schedule for accrediting homes—Continued

GROUP NO. 2

Patient rooms

	Points
1. The home provides the following minimum floor area per bed: 80 square feet for multiple-patient rooms and 120 for single-patient rooms (H 35.37, H 34.301, H 34.305). (Built-in closet space is included in computing the square feet; preexisting conditions are accepted.)	2
2. Separation of sexes. Sexes shall be separated by means of separate wings, floors, or rooms, except in cases of husband and wife. Rooms shall be so arranged that it will not be necessary for a patient to pass through another patient's room to gain access to a bathroom, dining room, day room or similar areas (H 34.325)	2
Total this section	4

GROUP NO. 2

Patient room equipment

1. Each patient shall have at least a standard 36-inch-wide bed with springs, a comfortable clean mattress and pillow. Cots shall not be used. Ambulatory patients shall occupy a bed of usual height instead of a high hospital bed (H 34.35, H 34.36)	2
2. Each bed shall have sufficient washable bedding and linen for warmth and cleanliness. 2 sheets, 2 pillowcases per pillow, and an adequate number of blankets for warmth shall be furnished at least once a week. Bed linen shall be changed promptly whenever soiled or unsanitary. Waterproof sheets or plastic mattress covers shall be used on every bed, regardless of the condition of the patient (H 34.37, H. 34.39). (1 white sheet shall be on the bed, as well as 1 plastic mattress cover.)	3
3. Side rails for beds shall be made available for the protection of patients when needed (H 34.405)	2
4. Lockers or closets shall be adequately provided for the storage of patient's clothing (H 34.415)	2
5. Bed screens for privacy shall be made available for use in multiple bedrooms by adequate cubicle curtains or portable screens (H 34.425)	2
6. Individual mouthwash cups, washbasins, bedpans, and standard urinals shall be provided for each patient. This equipment shall be so stored that it cannot be interchanged between patients. There shall be such other nursing equipment as may be required, including an adequate supply of rectal and mouth thermometers. Separate sputum receptacles with disposable containers shall be available for use as needed. There shall be adequate facilities for all necessary sterilization (H 34.435)	3
7. Each patient shall have individual towels and washcloths kept at the bedside (H 34.435)	2
8. A comfortable chair shall be available for each patient able to use one (H 34.475)	2
9. A bedside stand shall be available for each patient in his room, and storage space shall be provided near the bed for reasonable patient's possessions (H 34.49)	2
10. Every window shall be supplied with shades, draw drapes or other devices or materials which, when properly used and maintained, shall afford privacy to the occupant of each nursing unit (H 34.495)	2
11. All patient room doors shall be numbered (H 34.505)	2
12. A wheelchair with brakes shall be provided for patients as the need requires (H 34.51)	2
13. Means of calling attendants shall be provided for bedfast patients. Hand bells are acceptable but shall be readily accessible (H 34.513)	2
Total this section	28

Tentative point schedule for accrediting homes—Continued

GROUP NO. 2

Toilet facilities

	Points
1. (A) Separate indoor toilet facilities are recommended for male and female residents. There shall be: One toilet and 1 lavatory for every 8 female residents. One toilet and 1 lavatory for every 8 male residents. One bathtub or shower for every 20 residents. (The lavatory shall have both hot and cold running water. The water closet shall be water flushed and of approved type.)	
1. (B) There shall be a flush rim clinic service sink and a work counter on each floor where 10 or more bed patients are accommodated (H 34.555)	2. 0
2. Grab bars or handrails are provided in patient toilet rooms, shower rooms, and over bathtubs (H 35.50)	2.00
3. Separate toilet facilities are provided for employees (H 35.51)	2. 0
4. Urinals, if provided, have vertical handholds on both sides (H 35.52)	2. 0
5. Water closets have handrails on both sides (H 35.53)	2. 0
6. Lavatories are supported on brackets to allow wheelchairs to slide under them (H 35.54)	2. 0
Total this section	12. 0

GROUP NO. 2

Kitchen

1. The kitchen shall be located on the premises, or a satisfactory sanitary method of transportation of food shall be used so that the food can be served hot or cold as desired. Kitchen or food preparation areas shall not open into patient rooms, toilet rooms, or laundry (H 34.60, H 34.601)	2. 0
2. Adequate and convenient hand washing facilities shall be provided for use by food handlers, including hot and cold running water, soap and approved sanitary towels. Use of a common towel is prohibited (H 34.61)	2. 0
3. A 3-compartment sink is provided for dishwashing (H 34.64)	2. 0
Total this section	6. 0
Grand total, all categories of physical plant	90. 0

Tentative point schedule for accrediting homes

DIETARY

1. Personnel	45. 0
A. The program of the dietary department is under the direction of a nutritionist or a dietitian on a full-time basis or on a part-time basis in proportion to the number of patients in the home. Or the home gives satisfactory evidence of a consultant arrangement in its dietary planning. The minimum, under any arrangement, is ½ hour a week for 10 patients with at least 10 hours a week for every 200 patients	12. 0
B. The home has a skilled and experienced cook in charge of food preparation at every meal	8. 0
C. The home has a satisfactory ratio of dietary help: 3 to 4 persons for 1 to 20 patients; 4 to 8 persons for 20 to 50 patients, 12-plus persons for 50 and more patients	25. 0

Tentative point schedule for accrediting homes—Continued

DIETARY—continued

	Points
II. Dietary program	30.0
A. The home follows accepted principles in geriatrics in menu planning and food preparation. Half of the points allowed here are granted for the evidence provided by written menus that satisfactory standards are followed. The other half are granted by the inspector for direct evidence that the menus are followed	12.0
B. The dietary department has a written procedure manual covering its operation. This manual includes receipes properly standardized for the size of the home, procedures to guarantee sanitary food handling, proper storage, proper washing and rinsing of dishes and utensils, proper sanitizing of silverware and racked dishes, automatic detergent dispensing devices with automatic washing processes, proper dish drying procedures, and any other procedures necessary in the department. The inspector is satisfied that these procedures are followed	6.0
C. The dietary department gives evidence of overall cleanliness	3.0
D. No more than 14 hours elapse between the evening meal and breakfast	2.0
E. The department does not use donated foods prepared by home canning	2.0
F. Continuous dietary in-service training program, meetings at least twice a month, outline of material presented and discussed, signed attendance records	5.0
III. Space and equipment	15.0
A. Adequate space on a ratio basis for dietary facilities in general	4.0
B. Facilities for group dining	4.0
C. Adequate equipment for food preparation, including stove, oven, counter tops, vegetable sink, work space, hand washing, deep freeze, sinks, etc	4.0
D. A food preparation area tiled at least up to the wainscoating	1.0
E. Adequate dietary supplies on hand	2.0
IV. Library	4.0
Nutrition handbook, dietetic handbook, American Dietetic magazine, institutions.	
V. Code of ethics	3.0
A written code of ethics for the dietary department available and in use.	

Tentative point schedule for accrediting homes—Continued

DRUG CONTROL

	Points
I. Conformity with State code	25.0
If the home does not have bulk medications, 25 points will be allowed for evidence of compliance with the provisions of the State code pertaining to medicines and drugs.	
Alternate for homes dispensing bulk medications: For these homes, allow only 20 points; the additional 5 points can be gained by complying with the following provision:	
A periodic review of bulk medications by the medical director or the pharmacy committee of the staff, with a written record of the review, including the date on which it took place (5).	
A. H 33.401 Physician's orders written on chart or on prescription; telephone orders signed; delivery of drugs to the person in charge.	
B. H. 33.405 Medications left at bedside only upon written order of physician.	
C. H 33.415 Provisions for the proper storage of narcotics, proper records concerning them and/or the surrender of residual narcotics in the prescribed manner.	
D. H 33.421 Provision for medicine cabinets; care in dispensing medications.	
E. H 33.425 Destruction of medicine.	
F. H 33.43 Bulk supply of medicine only if part-time or consultant pharmacist on the staff.	
G. H 33.44 Accurate records concerning bulk medicines.	
H. H 33.45 Proper storage and handling of bulk medicines.	
II. Additional requirements for accreditation	25.0
A. Administration of medications under the supervision of a registered nurse	20.0
B. Destruction of drugs in the presence of 2 witnesses, who record the amount destroyed and sign their names	5.0

HOUSEKEEPING MAINTENANCE, AND REPAIR

	Points
I. Personnel	16.0
A. There is a proper ratio of housekeeping personnel to patients: 1 maid for every 25 units to be cleaned (4). There is an experienced or professionally trained housekeeper in charge of this department. In a home under 25 beds supervision may be a part of the workload of the administrator or some other person devoting part time to this function. At 100 beds the home should have a full-time supervisor. At 200 beds this supervisor should have an assistant (4)	8.0
B. The home has sufficient personnel for proper maintenance and repair or gives evidence that it has repair and maintenance work done by outside specialists (4).	
The home meets state standards in having properly licensed engineers (4)	8.0
II. Program	12.0
A. The home gives evidence of general cleanliness (2). The housekeeping department has written procedures for its routines (2)	4.0
B. The home gives evidence that it is in good repair and ademaintained (2). The home has written procedures for its maintenance and repair routines (2)	4.0
C. Continuous in-service training program, meetings at least twice a month, outline of material presented and discussed, signed attendance records	4.0

Tentative point schedule for accrediting homes—Continued

HOUSEKEEPING MAINTENANCE, AND REPAIR—continued

	Points
III. Space and equipment	5.0
A. There are adequate janitors' closets, office for the executive housekeeper, if any, and adequate equipment for housekeeping	2.5
B. The engineering and repair department has adequate room and adequate tools to perform the functions required of it	2.5
IV. Library	1.0
The home has a reference library on housekeeping, repairs and maintenance, and the housekeeping engineering and repairs staffs subscribe to appropriate magazines.	
V. Personnel policies	1.0
The home has written personnel policies in use for these staffs.	

MEDICAL RECORDS

I. Conformity with State code	25.0

25 points will be allowed for evidence of compliance with the provisions of the State code pertaining to medical records:

A. H 32.78 Written record of physical exams before admission.
B. H 32.784 Written record of annual physical exam.
C. H 32.785 Patient chart with nurse's notes.
D. H 32.80 Adequate records and reports, including H 32.81 as a mandatory requirement.
E. H 32.86 Written record of symptoms and complaints.
F. H 32.89 Written accident reports.
G. H 33.05 Annual physical examination and physician's visits as necessary.
H. H 32.265 Written orders for restraints and seclusions.
I. H 33.401 Written order for medicine or medical therapy.

II. Additional requirements for accreditation	25.0
A. The initial physical examination administered according to the form recommended by the State medical society. (While this form does not as yet exist, the consensus of the committee was that the medical society should be asked to prepare such a standardized form)	7.5
B. Annual physical examination administered according to the form recommended by the State medical society. (While this form does not as yet exist, the consensus of the committee was that the medical society should be asked to prepare such a standardized form)	7.5
C. If the home dispenses medications through its own pharmacist from its own bulk supply or if it has prescriptions for patients filled at a professional pharmacy, the prescription is recorded according to its formula on the patient's nursing chart	5.0
D. All patients are weighed monthly, their weight is recorded, and significant changes in weight are reported to the attending physician	5.0

Tentative point schedule for accrediting homes—Continued

MEDICAL AND DENTAL STAFF

MEDICAL STAFF

	Points
I. Personnel	43.0
A. Only licensed M.D.'s to practice in home or osteopaths, chiropodists, etc., if licensed M.D. as medical director allows them privileges in the home	6.0
B. Licensed M.D. as medical director of the home, caring for house patients (open staff and private selection of doctors allowed), responsible for enforcement of medical policies governing physicians privately practicing in the home, directing the home's medical and health program, and available in emergencies. Homes with 1 staff physician carrying out these duties receive the 25 points. In larger homes with a staff of 3 or more, 22 points granted for a licensed M.D. as medical director of the home; 3 points for staff organization if staff doctors meet at least annually and have records, pharmacy, and education committees	25.0
C. Appointment of M.D.'s by board with notification in writing	5.0
D. Written description of medical director's function in home and board (5) and written personnel policies, if any applicable to medical staff (2)	7.0
II. Medical program	27.0
A. Regular visits or office hours in home, preadmission and annual physical examinations, guidance and supervision of nursing, P.T., O.T., pharmacy, dietary, dental, and other appropriate departments; sanitary and health inspections	13.5
B. Medical staff observes medical policies of home: stop orders on medication, medical records up to date, close out medical record at death	13.5
III. Space and equipment	13.0
A. Treatment and examining room, especially to insure complete privacy and to provide maximum efficient operation for M.D.'s	4.0
B. Equipment: examination cart, otoscope, table, examining light, reflex hammer, blood pressure cuff, scale, sink and water	9.0
IV. Library	4.0
Medical dictionary, Merck manual, physician's desk reference.	
V. Medical code of ethics	3.0
The home has formally adopted the medical code of ethics prepared by the county or State medical society and physicians practicing in the home have familiarized themselves with it.	

DENTAL STAFF

The home has an adequate program, either on its premises or elsewhere, of professional dental care under the supervision of a qualified and licensed dentist formally appointed by the board	10.0

Tentative point schedule for accrediting homes—Continued

NURSING

	Points
I. Personnel	90.0
A. The correct ratio of patients and personnel. This is to be determined according to a formula by the person who accredits the home. He will rate patients on the basis of a checklist into minimum, moderate, and maximum care categories and allow an average time for each person in each category. A tentative rating sheet has been prepared	40.0
B. Professional personnel	50.0
1. The director of nursing must be an R.N	8.0
2. All R.N.'s and L.P.N.'s belong to a professional organization in their field	4.0
3. The home has on its staff the necessary number of professional people in the nursing department. If the home cares only for minimum care patients, it has 1.2 R.N.'s. For every 35 moderate-care patients it has on its staff 2.4 R.N.'s and 1 L.P.N. For every 35 maximum-care patients it has 6 R.N.'s on its staff scheduled 3–2–1 on the respective shifts and 3 L.P.N.'s	38.0
II. Program	60.0
A. A written procedure manual at every nursing station, adequately outlining all nursing procedures used in the home	28.0
B. Investigator's observation verifying that established procedures are followed in the home	12.0
C. Adequate orientation of new nursing personnel, including personnel policies, philosophy of the home, physical facility, and duties	4.0
D. Continuous nursing inservice training program, meetings at least twice a month, outline of material presented and discussed, signed attendance records, and professional leadership	12.0
E. Conference of the director of nursing with other department heads on formal and scheduled basis, at least twice a month	4.0
III. Space and equipment	30.0
A. Adequate nursing stations, storage areas, linen closets conveniently placed, and nurses' lockers with mirror	17.0
B. Adequate equipment, including autoclaves (if necessary), Hoyer lift, hopper, bedpan cleaner, emesis basins, and wash basins	13.0
IV. Library	8.0
A. Books for nursing personnel, Taber medical dictionary, Morrisey rehabilitation nursing (others)	4.0
B. Professional nursing magazines: 1 standard magazine for registered nursing and 1 standard magazine for licensed practical nurses and a geriatric journal	4.0
V. Personnel policies	6.0
Written personnel policies for the nursing staff in use.	
VI. Code of ethics	6.0
A written code of ethics for the nursing staff displayed and in use.	

Tentative point schedule for accrediting homes—Continued

RECREATION

	Points
I. Personnel	18.0
A. The recreation program is carried on by a properly qualified occupational therapist, recreational director, etc	9.0
B. A sufficient number of assistants staff the department either on a voluntary or a paid basis to enable all residents and patients to participate in the program	9.0
II. Program	11.0
A. There is a scheduled program for crafts, organized game or social activity weekly, music, monthly movie and birthday party, outside entertainment monthly, etc., and this is evidenced by a written schedule of these events	9.0
B. Inservice training program for other staff members at least 2 1-hour periods annually. (1) Members of the recreation staff attend appropriate institutes, etc. (1)	2.0
III. Space and equipment	6.0
The home provides television in patient areas, film equipment, organ or piano, radios, major craft equipment, and game equipment.	
IV. Library	1.0
The home has a library on recreation and subscribes to one or the other appropriate periodicals in the field.	
V. Personnel policies	1.0
Written personnel policies are in use for the recreation staff.	
VI. Code of ethics	1.0
A written code of ethics is in use for the recreation staff.	

REHABILITATION

Special notes

1. In this section only the prescribed professional activities of the occupational therapist and the physical therapist are rated. All activity and recreation programs are rated in the section entitled "Religion and Recreation."
2. Since there are few physiatrists and, however desirable their services may be, the average home could not be expected to enjoy even the part-time services of this professional person, they are classed with consultants to the medical staff and no point credit is given under "rehabilitation" for the use of their services by the home. This is not to be interpreted to mean that the accreditation committee does not encourage the use of their professional skills. It does mean only that because their services are not generally available there is no fair method by which all homes could be rated on the utilization of their services.
3. As the table below indicates, full consideration is given to homes whose patients are exclusively or largely in the care of their private physicians. Should these physicians prescribe what apparently is a reasonable volume of PT and OT, such a home will also receive adequate credit for its activity in which a special effort will have to be made by the home to educate these physicians concerning the values of OT and PT.
4. The schedule also gives adequate consideration to the smaller home which does not have an OT and a PT on its staff. Such a home will, however, have to give evidence that its residents and patients receive an adequate amount of these professional services outside of its premises. However, it seems reasonable that a home with a capacity of 50 or more patients would have an OT and PT on its staff on a part-time basis in proportion to its size, as indicated in the basic ratio below.
5. It is assumed that credit will be given only if MD prescriptions are issued and carried out by properly qualified professional people.

Occupational therapy	50.0

Tentative point schedule for accrediting homes—Continued

REHABILITATION—continued

	Points
I. Personnel	22.5
A. The proper ratio of patients to personnel. This is to be determined according to the formula of 1 full-time, 40-hour week, occupational therapist to 250 patients and 1 occupational therapy aid to every 60 patients. While adequately trained volunteer aids are encouraged, no credit is given for them in this section; credit, however, will be given under "recreation"	10.0
B. Professional personnel	12.5
1. The occupational therapist is properly qualified	7.5
2. The OT aids, supervised by an OT, have full-time training for 6 months under a licensed OT (no points without professional supervision)	5.0

NOTE.—The examiner will work with this ratio, taking the size of the home into consideration. If the home does not have an occupational therapist on its staff, he will give proper credit for the carrying out of OT prescriptions by qualified personnel on other premises which have a recognized OT program.

II. Program	15.0
A. An adequate number of medical prescriptions for occupational therapy	7.0
B. Adequate progress reports	3.0
C. Inservice training program for other staff members, at least 2 1-hour periods annually	3.0
D. Coordination of OT program with other staff members at staff meetings	2.0
III. Space and equipment	7.5
A. Adequate space for the occupational therapy department, depending on the size of the home	3.0
B. Adequate equipment. A list will be compiled	4.5
IV. Library	2.0
A. Basic occupational therapy texts	1.0
B. Professional occupational therapy periodical	1.0
V. Personnel policies	1.5
Written personnel policies for occupational therapy in use.	
VI. Code of Ethics	1.5
A written code of ethics for occupational therapy displayed and in use.	
Physical therapy	50.0
I. Personnel	22.5
A. The proper ratio of patients to personnel. This is to be determined according to the formula of 1 full-time, 40-hour week, physical therapist to 250 patients and 1 physical therapy aid	10.0
B. Professional personnel	12.5
1. The physical therapist is properly qualified and licensed to practice in the State	10.0
2. The PT aid, supervised by a PT, has full-time training for 6 months under a licensed PT (no points without professional supervision)	2.5

Tentative point schedule for accrediting homes—Continued

REHABILITATION—continued

	Points
II. Program	15.0
A. An adequate number of medical prescriptions for physical therapy	7.0
B. Adequate progress reports	3.0
C. Inservice training program for other staff members at least 2 1-hour periods annually	3.0
D. Coordination of PT program with other staff members at staff meetings	2.0
III. Space and equipment	7.5
A. Adequate space for the physical therapy department, depending on the size of the home	3.0
B. Adequate equipment. *Explanation* (*a*) Space adequate to provide gait training, which would include a parallel bar. (*b*) Space to give 1 or more of the heat modalities in privacy (treatment table and at least 1 medically approved item of heating equipment, choice up to the staff or consulting physician). (*c*) Space to provide opportunity to use medically approved exercise equipment or improved equipment of equivalent nature	4.5
IV. Library	2.0
A. Basic physical therapy texts	1.0
B. Professional physical therapy periodical	1.0
V. Personnel policies	1.5
Written personnel policies for physical therapy in use.	
VI. Code of ethics	1.5
A written code of ethics for physical therapy displayed and in use.	

NOTE.—The examiner will work with this ratio, taking the size of the home into consideration. If the home does not have a physical therapist on its staff, he will give proper credit for the carrying out of PT prescriptions by qualified personnel on other premises which have a recognized PT program.

RELIGION

I. Personnel	17.0
The home has a chaplain responsible for its religious services or for scheduling others to conduct them.	
II. Program	11.0
A. Services are conducted regularly, preferably on a weekly basis, in the home	6.0
B. The home has a written policy for notifying its chaplain when patients enter or when they become critically ill	5.0
III. Space and equipment	6.0
The home has adequate space to conduct religious services and basic equipment for this—piano or organ, altar (possibly collapsible), etc.	
IV. Library	3.0
The home has a religious library and subscribes to religious periodicals.	

SOCIAL SERVICE

I. Personnel	45.0
A. The correct ratio of patients and personnel. The standard of 1 full-time social worker or group worker to 150 persons is maintained. Full credit for all homes of whatever size which have this professional service on this basis	20.0
B. Professional personnel. The worker or workers are graduates of an accredited school of social work. In 1978 they must be, in addition, members of the Academy of Social Workers	25.0

Tentative point schedule for accrediting homes—Continued

SOCIAL SERVICE—continued

	Points
II. Program	30.0
A. The home through its social service has adequate admission service for its clients (6). This is supported by satisfactory records (2)	8.0
B. The home offers a therapeutic as well as a general social service to its residents and patients (6). This is supported by satisfactory records (2)	8.0
C. The home offers a consultation service to applicants who may not enter the home or may not need its services (6). This is supported by satisfactory records (2)	8.0
D. Inservice training program for other staff members at least 2 1-hour periods annually (3). Members of the social service staff attend appropriate institutes, etc. (3)	6.0
III. Space and equipment	15.0
The social service department has adequate space and equipment for its personnel, including clerical staff people, to function efficiently.	
IV. Library	4.0
An adequate library in the field of social work is maintained and representative journals are subscribed to.	
V. Personnel policies	3.0
Written personnel policies for the social work department are in use.	
VI. Code of ethics	3.0
A written code of ethics for social service is in use.	

APPENDIX IV

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

REPORT OF DIVISION (PROPOSED) FOR CARE INSTITUTIONS OTHER THAN HOSPITALS

FOREWORD

At its meeting of March 17, 1962, the Joint Commission on Accreditation of Hospitals took action to explore the feasibility and development of a program for accreditation of inpatient care institutions other than hospitals. Such a program, if inaugurated, to be carried out under the supervision and direction of the Joint Commission on Accreditation of Hospitals.

Accordingly, proposed rules and regulations, eligibility requirements, standards of accreditation, and administrative policies were prepared from material developed by the Liaison Committee of the American Hospital Association, American Medical Association, and American Nursing Home Association on Problems Concerning Institutional Care of Chronically Ill and Aged. The joint committee then extended an invitation to its' member organizations plus nine other national organizations to join in a review of the proposed program. The results of that review are recorded in this report.

The documents concerned were discussed point by point and this report deals with them in a like manner. The suggestions made will be incorporated into a report to be presented to the next meeting of the Joint Commission on Accreditation of Hospitals.

For the sake of brevity, comments relative to those points which brought forth little or no discussion and seemed to be acceptable to the discussants are not recorded. All documents discussed are incorporated, as they were presented, in the appendices of this report.

We thank those in attendance for taking time from busy schedules and for their fine advice and counsel.

TABLE OF CONTENTS

Part I. Participants.
Part II. Opening remarks, Dr. Nelson.
Opening remarks, Dr. Babcock.
Report of member organizations—Joint Commission on Accreditation of Hospitals.
Part III. Discussion of proposed rules and regulations of Joint Commission on Accreditation of Hospitals Division for Inpatient Care Institutions Other Than Hospitals.
Part IV. Discussion of proposed eligibility requirements and standards for accreditation of inpatient care institutions other than hospitals.
A. Eligibility requirements.
B. Standards.
Part V. Discussion of administrative policies.
Appendix A. Rules and regulations.
B. Requirements for accreditation.
C. Standards.
D. Administrative policies.

PART I

Participants

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Charles E. Caniff, executive director, Association of Rehibilitation Centers, Inc., Evanston, Ill.
Gerard J. Casey, D.D.S., secretary of the Council on Hospital Dental Service, American Dental Association, Chicago.
Helen V. Connors, R.N., associate executive secretary, American Nurses' Association, Inc., New York City.
Edwin L. Crosby, M.D., director, American Hospital Association, Chicago.
Lester Davis, executive director, American Association of Homes for the Aging, New York City.
Mrs. Margie S. Davis, accreditation chairman, region VI, American Nursing Home Association, Denver.
Harold E. Goetsch, director, Division for Inpatient Care Institutions Other Than Hospitals, Joint Commission on Accreditation of Hospitals, Chicago.
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Frank B. Kelly, M.D., representative, American College of Surgeons, Chicago.
Mrs. Lillian E. Kuster, executive director, National Federation of Licensed Practical Nurses, Inc., New York City.
Russell A. Nelson, M.D., chairman, Joint Commission on Accreditation of Hosiptals, Chicago.
Maurice J. Norby, deputy director, American Hospital Association, Chicago.
Edward Rosenow, M.D., executive director, American College of Physicians, Philadelphia.
Miss Marion L. Sheahan, deputy director, National League for Nursing, Inc., New York City.
Joseph Stetler, general counsel, American Medical Association, Chicago.
Chester L. Watts, administrative assistant, American Academy of General Practice, Kansas City, Mo.

PART II

Opening remarks by Russell A. Nelson, M.D.[1]

This is an invitational meeting of the Joint Commission on Accreditation of Hospitals set up to discuss a future national accreditation program for nursing homes and other inpatient care facilities.

This matter has been of great importance to the joint commission and its commissioners for the past year or more. At its last meeting in Chicago, March 17, we adopted a resolution relative to this subject which I will read to you in a moment. The purpose of this meeting is to bring together representatives of groups that we know have an interest in this field in hopes that there can be a free and open exchange of ideas and suggestions. We hope also to enlist your support in a national program for the accreditation of nursing homes and other medical facilities.

There are several in this room who could review the history and impact of the joint commission better than I, but I will hit a few high points.

The accreditation of hospitals, the approval of hospitals, was for many years carried on by the American College of Surgeons who were interested in elevating the standards of surgical and medical care in hospitals and to see that our general hospitals, as they were developing in this country, met at least the minimum standards of safety and sound professional operations.

About 1950, the American College of Surgeons indicated that it felt this responsibility should be carried by other groups and shared by other professional bodies. This led to the creation of the joint commission as an independent agency with representatives from the American College of Surgeons, the Ameri-

[1] Chairman, Joint Commission on Accreditation of Hospitals.

can Medical Association, the American Hospital Association, the American College of Physicians, and the Canadian Medical Association.

After some years of experience, our Canadian colleagues and friends established a separate Canadian Accreditation Commission so that now the members are the five that I mentioned less the Canadian Medical Association.

The purpose of the commission is the accreditation of hospitals and certain allied institutions on a voluntary basis with emphasis on the setting of standards, particularly as they relate to medical and professional care. The commission has been at work for 10 years under two very capable directors, both of whom are here, Dr. Crosby initially and then Dr. Babcock.

About 55 percent of the eligible hospitals in the United States have been accredited by the joint commission. The emphasis has been mostly on the acute general, short-term hospital where the percentage accredited accounts for over 90 percent of hospital admissions.

As you know, the commission operates on the basis that the institutions voluntarily ask for examination. Institutions may fail to meet the standards and are then called nonaccredited institutions or they may receive a provisional accreditation which is a short-term, temporary, or probational status and then finally full accreditation. In addition to general hospitals, the commission, to a limited extent, examines other institutions such as independent rehabilitation centers and independent outpatient departments. For the general hospital I feel that we have four levels of approval or accreditation.

First, is licensure of the general hospital by the State. Second, listing by the American Hospital Association, third, accreditation by the joint commission, and then as far as general hosptials are concerned, a fourth level of examination and approval which is for a variety of educational programs in hospitals.

The joint commission has been struggling with, as I think others have, the problem of how to set standards and apply these standards to the nursing homes of our country. We recognize the great growth that has taken place in these institutions in the last 30 years. We recognize the seriously increasing impact of chronic illness of an aging population in our people. We recognize the growing number and scope of the programs of public assistance for the sick, elderly, and the private programs under voluntary insurance that have every indication they will grow. All of this leads the commissioners to feel that there should be a program of standard setting and application of those standards.

The joint commission has examined its position relative to nursing home accreditation with great care and with a good bit of debate. The matter is still pending before our constituent parents, as it were, but as of March 17 past, the commissioners adopted the following resolution. I would like to read it for you and into the record.

"*Resolved*—

"The Joint Commission on Accreditation of Hospitals recognizes the desirabilitiy of establishing a program of survey and approval for inpatient care insituations other than hospitals, similar to its existing program of accredtation of hospitals. Moreover, we recognize the need for the implementation of such a certification process at the earliest possible date. The Joint Commission on Accreditation of Hospitals believes this program should be an extension of its present activities.

"We recommend that the constituent organizations of the Joint Commission of Accreditation of Hospitals express their agreement with this objective by a declaration of intent to participate in the financing of the new program of the Joint Commission on Accreditation of Hospitals through mutually agreeable methods.

"We request the chairman of the Joint Commission on Accreditation of Hospitals to address the constituent organizations in terms of the resolution so that this could serve as a basis of discussion by commissioners designated by the respective constituent organizations."

This resolution has been sent to all the present member organizations of the commission. The American Hospital Association has filed an agreement to proceed. The other member organizations have their decision pending.

The commission, in taking this action, and previously in its discussions, felt that it should proceed with speed, and has set as a target date of not later than January 1, 1963, for the inauguration of such a program.

It is the intention of the joint commission to see if it can properly take the responsibility for such program as we feel it is a natural extension of our activities and do so with the sponsorship and participation of groups such as yours joining with the commission in promoting the program.

Opening remarks, Kenneth B. Babcock, M.D.[2]

The joint commission, as it is presently constituted, is very similar to the diagram in your folder. Our advisory committee consists of the four executive secretaries of the organizations making up the joint commission. They review policy and make recommendations both to the commission and to their own constituent members. They have no final authority.

You, today, here represent, in a way, the advisory committee. We would hope that all of you would ultimately be members of the board of supervisors.

We have drawn up and sent to you and you have in your possession, tentative bylaws, rules, and regulations for the contemplated organization. We sent to you projected standards also. There is nothing final about them. It is hoped that after these introductory remarks that we will be able to take these documents and go over them item by item. They represent the thinking of the commission staff and that of the tripartite liaison committee. We have to have a beginning, but there is nothing, at this time, final about these bylaws, rules, and regulations or standards.

We hope that this will be a working conference or seminar, call it what you want, that can discuss and work with this material that we have prepared and come up with something presentable. You, then may go back to your organizations and say this is the tentative program. It behooves all of us to know exactly what this program is, what it contemplates, and how it is to be run because you have to go back and present it to your group for their active participation, we hope. There is much grassroots work to be done. This is the germ or the beginning of an idea, and we hope it can be developed and something can be consummated from it. That is all I would say at the present time.

REPORT OF ACTIONS BY MEMBER ORGANIZATIONS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS TO THE RESOLUTIONS OF MARCH 17, 1962

American Medical Association, F. J. L. Blasingame, M.D.

The Board of Trustees of the American Medical Association met in Chicago last month, and received a report by Dr. Appel, who reported on behalf of the American Medical Association commissioners to a committee of our board of trustees, our miscellaneous business committee, they in turn reported to the board of trustees. I have communicated to Dr. Babcock the action of the board of trustees of the American Medical Association which consisted of two things; one, to defer action on the request by the commission to approve a program to survey and approve inpatient care institutions other than hospitals. Second, they directed a study by an ad hoc committee composed of those physicians appointed as commissioners to the joint commission by the American Medical Association. Dr. Appel is to serve as chairman of this committee and has called a meeting or plans to call a meeting of the committee within the near future.

Our board action, I believe, can be summarized around three points which, I trust, the meeting today and future meetings will help clarify. The board felt that definitive action asked by the joint commission at the last meeting was premature, that the program contemplated could be costly, and the board of trustees was not in a humor to give tentative approval to a program, the need of which is admitted, until more was known concerning the cost. Second, there was a great deal of concern about the vagueness as related to organization; that is, how would the various groups that are concerned in this area, and admit an interest in it, brought into the program in a meaningful and effective way? And third, they want more definition as to the procedures to be used in this program, if it is to be instituted. In other words, how would it be carried out?

In part this was related to the effect a program might have on the program carried out presently by the commission which has increased in cost from year to year. In other words, the effect on getting the complete job done by the Joint Commission on Accreditation of Hospitals. Therefore, those of us here today are representing the American Medical Association in the peculiar position of

[2] Director, Joint Commission on Accreditation of Hospitals.

being in attendance with a direction from our board that action definitely has been deferred, until considerable more information is available.

It is probable that the American Medical Association committee will hold a number of meetings involving review with the representatives that are here today and other commissioners and may be in a position, before long to take definitive action. As of right now, however, they have specifically requested that action be deferred.

American College of Physicians, Edward C. Rosenow, Jr., M.D.

You will recall that when the resolution was adopted by the joint commission, our commissioners voted in opposition to the resolution. They reported to our board of regents, their opposition on the basis that this was too complicated a thing and added too much to the work of the commission, that it would handicap the working of the Joint Commission on Accreditation of Hospitals to take on this additional load.

We had an interesting and rather long discussion. The American College of Physicians is in a peculiar position. They almost reversed the opinion of the commissioners of the joint commission by saying that they voted in favor of this, in principle. One, they were very much in favor; somebody has to do this. It is a very necessary thing. Two, they thought it should be under the aegis and guidance of the Joint Commission on Accreditation of Hospitals. But three, they did say that we could give no more than moral support because, as those of you who are connected with the commission know, we are committed in finances to the joint commission, I would say, about a third more than the board of regents feels is justified in our dues structure, and to the things we are trying to do with what resources the college has. So that while they were in favor of this in principle, No. 1, it should be done; and No. 2, the joint commission should do it; No. 3, they could not commit any funds to it either now or later unless some way is figured out to reduce, somewhat, our contribution to the commission.

American College of Surgeons, John I. Brewer, M.D.

The surgeons have not taken any action because the regents have not met since they received the request and will not meet until June. That will be their first opportunity to study it.

American Hospital Association

(Dr. Nelson had reported in his opening remarks that the American Hospital Association had agreed to support the resolution of March 17 and is willing to provide financial support.)

PART III

Discussion of proposed organization and rules and regulations of Joint Commission on Accreditation of Hospitals, Division for Inpatient Care Institutions other than hospitals[8]

ARTICLE I. PURPOSE

It was suggested that the program be called a program of certification rather than accreditation to prevent confusion between the program of accreditation of hospitals and a program of accreditation of institutions other than hospitals. It was also suggested that the purpose be made to read "survey" in place of "inspection."

The consensus of the group was that the word "survey" be substituted for "inspection" and the word "accreditation" be retained.

ARTICLE II. AUTHORITY

Mrs. Davis suggested that article II placed final authority for accreditation of inpatient care institutions other than hospitals in the Joint Commission on Accreditation of Hospitals, which does not include the American Nursing Home Association. Upon being told that her suggestion was correct, Mrs. Davis stated that she felt that the American Nursing Home Association should be a component part of the Joint Commission on Accreditation of Hospitals because the American Nursing Home Association is the group directly concerned.

[8] App. A.

Mrs. Baird offered a compromise suggesting that, "The joint commission as presently constituted would have the overall authority. There would be two divisions, a division of hospital accreditation and a division of nursing home and related facilities accreditation with either both organizations sitting on both the boards of both divisions or the hospitals sitting only in the hospital division and the nursing home sitting only in the nursing home division. Therefore, we nursing homes are not trying to set standards for hospitals. Neither are hospitals intending to set standards for nursing homes."

Dr. Babcock described the composition of the present Joint Commission on Accreditation of Hospitals and explained how the member organizations appoint commissioners in a manner which provides representation of as many of the speciality and subspecialty groups as possible. He further pointed out the necessity of a unanimous vote of the member organizations to modify the commission structure.

Dr. Babcock then discussed the present financing structure of the Joint Commission on Accreditation of Hospitals and its budget. He noted that the budget is approximately $380,000 per year, which is paid on a pro rata basis by the four member organizations, each member organizations' share being based on its total representation in the commission. This explanation was made in order that the group could better understand the suggested financing of the proposed division for inpatient care institutions other than hospitals.

Dr. Rosenow stated his understanding was that the formation of a division for accreditation of inpatient care institutions other than hospitals as suggested, within the structure of the Joint Commission on Accreditation of Hospitals was probably the only way this program could be started. He further stated his understanding was that the division would operate as an autonomous and separate group with the commission exercising authority only to the extent as is necessary to assure that the division operates within the general policies of the commission. Dr. Nelson confirmed Dr. Rosenow's understanding and stated this was the intent of the commission.

Dr. Crosby pointed out that the proposed program is not to be concerned with nursing homes alone but must be concerned with all nonhospital institutions having inpatient medical facilities.

ARTICLE III. MEMBERS

Section 1. Original member organizations

It was asked whether or not the original membership of the division could be expanded to include organizations other than those presently suggested.

Dr. Babcock explained that the proposed list was drawn up simply as a suggestion to get the division organizational structure started and that additional organizations could be added to original membership. He stated that the document in question is in no way official, but is a working document to aid in the development of rules and regulations for the division which will ultimately be presented to the commission and will require official acceptance by the commission.

A reference to the division as being "comparable to the corporate structure of the Joint Commission on Accreditation of Hospitals" (organizational chart, app. A) and brought the question, Was the division intended to be a separate legal entity? Discussion of the point made clear that the division would not be a separate legal entity from the Joint Commission on Accreditation of Hospitals but would be comparable to the Joint Commission on Accreditation of Hospitals' organizational structure rather than corporate structure.

Section 3. Annual budget

The proposed annual budget of the division was read and explained. It was pointed out that funds made available under this budget would be needed for the year of 1963; or therefore, the first annual budget would need be approved in 1962.

It was suggested that this section be revised to include or an appropriate section be added which would provide an operating reserve for the division.

Dr. Babcock stated that the commission had suggested a division budget of approximately $100,000 per year for the years 1963, 1964, and 1965, thus each seat on the division board of supervisors would require a contribution of approximately $7,000 to $7,500 per year. He further pointed out that the budget of the division would increase as the program develops and particularly in the fourth year when the resurvey phase of the program would start.

Many questions with regard to the future cost of this program were asked. Most felt that this budget would rapidly equal or even exceed the present budget of the Joint Commission on Accreditation of Hospitals. To be most effective, the program must expand rapidly and member organizations should be prepared to increase their individual financial contributions as fast as the program expands.

It was suggested that member organizations of the division be asked to guarantee their support and financial contribution for a minimum of 3 years. Such a guarantee would assure that the program would be underwritten for a long enough time to allow it to develop in an orderly and proper manner and allow the program to prove its merit.

ARTICLE IV. MEETING OF MEMBERS AND ARTICLE V. BOARD OF SUPERVISORS

Discussion of articles IV and V made it quickly apparent that these articles need be combined into one. The opinion of the group seemed to indicate that one article dealing with the organizational structure and procedures and functions of the proposed board of supervisors would be appropriate.

The following revisions of the articles were suggested:

(*a*) Articles IV and V should be combined.

(*b*) Notice of meetings, when mailed, should be sent by certified mail.

(*c*) Provision for vote by proxy should be eliminated.

(*d*) Provision should be made for the appointment of alternates to serve in the absence of a supervisor.

(*e*) Provision should be made to insure rotation of supervisor appointments in order that continuity of division affairs may be achieved.

ARTICLE VI. OFFICERS

The group seemed to be of the opinion that this article was satisfactory and needed no change.

ARTICLE VII. COMMITTEES

Section 1. Advisory committee

It was explained that the provision for an advisory committee is intended to provide an opportunity for the executive directors of associations to form a staff body for discussion, liaison and provide an opportunity for participating and other interested groups a chance to express themselves to the staff and the board of supervisors. The group indicated that no revisions were necessary in this article.

ARTICLE VIII. SECRETARY OF THE DIVISION

The office of secretary of the board of supervisors and the duties and authority of the secretary were reviewed and discussed. No revision of this article seemed to be indicated.

ARTICLE IX. CHANGE OF RULES

Article IX required no discussion and needs be revised only to reflect changes made in the revision of articles IV and V.

PART IV—A

Discussion of proposed eligibility requirement for acreditation[4]

1. Listed by the American Hospital Association.

Mrs. Baird stated that the American Nursing Home Association could not accept the requirement of listing by the American Hospital Association.

Mrs. Baird proposed that the program of accreditation presently utilized by the American Nursing Home Association be made a prerequisite for the Joint Commission on Accreditation of Hospitals, Division for Inpatient Care Institutions other than Hospitals rather than the listing program of the American Hospital Association.

Mrs. Baird explained that the American Nursing Home Association is of the opinion that the program of the American Nursing Home Association is preferable in that it: (*a*) Recognizes the three types of nursing home prevalent in the United States today, (*b*) the standards of the hospital (American Hospital Association) listing program are not as realistic or as high as that projected by

[4] App. B.

the Nursing Homes Association's accreditation program, and (*c*) hospitals should list hospitals and nursing homes should list nursing homes.

In answer to the question of who might list inpatient care institutions other than hospitals and other than nursing homes if the American Nursing Home Association were to set up a program of listing nursing homes; Mrs. Baird suggested that other organizations might set up listing programs for the type of institution each is primarily interested in; i.e., the American Association of Homes for the Aged would list homes for the aged and the Association of Rehabilitation Centers would list rehabilitation centers.

2. Have been in operation at least 12 months.

This requirement seemed to be acceptable with no question.

PART IV—B

Standards for accreditation of inpatient care institutions other than hospitals [6]

As this discussion opened Dr. Babcock pointed out the importance of standards being so designed to insure that the standards consider the objectives of the institution and the needs of the individuals cared for in the institution. He further pointed out that the methods used to achieve the standards may vary with the ownership, type, and size of the institution but to achieve accreditation the institution must carry out the intent of the standards. Dr. Babcock went on to say that the standards, as proposed, were to be considered as basic principles which will be supplemented with interpretations and further details as the program develops.

With these comments in mind the proposed standards for accreditation of inpatient care institutions other than hospitals were reviewed and discussed standard by standard.

The following suggestions and questions were discussed:

I. Administration

A. Governing body:

3(*a*) It was explained that this standard was only to assure that legal requirements are met.

3(*d*) This standard is to assure that some one person who is qualified is appointed and held responsible for the administration of the institution.

B. Physical plant: Questions regarding these standards were primarily those having to do with interpretation, intent, and understanding.

C. Facilities and services which shall be maintained:

1. Dietary service: (*c*) There was question here with regard to the wisdom of accepting supervision by a registered nurse of dietary services in an institution. Some expressed an opinion that this is not a responsibility properly placed on a registered nurse. This standard needs further interpretation and clarification.

2. Health records: This section of the standards seemed to be generally acceptable as written.

3. Nursing service:

(*a*) Personnel:

Discussion of this standard centered around the requirement of a graduate registered nurse employed full time and who is responsible for the nursing service. Opinions were expressed that in certain situations this requirement could be met just as well by a licensed practical nurse. Generally the group seemed to feel that the standard remain as it is with consideration being given to individual situations as they arise.

Several members of the group reminded that the standards, of necessity, must be at a level to be practical but also must be high enough to encourage better patient care and be a goal to be attained. It was pointed out that if the standards are not high enough to encourage improvement over the present quality of care, the program should be changed to "criteria for accreditation" in place of "standards for accreditation."

(*b*) Responsibilities and organization: It was suggested that items 3 and 4 be made mandatory and the word "shall" replace the word "should."

[6] App. C.

4. Medications: Several questions relating to the storage, dispensing, and administration of drugs and medicine were asked. An interpretation of the term "professional advice" was also discussed. The group agreed that this section needs further detail and clarification.

5. Availability of laboratory and other special diagnostic services: A question related to the mechanics of this standard was asked. Discussion brought out that the requirements could be met in any one of several ways so long as the intent of the standard is fulfilled. The standard is intended to assure that these services are available in a manner which is convenient and can be done with proper regard to the patients' well-being.

6. Availability of hospital inpatient services: This section brought several questions and much discussion as to meaning and intent of this standard. The group generally expressed agreement with the desirability of an arrangement between a hospital and the institution whereby the facilities of the hospital would be available to the patient requiring them with a minimum of delay. This section needs more study of the details involved.

II. Medical and dental services

After thorough discussion, this section of the standards were generally acceptable to the group.

III. Facilities and services which may be essential according to the objectives of the institution and the needs of the individuals accepted for care

Dr. Babcock explained that the standards are divided into two parts: part I, those facilities and services which would be required for accreditation; and part II, those facilities and services which are desirable and may be essential to properly carry out the objectives of the institution and to serve the needs of those accepted for care.

Section III, facilities and services which may be essential, represents part II of the standards and was discussed much as one subject with several questions of intent being asked and discussed.

Two suggestions of note were made:

1. Those items not specifically related to nursing homes, per se, should be so marked.

2. This section of the standards should be written in a manner which will clearly indicate to even the casual reader that certain standards may apply in only specific situations or type of institution.

PART V

Discussion of administrative policies[6]

General

1. Cost of surveys:

Discussion brought forth a number of questions in regard to financing this program in a manner which would allow those institutions requesting survey to be served with no charge to the institution. A suggestion was made that, if financing in sufficient quantity was not available from the member organizations of the division, consideration be given to asking the member organizations to contribute to the extent of the administrative or overhead costs and a fee sufficient to cover the cost of the division field staff be made to institutions requesting survey.

The group was asked to express an informal opinion to the question: "Should the entire cost of the program be prorated among the member organizations of the division and be of no cost to institutions requesting survey?" There were three affirmative votes. To the question: "Should a fee sufficient to cover the cost of survey be charged to institutions requesting survey and only the overhead costs of the program be prorated among the member organizations?" there were seven affirmative votes.

Several members of the group stated that they personally preferred a "no fee" program but in consideration of the financial commitments which would be required of their organizations they felt impelled to cast their vote in favor of a "fee for survey" program.

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[6] App. D.

2. Survey and accreditation of multicare facilities: The question of developing standards for that part of an institution which is other than medical or nursing was discussed. It was pointed out that this policy needs study and if adopted, must be developed further.

Surveys

3. Resurveys: The group asked that this policy be further detailed and clarified so far as a resurvey requirement upon change of ownership is concerned.

Appendix A

Rules and Regulations

ARTICLE I—PURPOSE

The purposes of the division are:

(*a*) To conduct under the auspices and supervision of the Joint Commission on Accreditation of Hospitals an inspection and accreditation program which will encourage physicians and inpatient care institutions other than hospitals voluntarily—

(1) to apply certain basic principles of organization and administration for efficient care of the patient;

(2) to promote high quality of medical and institutional care in all its aspects in order to give patients the greatest benefits that medical science has to offer; and

(3) to maintain the essential services in the institution through coordinated effort of the medical staff and the governing body or owners of the institution.

(*b*) To formulate standards for institutional operation.

(*c*) To recognize compliance with standards by issuance of certificates of accreditation.

(*d*) To assume such other responsibilities and to conduct such other activities as are compatible with the operation of an accreditation program.

ARTICLE II—AUTHORITY

The division shall be governed by the bylaws of the Joint Commission on Accreditation of Hospitals and shall assume those responsibilities for the accreditation of inpatient care institutions other than hospitals as the board of commissioners delegates to the division.

ARTICLE III—MEMBERS

SEC. 1. *Original member organizations.*—The member organizations of the division shall, subject to their prior approval, be the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and American Nursing Home Association.

SEC. 2. *Additional member organizations.*—Additional organizations may be admitted to membership in this division upon the written approval of all member organizations of the division and ratified by the board of commissioners of the Joint Commission on Accreditation of Hospitals.

SEC. 3. *Annual budget.*—The budget of the division shall be administered separately from other funds of the Joint Commission on Accreditation of Hospitals and for the year 1962 shall be not less than $50,000. Commencing with the annual meeting in 1963 and at each annual meeting thereafter, the member organizations shall fix the budget for the current calendar year by a majority of the votes of the member organizations and the amount thereof shall be paid by the member organizations, one-half within 30 days thereafter and the balance on July 1. Any budget may be revised at any time by a majority of the votes of member organizations and if such revision results in an increase, the amount thereof shall be payable by the member organizations forthwith. Each member organization shall pay to the division that proportion of each budget which the number of votes to which such member organization is entitled, bears to the total number of votes of all member organizations (art. IV, sec. 3).

SEC. 4. *Resignation.*—Any member organization which is not delinquent in the payment of any amount owing to this division may resign, effective on December 31 of any year, upon giving to this division 90 days' previous notice in

writing. In the event of any such resignation, the resigned member organization shall have no claim upon any assets of this division.

SEC. 5. *Termination of membership.*—If any member organization shall fail to make any payment to this division within 30 days after the same becomes due, its membership shall forthwith terminate and it shall have no claim on any of the assets of this division.

SEC. 6. *Reinstatement.*—If any member organization shall resign or if its memship shall be terminated, it shall be eligible for reinstatement upon the affirmative vote of all remaining member organizations only after the expiration of 1 full year and upon payment to this division of an amount equal to the full amount it would have been required to pay if it had continued its membership.

SEC. 7. *Transfer.*—Membership in this division is not transferable or assignable.

ARTICLE IV—MEETING OF MEMBERS

SECTION 1. *Annual meeting.*—An annual meeting of the member organizations shall be held during the month of December in each year, commencing with the year 19— (the date, time, and place to be fixed by the division) for the purpose of fixing and approving the budget for the next calendar year and for the transaction of such other business as may come before the meeting.

SEC. 2. *Special meeting.*—Special meetings of the member organizations may be called by the chairman, the board of commissioners, any member organization, or board of supervisors (art. V).

SEC. 3. *Voting.*—At all meetings of member organizations, the respective member organizations shall be entitled to the following number of votes: American Hospital Association, —— votes; American Medical Association, —— votes; American Nursing Home Association, —— votes; American College of Physicians, —— votes; and American College of Surgeons, —— votes.

SEC. 4. *Place.*—The board of supervisors may designate any place, either within or without the State of Illinois, as the place of meeting for any annual meeting or for any special meeting called by the board. If no designation is made or if a special meeting be otherwise called, the place of meeting shall be the office of the division in the State of Illinois: *Provided, howver*, That if all of the member organizations shall meet at any time and place and consent to the holding of a meeting, such meeting shall be valid without call or notice and at such meeting any action may be taken by the division.

SEC. 5. *Notice.*—Written notice stating the place, day, and hour and the business to be transacted shall be delivered, either personally or by mail, to each member organization not less than 10 nor more than 40 days before the date of each meeting of member organizations. If mailed, the notice shall be deemed delivered when deposited in the U.S. mail addressed to the member organization at its address as it appears on the records of the division with postage thereon prepaid.

SEC. 6. *Informal action.*—Any action required to be taken at a meeting of member organizations may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by all of the member organizations.

SEC. 7. *Quorum.*—Member organizations holding a majority of the weighted votes pursuant to this article shall constitute a quorum. If a quorum is not present at any meeting, the member organizations present may adjourn the meeting from time to time without further notice.

SEC. 8. *Proxies.*—Any member organization may vote by proxy executed in writing.

ARTICLE V—BOARD OF SUPERVISORS

SECTION 1. *Number and qualifications.*—The affairs of the division shall be managed by a board of not more than 15 supervisors. Supervisors may, but need not, be affiliated with a member organization.

SEC. 2. *Representation.*—Each member organization shall have the right to appoint one supervisor for each vote to which it is entitled.

SEC. 3. *Appointments.*—As the term of each supervisor hereafter appointed shall end, the member organization which appointed him shall appoint his successor to serve for a period of 3 years. In the event of the death, resignation, or inability to act of a supervisor, the member organization which appointed him shall appoint his successor to serve for the unexpired term. All appoint-

ments shall be in writing and executed on behalf of a member organization by its president or his designate and delivered to the designated office of the division. If a member organization fails for 90 days to make an appointment pursuant to the foregoing provisions, then the division by action of three-fourths of the remaining supervisors shall appoint a successor from persons affiliated with such member organization.

SEC. 4. *Budget.*—The board shall, in each year, recommend to the division an operating budget for the next calendar year. The board may adjust budget items within the total limits of the approved budget at any regular or special meeting during the year.

SEC. 5. *General powers.*—The board shall have power and authority to cause the division to do and perform all acts and things not inconsistent with the articles of incorporation or the bylaws of the Joint Commission on Accreditation of Hospitals, or these rules and regulations.

SEC. 6. *Annual meeting.*—A regular annual meeting of the board of supervisors shall be held immediately after, and at the same place as, the annual meeting of member organizations. At this meeting the board shall receive the annual report of the secretary (art. VI, sec. 8) and of committee chairmen and shall conduct a full business session, including the election of officers.

SEC. 7. *Special meeting.*—Special meetings of the board of supervisors may be called by or at the request of the chairman or any four supervisors. The persons or persons authorized to call special meetings of the board may fix any place, either within or without the State of Illinois, as the place for holding any meeting called by them. No business shall be transacted at a special meeting other than that stated in the notice.

SEC. 8. *Notice.*—Notice of any meeting of the board shall be given at least 10 days previous thereto by written notice delivered personally or sent by mail or telegram to each supervisor at his address as shown by the records of the division. If mailed, such notice shall be deemed to be delivered when deposited in the U.S. mail in a sealed envelope so addressed, with postage thereon prepaid. If notice be given by telegram, such notice shall be deemed to be delivered when the telegram is delivered to the telegraph company.

SEC. 9. *Quorum.*—At least one-half plus one of the total number of supervisors shall constitute a quorum for the transaction of business at any meeting of the board: *Provided*, That, if less than this number are present, a majority of those present may adjourn the meeting from time to time without further notice.

SEC. 10. *Manner of acting.*—The act of a majority of the supervisors present at a meeting at which a quorum is present shall be the act of the board, except where otherwise provided by law or by these rules and regulations.

SEC. 11. *Procedure.*—The conduct of all meetings of the board shall be governed by Sturgis' Standard Code of Parliamentary Procedure.

ARTICLE VI—OFFICERS

SECTION 1. *Officers.*—The officers of the division shall be a chairman, a vice chairman, a secretary, and a treasurer and such other officers as the board may authorize, all of whom, except the secretary, shall be elected from members of the board of supervisors.

SEC. 2. *Election.*—At each annual meeting the board shall elect officers in the following order: chairman, vice chairman, and treasurer. Election shall be by secret ballot with all supervisors present, including the chairman of the meeting, having the privilege of voting. The two supervisors receiving the greatest number of votes cast for an office on the first ballot shall be declared nominees for such office and a second ballot, or, in case of a tie, two subsequent ballots shall be taken for the election by majority vote of such officer from those nominated. If neither nominee receives a majority vote after three ballots, the two nominees shall draw lots for the office. If, on the first ballot, three supervisors shall tie for the highest number of votes or there is a tie for second and third positions as nominees, then the three supervisors receiving the greatest number of votes shall be declared nominees. In case of three nominees, up to three ballots shall be taken in an effort to obtain a majority vote for one nominee. If a majority is not obtained in this manner, the nominee receiving the greatest number of votes on the last ballot shall be declared elected or, in case of a tie, they shall draw lots for the office.

SEC. 3. *Term of office.*—Each officer, except the secretary, shall hold office for 1 year and until his successor is elected and qualified. The chairman may serve a maximum of 2 consecutive years and thereafter shall be eligible for reelection only after one full period between annual meetings shall have elapsed. Other officers shall be eligible for reelection.

SEC. 4. *Removal.*—Any officer may be removed from office by a two-thirds vote of the supervisors attending any regular or special meeting of the board at which a quorum is present.

SEC. 5. *Vacancies.*—A vacancy in any office because of death, resignation, removal, or incapacity shall be filled in the manner prescribed for the annual election of officers at the meeting of the board next following.

SEC. 6. *Chairman.*—The chairman shall preside at all meetings of the member organizations and the board of supervisors.

SEC. 7. *Vice chairman.*—The vice chairman shall act as chairman in the absence or incapacity of the chairman, and when so acting, shall have all the responsibility, power, and authority of the chairman.

SEC. 8. *Secretary.*—The appointed secretary shall, ex officio, be secretary of the division. This person shall keep the minutes of the meetings of member organizations and the board of supervisors; prepare agenda for each meeting; see that all notices are duly given in accordance with the provisions of these rules or as required by law; be the custodian of the records; keep a register of the name and address of each member organization and each supervisor; and in general perform all duties incident to the office of secretary.

SEC. 9. *Treasurer.*—The treasurer shall have charge and custody of and be responsible for all funds and securities of the division, receive and give receipts for moneys due and payable to the division from any source whatsoever, and deposit all such moneys in the name of the division in such banks, trust companies, or other depositories as may be designated by the board of supervisors; see that all authorized accounts payable are paid promptly; see that an adequate accounting system is maintained to give a true and accurate accounting of the financial transactions of the division and that reports of such transactions are presented to the board; and in general perform all duties incident to the office of treasurer.

SEC. 10. *Bonds.*—All officers and agents of the division responsible for the receipt, custody, or disbursement of funds shall give bonds for the faithful discharge of their duties in such sums and with such sureties as the board of supervisors shall determine.

ARTICLE VII—COMMITTEES

SECTION 1. *Advisory committee.*—There shall be an advisory committee composed of the chief administrative officer of each member organization or such person as the member organization may designate, the director of the Joint Commission on Accreditation of Hospitals, the secretary of the division, and the chief administrative officer or such other person as may be designated by other interested professional and health organizations which organizations have been approved for representation by the board of supervisors. The secretary of the division shall act as chairman of the advisory committee. Members of this committee shall receive no stipends and all expenses incurred in attending meetings shall be paid by the organization which the member represents. It shall be the duty of the advisory committee to—

(*a*) Act through the board of supervisors to recommend standards of performance in inpatient care institutions other than hospitals which may embody consideration of all administrative and professional aspects of the organization and operation of such institutions, but such standards shall not primarily relate to or bear upon financial relations between the institutions and the members of their medical staffs or other personnel.

(*b*) Counsel with the secretary of this division regarding all matters relating to the scheduling and conduct of institution surveys.

(*c*) Recommend to this division survey procedures, including the form of reports and the manner of their analysis and rating.

(*d*) Assist the secretary of this division in the interpretation and promotion of the accreditation program for inpatient care institutions other than hospitals.

SEC. 2. *Special committees.*—Special committees may be appointed by the chairman from members of the board of supervisors, members of the advisory committee, and persons affiliated with one or more member organizations, with the concurrence of the board of supervisors, for such purposes as circumstances warrant. Such special committees shall limit their activities to the accomplishment of the tasks for which they shall be created. They shall have no power to act except as such power shall be specifically conferred by the action of the board. Upon completion of the tasks for which appointed, such special committees shall stand discharged.

SEC. 3. *Rules.*—Each committee may adopt rules for its own government not inconsistent with these rules and regulations or with rules adopted by the board of supervisors.

ARTICLE VIII—SECRETARY OF THE DIVISION

SECTION 1. *Qualifications.*—The secretary shall be an individual experienced in the administration of health care facilities or programs.

SEC. 2. *Employment.*—The director of the Joint Commission on Accreditation of Hospitals shall have the right to employ the secretary, fix and alter the amount of his compensation, and dismiss the secretary from the employ of the division.

SEC. 3. *Conditions.*—The secretary shall be a full-time salaried employee of the division and shall obtain approval from the director of the commission prior to accepting any work assignments not having direct bearing on or relationship to the accreditation program. All earned income which the secretary obtains from other sources in the health field supplemental to the salary paid to the secretary by the division shall be turned over to the division and shall become its property.

SEC. 4. *Duties and authority.*—The secretary shall be an assistant director of the Joint Commission on Accreditation of Hospitals and administrative officer of the division. The secretary shall be given authority and shall be held responsible for the administration of this accreditation program in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by the board of supervisors or by any of its committees to which the board shall have delegated power for such action, or by limitations stated in these rules and regulations or by the director of the Joint Commission on Accreditation of Hospitals. In addition, the secretary shall have the following specific authority and duties:

(*a*) To prepare an annual budget showing expected receipts and expenditures; to prepare the assessments for expenses under the budget for each member organization in accord with current policy for such allocation, and to present the amount of the contribution to the budget assessed each member organization.

(*b*) To submit reports of activities to the board of supervisors or its authorized committees as requested.

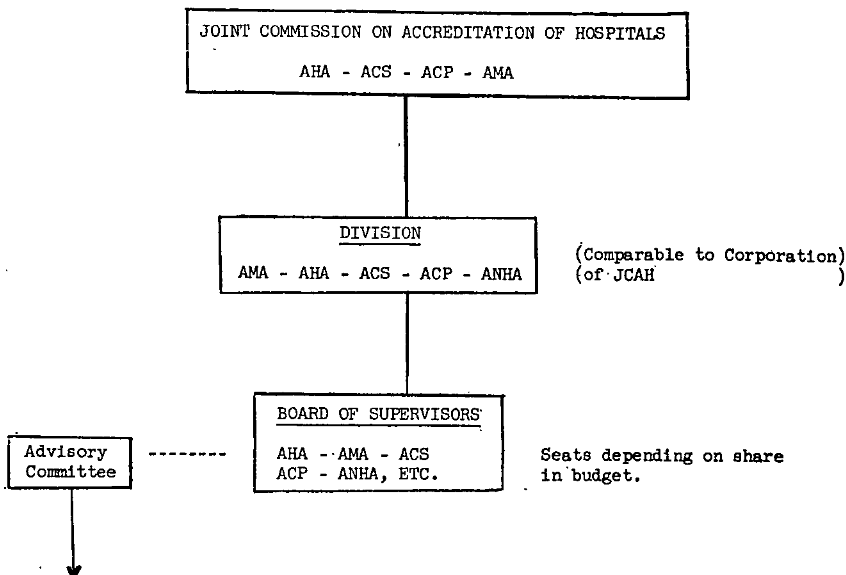
(*c*) To attend all meetings of the division.

(*d*) To serve as liaison officer and to channel all official communications between the division and the member organizations.

(*e*) To perform such other duties as may be assigned by the board of supervisors.

ARTICLE IX—CHANGE OF RULES

These rules and regulations may be altered, amended, or repealed and new rules and regulations may be adopted by the affirmative vote of member organizations representing three-fourths of the votes of all member organizations at any regular or special meeting of the member organizations, subject to the approval of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals.



Representatives from:

American Medical Association
American Hospital Association
American College of Surgeons
American College of Physicians
American Nursing Home Association
American Association of Homes for the Aging
American Dental Association
American Nurses' Association, Inc.
American Psychiatric Association
Association of Rehabilitation Centers
Federation of Licensed Practical Nurses
National League for Nursing
American Academy of General Practice

Appendix B

ELIGIBILITY FOR ACCREDITATION

1. Listed by the American Hospital Association.
2. Have been in operation at least 12 months.

BASIC REQUIREMENTS

The following basic requirements must be fulfilled in order for an inpatient care institution other than a hospital to be accredited:

I. Administration

A. Administrator: There shall be a qualified administrator who represents the governing body (if there is an organized governing body), and who is responsible for the conduct of the institution.

B. Physical plant: The buildings of the institution shall be constructed, arranged, and maintained to insure the safety of the patient; and must provide facilities for the treatment and services appropriate to the needs of the individuals accepted for care.

C. The following facilities and services shall be maintained:
1. Dietary.
2. Health records.
3. Nursing.
4. Medications.
5. Availability of laboratory and other special diagnostic services.
6. Availability of hospital inpatient services.

II. Medical and dental services

There shall be medical and dental services available for all residents at all times and there shall be provision for the evaluation of the quality of the care practiced.

FACILITIES AND SERVICES THAT MAY BE ESSENTIAL

Restorative services.
Outpatient services.
Social services.
Diversional services.
School services.
Podiatry services.
Personal grooming services.

APPENDIX C

To implement the basic requirements, the following standards are outlined. These standards must be met according to the objectives of the institution and to the needs of the individuals accepted for care. The methods used to achieve these standards may vary with the ownership, type, and size of the institution; but to achieve accreditation, the institution must carry out the intent of the standards.

I. ADMINISTRATION

A. Governing body

1. There shall be full disclosure of the actual owners.
2. If the institution is owned by a corporation, there shall be full disclosure of the directors, officers, and stockholders of the corporation.
3. For effective performance the governing body or comparable authority should do the following:
(*a*) Adopt bylaws in accordance with legal requirements.
(*b*) Meet at regular stated intervals and maintain a permanent record of proceedings and actions.
(*c*) Appoint members of the medical staff.
(*d*) Appoint a qualified administrator as the official representative of the governing body, who is responsible for the management of the institution.
(*e*) Provide a physical plant equipped and staffed to maintain the needed facilities and services for those individuals accepted for care, including arrangements for services outside the institution.

B. Physical plant

The building must be solidly constructed with adequate space and safeguards for each patient or resident. Space shall not be less than required by existing legal codes. The institution shall provide for at least:
1. Fire protection by the elimination of fire hazards; the installation of necessary safeguards such as extinguishers, sprinkling devices, and fire barriers to insure rapid and effective fire control; and the adoption of written fire control plans rehearsed at least three times a year by key personnel.
2. A sanitary environment to avoid sources and transmission of infections.
3. Facilities for temporary isolation of patients with communicable diseases and for privacy of terminal and disoriented patients.
4. Separate facilities for children, if accepted for care.
5. Adequate lighting and ventilation.
6. Adequate toilet and bathroom facilities.
7. Storage space and lockers for patients or residents.
8. Nursing stations as needed.
9. Corridors which permit easy passage of wheelchairs.
10. Grab rails and call signaling devices in bathrooms and toilets.
11. Protective devices to prevent accidents to ambulatory patients.

12. Rooms for patients or residents sufficiently large to prevent overcrowding.
13. Adequate space for recreational activities.
14. Adequate equipment for the care and comfort of patients or residents in bedrooms, nursing units, and other essential areas.

C. Facilities and services which shall be maintained

1. Dietary services.

(*a*) Facilities shall be provided that meet the requirements of the local sanitary code for the storage, preparation, and distribution of food for the general dietary needs of the institution. These shall include facilities for the preparation of special diets.

(*b*) There shall be a systematic record of menus of the meals as served, including special diets. These shall substantiate that a balanced and varied diet is provided.

(*c*) There shall be supervision of the dietary services by a nutritionist, dietitian, or registered nurse.

2. Health records.

(*a*) There shall be a health record maintained on every individual admitted for care in the institution.

(*b*) Records shall be kept inviolate and preserved for period of time not less that that determined by the statute of limitations in the respective State.

(*c*) All clinical and pertinent social information pertaining to a patient should be centralized in the patient's record.

(*d*) The health record shall contain at least identifying information, persons to be notified in emergency, name of attending physician, diagnoses, medical history and physical examination report, record of diagnostic procedures, signed physicians' orders for all treatments and medications, record of treatments and medications given, and medical and nursing progress notes.

3. Nursing service.

(*a*) Personnel:

(1) There must be a graduate registered nurse employed on a full-time basis who is responsible for the nursing service.

(2) There must be at least one registered nurse or a licensed practical or licensed vocational nurse on duty at all times.

(3) There must be registered nurses, licensed practical nurses, and ancillary nursing service personnel in sufficient numbers to provide safe nursing care for all patients at all times.

(*b*) Responsibilities and organization:

(1) Responsibilities and duties for each category of nursing personnel shall be delineated.

(2) Members of the nursing staff shall be qualified by education, experience, and demonstrated ability for the positions to which they are appointed.

(3) Written nursing care procedures should be available on all patient units.

(4) Nursing care plans should be written for patients requiring skilled nursing care and for others with special nursing problems.

(5) All patients must be visited by a registered nurse with sufficient frequency to assure safe nursing care.

4. Medications.

(*a*) Facilities shall be provided for the storage, safeguarding, and dispensing of drugs.

(*b*) There should be arrangements for competent professional advice regarding pharmaceutical services, drugs, and administrative policies in relation to drug control.

(*c*) Drugs dispensed shall meet the standards of the United States Pharmacopeia, National Formulary, or New and Nonofficial Drugs.

(*d*) Policies must be established to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage.

(*e*) There shall be provision for the control of narcotics and other medications.

(*f*) Such records shall be maintained as are required by law.

5. Availability of laboratory and other special diagnostic services.

(*a*) There shall be provision for obtaining clinical laboratory, diagnostic radiological services, and such other diagnostic services as are needed for adequate care of the patients or residents.

(*b*) These services shall be regularly and conveniently available.
6. Availability of hospital inpatient services.
(*a*) There shall be formal arrangements with at least one hospital where patients or residents whose condition requires it, will be admitted with minimum delay.
(*b*) Any other arrangements for hospitalization will be the responsibility of the patient's attending physician.

II. MEDICAL AND DENTAL SERVICES

A. Membership

Only physicians and dentists qualified legally, professionally, and ethically shall be permitted to admit and attend patients or residents.

B. Organization

1. There shall be bylaws and/or rules and regulations subscribed to by the medical and dental staff attending patients or residents in the institution.
2. There shall be a formal arrangement with a doctor of medicine or a committee controlled by doctors of medicine to evaluate and supervise the quality of care practiced in the institution.
3. There shall be formal arrangements in the absence of the attending physician or dentist to provide emergency care.

C. Each patient shall be under the regular medical care and supervision of a licensed physician; there shall be evidence that all patients are visited with sufficient frequency to assure adequate medical care.

D. There shall be provision for regular periodic reevaluations of the health status of all patients or residents.

III. FACILITIES AND SERVICES WHICH MAY BE ESSENTIAL ACCORDING TO THE OBJECTIVES OF THE INSTITUTION AND THE NEEDS OF THE INDIVIDUALS ACCEPTED FOR CARE

A. Restorative services

1. An institution accepting long-stay patients or residents shall provide at least the facilities and services needed to promote the achievement and maintenance of an optimal level of self-care.
2. Restorative procedures beyond the scope of the institution should be provided through arrangements with other appropriate community facilities and agencies.
3. An institution accepting patients for definitive rehabilitation must provide adequate facilities, equipment, and qualified personnel to accomplish the rehabilitation goals. The service shall be under the direction of a qualified physician.

B. Output services

1. Adequate space, facilities, and personnel should be provided according to the needs of the patients.
2. Medical records should be maintained and correlated with other health records.

C. Social services

1. Social services should be regularly and conveniently available to patients and residents.
2. Social services should be supervised by a qualified social worker.
3. Social services beyond the scope of the institution should be provided through arrangements with other appropriate community agencies.

D. Diversional services

Regular recreational and other diversional activities should be provided for long-stay patients and residents.

E. School services

1. A regular school program should be provided for long-stay school age children. These program should be under the direction of the appropriate community board of education.
2. Specialized school programs appropriate for the capacities of mentally retarded or other handicapped children should be provided.

F. Podiatry services

Services of qualified podiatrists should be available to patients and residents in long-stay institutions.

G. Personal grooming services

Arrangements for the availability of personal grooming services should be provided.

APPENDIX D

ADMINISTRATIVE POLICIES

General

1. Accreditation program is on a voluntary basis without cost to the institution and accreditation is granted only on the basis of a survey.

2. A survey for accreditation will be conducted upon written request from the administrator or governing authority of any inpatient care institution other than a hospital meeting the eligibility requirements.

3. If an institution has residential accommodations in addition to facilities with medical and nursing services, the entire institution will be surveyed provided that:

(*a*) Health services are available to the occupants of the residential accommodations on an ambulatory basis; and

(*b*) The patients receiving continuous medical and nursing care are housed in an identifiable unit.

In this event, the surveyor shall record the number of beds in the inpatient care unit separately from the residential beds. Accreditation will be based on the standards applicable to the entire institution.

Surveys

1. Surveys may be conducted by physicians, registered nurses, or other individuals competent in the field.

2. Accreditation shall be granted for 3 years or 1 year. Other accreditation policies will be consistent with those established for the accreditation of hospitals.

3. A resurvey will be conducted at any time circumstances warrant. A change in individual ownership will require a resurvey for continued accreditation.

APPENDIX V

ACCREDITATION OF NURSING HOMES

CHRONOLOGY OF ACTIONS

Prepared by American Hospital Association

December 13, 1957—Committee on listings

Voted: To request the Committee on Chronic Illness, while it is considering recommendations regarding the type of program the American Hospital Association should conduct for nursing homes, to consider the inclusion of a listing category for long-term-care facilities that cannot now be listed as hospitals.

February 10, 1958—Meeting of AHA with ANHA (professional liaison committee)

President of American Nursing Home Association reported on a pilot classification project to be carried out in Illinois. "The representatives of the AHA made it quite clear that an accreditation program on a State-by-State basis, with each State autonomous, is not likely to be successful. It was strongly recommended that the goal be a national classification program administered by a central body."

May 6, 1958—Committee on Chronic Illness

Voted: To establish a listing program for parahospitals, which meet the definition of and criteria for such facilities. (Criteria attached in appendix.)

July 9, 1958—Joint Committee of Trustees of AHA–AMA

Voted: To recommend that the AHA list nursing homes; further, to recommend that standards as a basis for such listings be developed by the Council on Professional Practice of the AHA in cooperation with the Council on Medical Service of the AMA.

August 17, 1958—Board of Trustees, American Hospital Association

Approved the above vote of the joint committee of boards.

September 26, 1958—Liaison Committee, AHA–ANHA

Representatives of AMA Council on Medical Service present by invitation.
Proposed listing requirements were reviewed, amended, and approved as amended. Recommendations made to conduct the listing program under joint sponsorship of AHA, AMA, and ANHA.
(The latter was disapproved by Council on Professional Practice, September 28, 1958; but Tripartite Committee suggested as advisory body.)

November 20, 1958—Coordinating Council and Board of AHA

Voted:
To adopt the listing requirements for inpatient care institutions other than hospitals; further
To offer a listing program to inpatient care institutions other than hospitals, the mechanics for carrying out such listing program to be the same as those for listing hospitals.

February 2, 1959—Coordinating Council and Board

Voted: To appoint representatives of this association, to meet with representatives of the ANHA, if requested, to discuss the matter of listing nursing homes.
Meeting held March 1959.

June 23, 1959—American Nursing Home Association—Meeting of Governing Council

It was moved and voted: That the American Nursing Home Association approve the listing program as proposed by the American Hospital Association, subject to the Tripartite Liaison Committee serving in a consulting capacity to the policymaking group for listing.
(Approved by Council on Professional Practice, March 17–18, 1960.)

October 10, 1959—Tripartite Committee Meeting

The President of ANHA described the efforts of that organization to develop a project for classifying nursing homes. Financing being sought.

Listing.—It was agreed that the AMA and ANHA would publicize the AHA listing program, since everyone was agreed on its advantages.

Accreditation.—The Buffalo, New York, plan of the Council for Accrediation of Nursing Homes, Inc., was discussed, including its plan to expand into a national organization.

May 26, 1960—Meeting of Staff of Tripartite Committee

Staff prepared a plan for evaluation of inpatient facilities other than hospitals; including criteria to be used as a "Study Plan for Preparing Standards of Care for Evaluating Inpatient Facilities other than Hospitals."

June 1960—Promotion of Accreditation

A statement of the association's philosophy of a sound accreditation program for health care facilities was developed. This was used by staff to introduce a philosophical concept of accreditation in talks given at institutes and other meetings at which administrators of long-term facilities were represented. The statement was also incorporated in the materials transmitted by the staff of the Tripartite Committee to the JCAH.

June 26, 1960—Meeting of Staff of Tripartite Committee

Staff reviewed study plan developed at previous meeting, and outlined a research project for evaluation of proposed standards, including specific aims and method of procedure.

September 23, 1960—Meeting of Tripartite Liaison Committee

Voted: The committee voted to approve the aims and method procedure for the project (titled "Study Plan for Preparing Standards of Care for Evaluating Inpatient Facilities Other Than Hospitals").

The committee recommended to appointive organizations in the AHA, AMA, and ANHA that they endorse the project and authorize the committee to get the project underway. The committee anticipates that this project will be financed from sources other than the parent organization.

November 14, 1960—Committee on Care of Chronically Ill and Aged

Study plan on standards of care reviewed. Reported that ANHA had approved the study plan but would undertake unilaterally an accreditation program for nursing homes.

Voted to recommend:

To urge that the association formulate, in cooperation with other national organizations concerned with the quality of care provided in inpatient care institutions other than hospitals, including nursing homes with skilled nursing service, criteria and methods for evaluation and approval of these health care facilities; further

To urge that the American Hospital Association's representatives to the JCAH encourage the Joint Commission to accept responsibility for administering an approval program of inpatient care institutions other than hospitals.

May 18, 1961—Board of Trustees, American Hospital Association

Voted (approved the above with following change in second paragraph): To recommend to the Joint Commission on Accreditation of Hospitals that it accept responsibility for administering an accreditation program for inpatient care institutions other than hospitals, including nursing homes with skilled nursing services.

May 22, 1961—Meeting of Tripartite Liaison Committee

Report of parent organizations.

AHA reported the action of May 1961 of board of trustees on accreditation. (See above.)

AMA Council on Medical Service.

Voted:

To reiterate its endorsement of the recommendations of the Tripartite Committee; namely, a pilot study to determine criteria and methods for evaluating quality of care in inpatient care institutions other than hospitals; further

To support only a multilateral accreditation program which is sponsored by various national organizations concerned with this problem.

May 22, 1961—ANHA

Developed its own program in order to stimulate and encourage the interests of other organizations.

Might be in favor of an accrediation program administered by JCAH provided ANHA had appropriate representation.

VOTED: To have staff review the present accreditation program of the ANHA in all its aspects, to determine its strengths and weaknesses, and to make recommendations to the committee concerning the future of a nursing home accreditation program, particularly in the light of the different actions by the constituent parent organizations of the committee.

June 1961—Staff of AHA and AMA Meeting With ANHA Accreditation Committee (chairman, Dr. E. C. Kocovsky)

October 23, 1961—Meeting of Tripartite Liaison Committee

Committee reviewed comments of June 1961 meeting. The following resolution was approved:

"Whereas the Liaison Committee of the AHA, AMA, and ANHA on Problems Concerning the Institutional Care of the Chronically Ill and Aged recognizes the urgent need for an accreditation program for inpatient care institutions other than hospitals; and

"Whereas the American Nursing Home Association is now embarking on an accreditation program for nursing homes; and

"Whereas the Joint Commission on Accreditation of Hospitals is actually the logical choice for administering accreditation programs for all types of health care facilities: Therefore be it

"*Resolved*, That the Liaison Committee urge the Joint Commission on Accreditation of Hospitals (1) to take early action on the question of assuming responsibility for accreditation of all types of health care facilities, and (2) if this action is favorable, to assure the American Nursing Home Association of adequate representation in the operation of such an accreditation program for nursing homes."

ANHA representatives raised a question as to the attitude of the committee toward the ANHA accreditation program in the event that the JCAH did not accept responsibility for accreditation of nursing homes. Committee members generally agreed that the ANHA program would warrant serious consideration by the AHA and AMA as an alternative to a program administered by the JCAH.

December 9, 1961—JCAH Board of Commissioners Meeting

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals stated that the problem of accreditation of inpatient care institutions other than hospitals is of grave importance and is a job that should be done; that the Joint Commission on Accreditation of Hospitals by virtue of its experience, knowledge, and prestige appears to be the logical organization to

supervise such a program. The commissioners were of the opinion that the commission can and should administer the program if financial support is available. The commissioners voted that the commission seek to acquire funds to develop a program. The primary work of the program would include the development of acceptable standards and other documents necessary for the instigation of a program, an estimate of initial and projected costs, a projected 1-year budget, and any other pertinent facts.

March 1962—AHA Staff

For use of JCAH, prepared:

(1) Proposed standards for accreditation of inpatient care institutions other than hospitals.

(2) Draft of questionnaire to be sent in advance.

(3) Draft of evaluation form for surveyors.

March 17, 1962—JCAH Board of Commissioners Meeting

The commissioners passed a resolution which recognized the desirability of establishing a program of survey and approval for inpatient care institutions other than hospitals similar to its existing program of accreditation of hospitals. The resolution also recognized the need for implementation of such a certification process at the earliest possible date and expressed the belief that this program should be an extension of the present activities of the Joint Commission. The commissioners requested that the constituent organizations of the Joint Commission express their agreement with the objective of the resolution by a declaration of intent to participate in the program.

April 2, 1962—Meeting of Liaison Committee

Progress report but no action.

January 1959 to April 1962—Efforts to finance listing and accreditation programs

Between January 1959 and April 1962, when the Hartford Foundation awarded a grant of $49,500 to the Hospital Research and Educational Trust, the association submitted proposals to several foundations, such as the Avalon Foundation, Ford Foundation, and the Kellogg Foundation, for funds to develop and test criteria for the association's listing program, and for an accreditation program for inpatient care institutions other than hospitals. To this end, there were several informal meetings with representatives of these foundations, and several proposals were developed by staff.

April 1, 1962—

The John A. Hartford Foundation, Inc., made a grant of $49,500 to the hospital research and educational trust to carry out the development and initial implementation of a program of accreditation for inpatient care institutions other than hospitals. This program to be conducted under the supervision of the JCAH.

April 2, 1962—Staff of JCAH

Harold E. Goetsch joined the staff of the Joint Commission on Accreditation of Hospitals with the responsibility of developing and implementation of the program.

May 7, 1962—JCAH-Special Meeting of National Organizations

On the invitation of the Joint Commission, representatives from—

American Academy of General Practice,
American Association of Homes for the Aging,
American Association of Rehabilitation Centers, Inc.,
American College of Physicians,
American College of Surgeons,
American Dental Association,
American Hospital Association,
American Medical Association,
American Nurses' Association, Inc.,
American Nursing Home Association,
National Federation of Licensed Practical Nurses, Inc., and
National League for Nursing, Inc.

met in Chicago, reviewed the proposed organizational structure and program in anticipation of a future formal relationship with the commission.

August 4, 1962—JCAH Board of Commissioners Meeting

Voted to recommend to the member organizations—

To establish a division for accreditation of inpatient care institutions other than hospitals, effective January 1, 1963, which will recommend to the Joint Commission on Accreditation of Hospitals policies and procedures for surveying and accrediting of such institutions, and which will be subject to the ultimate and final authority of the Joint Commission on Accreditation of Hospitals, and which will have a board of not more than 15 members, 1 each of whom shall be from each member organization of the Joint Commission on Accreditation of Hospitals and, in addition, the majority of the remaining members shall be representative of inpatient care institutions other than hospitals.

To finance this division for accreditation of inpatient care institutions other than hospitals by budgeting separately for administrative costs and direct costs for surveying; two-thirds of the administrative costs to be paid by the Joint Commission on Accreditation of Hospitals and one-third to be prorated among the other members of the board of the division, the costs of surveying for accreditation to be prorated among the institutions surveyed, effective January 1, 1964.

Voted: To call a meeting of the members of the corporation as soon as possible to consider necessary changes in the bylaws and the budget so as to establish this new division for accreditation of inpatient care institutions other than hospitals, effective January 1, 1963.

Voted: That the eligibility requirements for survey for accreditation of inpatient care institutions other than hospitals should be established and administered by the Joint Commission on Accreditation of Hospitals.

Voted: To seek funds from a foundation or other source for continuation and operation of the program for accreditation of inpatient care institutions other than hospitals for the year 1963.

November 15, 1962—Board of Trustees

Voted: To include in the registration requirements for inpatient care institutions other than hospitals the following principles:

1. (Requirement 2) That the facility shall be licensed or approved by the legally authorized agency or agencies.
2. (Requirement 7) That the nursing service in the institution should be under the supervision of a registered nurse and that there should be such other nursing personnel as are necessary to provide adequate care of patients 24 hours a day.
3. (Requirement 8) That there shall be evidence that food served to patients meets their nutritional and dietary requirements, as reflected in menus that are planned in advance and kept on file for at least one month.
4. (Requirement 9) That the physical plant shall be safe and sanitary and that the number of patients accepted shall not overtax the facility.
5. (Requirement 10) That there should be proper storage and control of narcotics and other medications and procedures for proper issuance in accordance with physicians' orders; *further*

To refer this action to the Council on Association Services for incorporation in the Association Regulations of the American Hospital Association.

December 8, 1962—JCAH Board of Commissioners Meeting

It was reported to the Board of Commissioners that three of the four member organizations of the commission approved the program presented in principle and also that, of the organizations approached to become members of the division of inpatient care institutions other than hospitals, all had expressed their intention to participate except the American Nursing Home Association. It was reported that the American Medical Association's board of trustees had voted in its meeting of November 24–29, 1962, to open negotiations with the American Nursing Home Association with the idea of activating the National Council for Accreditation of Nursing Homes. The board also voted that the American Medical Association representatives to the Board of Commissioners be instructed to oppose the Accreditation of Nursing Homes by the Joint Commission.

The commissioners took action to delay implementation of previous recommendations and voted to appoint an ad hoc committee of four members of the commission, one representing each member organization of the commission. The committee is to obtain information about inpatient care institutions other than hospitals and to present recommendations as to policy and action of the Joint Commission on Accreditation of Hospitals in this field of accreditation. The commissioners also voted that the Joint Commission urge the Board of

Trustees of the American Medical Association to reconsider its action of November 24, 1962.

January 12, 1963—JCAH special committee meeting

The Joint Commission Ad Hoc Committee on Inpatient Care Institutions Other Than Hospitals, having been duly appointed, met in Chicago and prepared seven major recommendations to be presented at the next meeting of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals.

RECOMMENDATIONS OF AD HOC COMMITTEE ON INPATIENT CARE INSTITUTIONS OTHER THAN HOSPITALS

1. That the Joint Commission base its consideration of a program of accreditation for inpatient care institutions other than hospitals on the data and information now available since no purpose would seem to be served by the Joint Commission conducting an independent study.
2. That the Joint Commission on Accreditation of Hospitals establish a division for accreditation of inpatient care institutions other than hospitals.
3. That representation on the division for accreditation of inpatient care institutions other than hospitals be as follows:

American Nursing Home Association	3
American Association of Homes for the Aging	2
American Nurses' Association	1
National League for Nursing	1
National Federation of Licensed Practical Nurses	1
American Dental Association	1
National Association of Social Workers	1
American Hospital Association	1
American College of Surgeons	1
American College of Physicians	1
American Medical Association	1

4. That the Joint Commission reaffirm its pledge of financial support of the division as outlined at the December meeting of the Board of Commissioners.
5. That the program of accreditation for inpatient care institutions other than hospitals be confined to skilled nursing facilities in the beginning and that consideration be given as early as possible to extending the program to residential facilities.
6. That the standards of accreditation, as prepared to date, be reviewed, amended, and approved by the division before submission to the Board of Commissioners for final approval.
7. That as soon as possible after the next meeting of the American Medical Association Board of Trustees, the committee chairman, one committee member, and the director of the Joint Commission meet with the officers of the American Nursing Home Association, review the program to date and resolve, if possible, any differences which may still exist.

March 9, 1963—JCAH Board of Commissioners Meeting

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals met, reviewed previous action of the commission, and carefully listened to a report of the American Medical Association activities with the American Nursing Home Association. It quickly became apparent that an impasse had been reached and so the Board of Commissioners voted to discontinue at this time any further action toward the development and implementation of a program of accreditation of inpatient care institutions other than hospitals by the Joint Commission on Accreditation of Hospitals, and further to remain receptive to any future invitations to undertake such a program.

April 1963—AMA–ANHA

AMA–ANHA announced the establishment of the jointly sponsored National Council for the Accreditation of Nursing Homes. Appointment of Henry A. Holle, M.D., to the position of executive director was also announced.

May 1963—AAHA Executive Board

Resolved:

"That the executive committee immediately take steps to implement the accreditation resolution of the association, preferably with a multilateral approach to the problem.

"That the chairman appoint a committee on accreditation.

"That this committee present concrete proposals at the next meeting of the executive committee.

"That exploratory conferences be held with the AHA and other appropriate national professional organizations on this matter of accreditation."

October 3, 1963—AHA Council on Long-Term Care

Rev. William T. Eggers, representing AAHA, attended the council meeting and presented a proposal of his association for an accreditation program. The council recommended approval of AHA participation. (See November 21, 1963, action of board of trustees.)

November 7, 1963—Meeting on Accreditation Convened by AAHA

Associations represented: AAHA, ACP, ACS, ADA, AHA, ANHA, ANA, APA, ARC, NASW, NFLPN, and NLN.

A proposal for a multilaterally sponsored program for accreditation of long-term-care facilities was presented and discussed. The group agreed to a second meeting for further consideration of the proposal.

November 21, 1963—Board of trustees

Voted: To develop and implement as rapidly as possible, in cooperation with other appropriate national organizations, an accreditation program for long-term-care facilities having acceptable written agreements with general hospitals to meet the need of these facilities until such a program is undertaken by the Joint Commission on Accreditation of Hospitals.

January 1, 1964—National Council for the Accreditation of Nursing Homes

Letter sent by its chairman, H. Close Heseltine, M.D., to each participant in the November 7, 1963, meeting inviting him to attend the March 16 meeting of the board of directors to discuss possibility of becoming a member of the National Council.

February 20, 1964—Second meeting convened by AAHA to consider an accreditation program for specialized health facilities

A steering committee was formed, with one representative of each organization. The steering committee was directed to (1) request a meeting with representatives of the National Council prior to its March 16 board meeting; (2) ask the JCAH to reconsider its earlier action; and (3) develop a proposal for a new structure, multilaterally sponsored.

February 20, 1964—Meeting of steering committee on accreditation of specialized health facilities.

Present: AAHA, ADA, AHA, AMA, ANA, ANHA, ARC, and NASW.

The committee agreed that there should be unity and multilateral sponsorship of all health care facilities; that the immediate objective is a unified accreditation program for nursing homes, homes for the aged, and rehabilitation centers.

Authorized a subcommittee of three to (1) request a meeting with the National Council for the Accreditation of Nursing Homes; (2) request the JCAH to reconsider its action of April 1963; (3) request a meeting with the Ad Hoc Committee on Accreditation of Rehabilitation Facilities.

March 6, 1964—Meeting with executive committee of the National Council for Accredition of Nursing Homes.

AMA members of executive committee indicated possibility of inviting AHA and ADA to join council.

March 14, 1964—Meeting with Ad Hoc Committee on Accreditation of Rehabilitation Facilities

March 21, 1964—Meeting of Board of Commissioners, JCAH

The question of reconsideration of its April 1963 action was referred to the four sponsoring organizations.

March 23, 1964—Second meeting of steering committee

Appointed a subcommittee to prepare a detailed proposal. Agreed to meet again late in April.

APPENDIX VI

Supplemental Information

Submitted by Dr. H. Close Hesseltine, Chairman of the National Council for Accreditation of Nursing Homes, and Mr. Alton Barlow

Chronology of Accreditation Program for Nursing Homes and Related Facilities

1954—American Nursing Home Association annual convention voted that the lead in introducing "acceptable standards for nursing homes" and an eventual accreditation program for such facilities be taken by this association.

1958–60—State nursing home associations in Connecticut, California, and Wisconsin established their own accreditation programs.

1959—American Hospital Association and American Nursing Home Association approved a listing program for nursing homes with survey for such listing to be conducted by the AHA.

May 1960—American Nursing Home Association Mid-year Governing Council approved the appointment of a committee to formulate standards for accreditation.

October 1960—House of Delegates of American Nursing Home Association at annual convention approved the accreditation program as presented by the ad hoc committee. This first effort was State and regionally implemented and controlled.

November 1960—Surveys to evaluate the accreditation criteria were conducted in Wisconsin and Connecticut.

May 22, 1961—Tripartite Liaison Committee, composed of the American Medical Association, American Hospital Association, and American Nursing Home Association, recommended that the parent organizations endorse a pilot project for assessing standards to be used for evaluating inpatient facilities other than hospitals. The committee also voted to have staff review the present ANHA accreditation program.

PILOT PROJECT FOR ASSESSING STANDARDS TO BE USED FOR EVALUATING INPATIENT FACILITIES OTHER THAN HOSPITALS

The Tripartite Committee had recommended that the parent organizations endorse the project and authorize the Committee to get the project underway.

Committee action.—The committee took cognizance of the actions of the Joint Council To Improve the Health Care of the Aged on the accreditation of nursing homes.

The committee voted to have staff review the present accreditation program of the ANHA in all its aspects, to determine its strengths and weaknesses, and to make recommendations to the committee concerning the future of a nursing home accreditation program, particularly in the light of the different actions by the constituent parent organizations of the committee.

April 5, 1961—Joint Council To Improve the Health Care of the Aged was requested to consider sponsorship of the accreditation program. However, the component organizations (American Medical Association, American Hospital Association, American Dental Association, and ANHA) did not feel such a step was a logical extension of the council's service.

May 1961—American Hospital Association made recommendation to the Joint Commission for Accreditation of Hospitals.

American Hospital Association.—The Committee on Care of the Chronically Ill and the Aged of the American Hospital Association has also considered the recommendations for a pilot study. This committee has some doubt concerning the need for a study and believes that the experience of the Joint Commission on Accreditation of Hospitals, supplemented by data obtainable through the AHA listing program and State licensure programs, may well provide sufficient information. Based on the recommendations of this committee, the AHA Board of Trustees voted these recommendations in May 1961:

"(1) To urge that the AHA formulate in cooperation with other national organizations concerned with the quality of care provided in inpatient care institutions other than hospitals, including nursing homes with skilled nursing services, criteria, and methods for evaluation and approval of these health care facilities; further

"(2) To recommend to the Joint Commission on Accreditation of Hospitals that it accept responsibility for administering an accreditation program for inpatient care institutions other than hospitals."

These recommendations have been approved by the AHA Board of Trustees. Furthermore, the board is sending a letter to the Joint Commission to ascertain the extent of their interest in developing and administering such an accreditation program.

American Medical Association.—The study plan of the Tripartite Committee was endorsed by the Council on Medical Service at its November 1960 meeting and the Tripartite Committee was authorized to initiate work on the project.

The Committee on Medical Facilities considered the recommendations of the Tripartite Committee, the activities of the ANHA and the AHA, and recommend that the Council on Medical Service reiterate its endorsement of a pilot study under the direction of the Tripartite Liaison Committee.

At its meeting on March 4, 1961, the Council on Medical Service of the American Medical Association reconsidered its recommendation for the Tripartite Committee to undertake a study project to develop criteria and methods for evaluating inpatient care institutions other than hospitals. The Council on Medical Service was given information on the actions of the American Nursing Home Association in approving the study plan proposed by the liaison committee and in sponsoring unilaterally an accreditation program for nursing homes. The Council on Medical Service was also furnished information on the resolutions of the Committee on Care of the Chronically Ill and of the Aged of the American Hospital Association on the recommendations of the Tripartite Committee.

The Council on Medical Service voted to reiterate its endorsement of the recommendations of the Tripartite Committee; namely, for a pilot study to determine criteria and methods for evaluating the quality of care in inpatient care institutions other than hospitals. The Council on Medical Service also voted to support only a multilateral accreditation program which is sponsored by various national organizations concerned with this problem.

American Nursing Home Association.—Although the ANHA has endorsed the study plan, it has also initiated unilaterally an accreditation program.

The ANHA developed its own accreditation program in order to stimulate and encourage the interest of other organizations.

During the discussion of these various actions, it was indicated that ANHA might be in favor of an accreditation program administered by the Joint Commission on Accreditation of Hospitals provided ANHA had appropriate representation.

May 1961—ANHA Accreditation Committee voted to cooperate to the fullest with the Joint Commission for Accreditation of Hospitals.

American Nursing Home Association.—The Accreditation Committee of the American Nursing Home Association voted to recommend to its governing council that the ANHA cooperate to the fullest extent with the Joint Commission on Accreditation of Hospitals in developing a program for the accreditation of nursing homes.

June 1961—Tripartite Liaison Committee staff met with ANHA Accreditation Committee chairman to discuss the program and suggest revisions.

In June 1961, Liaison Committee staff had met with Elmer C. Kocovsky, M.D., chairman of the ANHA Accreditation Committee who explained the ANHA accreditation program in detail. It was pointed out to Dr. Kocovsky that AMA

and AHA had officially gone on record in favor of a multilateral accreditation program sponsored by various national organizations concerned with nursing home care. AMA staff, in a memorandum of August 24, offered specific comments on the existing ANHA program.

In response to these comments, ANHA has made various changes in the organization and administration of their accreditation program. ANHA recognizes that its new program still contained certain weaknesses, such as lack of firm financing and too much dependence on voluntary staff and committees. ANHA recognizes the need for upgrading the original set of standards and developing a complete surveyor's manual. To make these improvements, ANHA is allocating $12,500 for the operation of its accreditation program in 1962. Dr. Anderson raised the question as to whether ANHA had discussed its accreditation program with the Joint Commission on Accreditation of Hospitals (JCAH).

ANHA representatives indicated that in their opinion, no interest in assuming responsibility for an accreditation program had ever been evinced by JCAH. Dr. Anderson said that the JCAH might now be interested in taking on this responsibility and was planning to discuss this subject at its next meeting in December 1961. ANHA representatives believed that ANHA would seriously consider the transfer of their own accreditation program to JCAH if ANHA had equal representation with other organizations in its administration. Dr. Anderson offered to convey to the JCAH the interest of ANHA in meeting with the Joint Commission when it considered broadening its accreditation responsibilities. After considerably more discussion on the desirability of a multilateral system of accreditation, the Liaison Committee passed the following resolution:

"Whereas the Liaison Committee of the AHA, AMA, and ANHA on Problems Concerning the Institutional Care of the Chronically Ill and Aged recognizes the urgent need for an accreditation program for inpatient care institutions other than hospitals; and

"Whereas the American Nursing Home Association is now embarking on an accreditation program for nursing homes; and

"Whereas the Joint Commission on Accreditation of Hospitals is actually the logical choice for administering accreditation programs for all types of health care facilities: Therefore be it

"*Resolved*, That the Liaison Committee urge the Joint Commission on Accreditation of Hospitals (1) to take early action on the question of assuming responsibility for accreditation of all types of health care facilities and (2) if this action is favorable, to assure the American Nursing Home Association of adequate representation in the operation of such an accreditation program for nursing homes."

ANHA representatives raised a question as to the attitude of the committee toward the ANHA accreditation program in the event that the JCAH did not accept responsibility for accreditation of nursing homes. Committee members generally agreed that the ANHA program would warrant serious consideration by the AHA and AMA as an alternative to a program administered by the JCAH.

August 30, 1961—ANHA Accreditation Committee met with staff of member organizations of the Joint Council To Improve the Health Care of the Aged (AMA, AHA and ADA) as well as the executive director of the Joint Council to discuss the program as revised in line with their previous suggestions both through this committee and the Tripartite Liaison Committee.

October 23, 1961—Recommendation of the Tripartite Liaison Committee to the Joint Commission for Accreditation of Hospitals.

To: Liaison Committee (AHA, AMA, ANHA).
From: Willard Wright, M.D., secretary, Liaison Committee.
Date: February 15, 1962.
Subject: Next meeting of the Liaison Committee, April 2, 1962.

We wish to notify you that the next meeting of the Liaison Committee will be held on Monday, April 2, 1962, at AMA headquarters. By that date the Joint Commission on Accreditation of Hospitals will have acted on recommendations for it to assume responsibility for accreditation of inpatient institutions other than hospitals.

RECOMMENDATION FOR JOINT COMMISSION ON ACCREDITATION OF HOSPITALS TO ASSUME RESPONSIBILITY FOR ACCREDITATION OF INPATIENT INSTITUTIONS OTHER THAN HOSPITALS

At its last meeting, the Liaison Committee passed a resolution urging the Joint Commission on Accreditation of Hospitals—

(*a*) To take early action on the question of assuming responsibility for accreditation of all types of health care facilities; and

(*b*) If the action is favorable, to assure the American Nursing Home Association of adequate representation in the operation of such an accreditation program for nursing homes.

October 1960—Program, as revised including suggestions from medical and paramedical groups, approved by the ANHA house of delegates at annual convention. Program now removed from State and regional control to one implemented and administered from a national level.

November 29, 1961—Recommendation from the American Medical Association to the Joint Commission for Accreditation of Hospitals.

American Medical Association.—The AMA Board of Trustees at its meeting November 24–29, 1961, voted to receive the report from the Council on Medical Service which suggested that the Joint Commission on Accreditation of Hospitals be requested to consider assuming the function of accrediting inpatient medical facilities, and that the report be forwarded to the Joint Commission. A letter was sent to Dr. Babcock of the Joint Commission suggesting consideration of the recommendation of the Council on Medical Service.

December 1961—Joint Commission for Accreditation of Hospitals voted to consider accreditation of inpatient facilities other than hospitals.

Babcock: December 31, 1962, at Conference of Secretaries of Hospital Associations.

"The subject of accreditation of inpatient institutions other than hospitals was first brought to the attention of the JCAH last May, when we received the vote of the AHA Board of Trustees.

"A committee was then appointed, under the chairmanship of Ray Brown, and held two meetings.

"Last month (December 1961) the JCAH voted that—

"Accreditation of inpatient facilities other than hospitals is a problem of grave importance and a job that should be done.

"Accreditation should be done preferably by a national nonprofit, nonmental organization with sufficient stature to do the job.

"The JCAH appears to be the logical organization to supervise such program, but (it) would not jeopardize the autonomy of the JCAH.

"The JCAH seek to acquire funds, develop acceptable standards, and establish projected costs and a budget for the first year.

"The JCAH recruit additional staff for the conduct of such a program."

January 1, 1962—American Medical Association, American Hospital Association, American Dental Association, and American Nursing Home Association were invited to appoint representatives to the National Council for Accreditation of Nursing Homes and Related Facilities.

JANUARY 16, 1962.

F. J. L. BLASINGAME, M.D.,
Executive Vice President, American Medical Association,
Chicago, Ill.

DEAR DR. BLASINGAME: One of the most ambitious ventures in the thirteen years existence of the American Nursing Home Association, the planning and implementation of a national accreditation program for nursing homes and related facilities, is now approaching completion.

The original program, as adopted in October 1960, was submitted to the American Medical Association and the American Hospital Association for their comments and criticism. In August of 1961, at a meeting between representatives of the American Nursing Home Association, American Medical Association, American Hospital Association, and, in addition, the American Dental Association, these comments and criticisms were received and discussed. As a result the program was revised, substantially, so as to be multilateral and to simplify

operating procedure. The revised program was approved by the American Nursing Home Association at its 1961 convention and submitted to the Tripartite Liaison Committee for suggestion. Their recommendations, in part, have been incorporated in the program as now submitted to you in the following documents:

1. Explanatory statement.
2. Accreditation program (revised December 13, 1961).
3. Flow chart and diagram.

Under the present accreditation program the American Medical Association, American Hospital Association, American Dental Association, and American Nurses' Association are requested to appoint two representatives to the National Accreditation Committee, one voting delegate and one alternate without vote. An additional alternate delegate may be named to assure the presence of two representatives at all committee meetings should another delegate's absence be compelled.

The American Nursing Home Association Accreditation Committee is anxious to have a National Accreditation Committee constituted by March 1, 1962. Accordingly, we request that the names of the representatives appointed by your organization be forwarded, to the undersigned, at your earliest possible convenience.

Very truly yours,

(Mrs.) ELEANOR B. BAIRD,
Chairman, Accreditation Committee.

JANUARY 26, 1962.

Mrs. ELEANOR B. BAIRD,
Chairman, Accreditation Committee, American Nursing Home Association, New Milford, Conn.

DEAR MRS. BAIRD: Thank you for your letter of January 16, 1962, concerning the implementation of the American Nursing Home Association's National Accreditation program for nursing homes and related facilities.

Inasmuch as a formal request has been made to the Joint Commission on Accreditation of Hospitals to undertake the administration of an accreditation program for nursing homes and similar long-term-care facilities, we believe it is inadvisable for us to nominate representatives to your National Accreditation Committee at this time.

Sincerely,

MAURICE J. NORBY,
Secretary, American Hospital Association.

FEBRUARY 8, 1962.

Mrs. ELEANOR B. BAIRD,
Chairman, Accreditation Committee, American Nursing Home Association, New Milford, Conn.

DEAR MRS. BAIRD: I enjoyed very much our meeting at the Pearson Hotel during your recent visit to Chicago. I thought it best to send you this follow-up letter confirming the views I expressed on the ANHA accreditation program during your Chicago visit.

As I indicated, the American Dental Association as a member of the Joint Council To Improve the Health Care of the Aged, would prefer an accreditation program for nursing homes under the auspices of a multirepresentative agency such as the Joint Commission on Hospital Accreditation. I believe the American Dental Association would be attracted to spend more of its resources and efforts in behalf of a program under the Joint Commission than in support of a program that dealt only with nursing homes.

I wish to commend you for the excellent work you have done in preparing the ANHA plan. In my opinion you have resimulated all of the interested groups and this should produce a quick reaction from the Joint Commission on Hospital Accreditation in the very near future.

Sincerely yours,

BERNARD J. CONWAY,
Assistant Secretary, Legal Affairs.

February 1, 1961—National Council for Accreditation of Nursing Homes and Related Facilities incorporated in District of Columbia.

March 1, 1961—First surveys under national program begun.

March 17, 1962—Joint Commission for Accreditation of Hospitals' resolution in regard to accreditation of inpatient facilities other than hospitals.

"The Joint Commission on Accreditation of Hospitals recognizes the desirability of establishing a program of survey and approval for inpatient care institutions other than hospitals, similar to its existing program of accreditation of hospitals. Moreover, we recognize the need for the implementation of such a certification process at the earliest possible date. The Joint Commission on Accreditation of Hospitals believes this program should be an extension of its present activities.

"We recommend that the constituent organizations of the Joint Commission on Accreditation of Hospitals express their agreement with this objective by a declaration of intent to participate in the financing of the new program of the Joint Commission on Accreditation of Hospitals through mutually agreeable methods.

"We request the chairman of the Joint Commission on Accreditation of Hospitals to address the constituent organizations in terms of the resolution so that this could serve as a basis of discussion by commissioners designated by the repective constituent organizations."

This resolution was transmitted by the director of the Joint Commission to the four member organizations for action by their governing boards. All organizations will have an opportunity to act on this by midsummer. The American Hospital Association already is on record as having agreed to advance funds until financing for the first year of the project has been obtained.

The Joint Commission on Accreditation of Hospitals plans to call a meeting, probably in May 1962, of an advisory committee composed of representatives of the several national organizations concerned with the problem of accreditation of inpatient care institutions other than hospitals.

Mrs. Baird, chairman of the Committee on Accreditation of the American Nursing Home Association, reported the action recently taken by the governing council of that organization to activate its own program, but to explore amalgamation of this program with that of the Joint Commission on Accreditation of Hospitals under certain conditions. In the event of amalgamation of this program with that of the Joint Commission, the American Nursing Home Association would request the Joint Commission to use listing by the American Nursing Home Association as a prerequisite for listing in lieu of the present proposal that these institutions be listed by the American Hospital Association. There was considerable discussion concerning activation of the programs of the ANHA and of the JCAH. The Liaison Committee agreed that no further action on its part in this matter is indicated at this time.

May 1962—A meeting was called by Joint Commission for Accreditation of Hospitals of organizations they felt would be interested in accreditation of inpatient facilities other than hospitals. Organizations represented:

American Medical Association.
American Hospital Association.
American Dental Association.
American Nurses' Association.
American Nursing Home Association.
American Association of Homes for the Aged.
American Psychiatric Association.
Academy of General Practice.
American College of Surgeons.
American College of Physicians.
Federation of Licensed Practical Nurses.
National League for Nursing.
Association of Rehabilitation Centers.

At this meeting AHA was the only organization prepared to make a formal commitment although other organizations agreed with the proposal in principle.

August 1962—The first accreditation certificates were issued at the annual convention of ANHA.

March 12, 1963—Joint Commission for Accreditation of Hospitals voted to discontinue any further action.

MARCH 12, 1963.

MR. ALFRED S. ERCOLANO,
Executive Director, American Nursing Home Association,
Washington, D.C.

DEAR MR. ERCOLANO: For your information, I wish to transmit the following: "The commissioners of the Joint Commission on Accreditation of Hospitals at their March 9 meeting voted to discontinue at this time any further action toward the development of a program for accreditation of inpatient care institutions other than hospitals."

Sincerely yours,

KENNETH B. BABCOCK, M.D.,
Director, Joint Commission on Accreditation of Hospitals.

May 1963—The American Medical Association joined the American Nursing Home Association in the National Council for Accreditation of Nursing Homes and Related Facilities.

August 1963—The National Council opened office in Chicago, Ill., and employed an executive director. The surveys continued.

November 1963—The American Association of Homes for Aged invited the same 13 organizations as listed under date of May 1962 to meet and discuss a multilateral accreditation program.

Again, none of the organizations represented were able to make a formal commitment for participation in the program or for any financial support.

February 20, 1964—Second meeting of the group under the leadership of the American Association of Homes for Aged was held and a steering committee was formed.

CHARGES TO COMMITTEE

The chairman reviewed the charges given to the committee:

1. To request a meeting of representatives of the steering committee with representatives of the National Council for the Accreditation of Nursing Homes prior to the March 16 meeting of the National Council's board of directors, to discuss the possibilities of broadening both its sponsorship and areas of interest, and to obtain specific information concerning the conditions under which this might be achieved.

2. To request the Joint Commission on Accreditation of Hospitals to reconsider its earlier action of March 1963 with respect to accreditation of inpatient care institutions other than hospitals and also to consider accreditation of other specialized health facilities.

3. To develop a proposal for a new structure to provide a unified multilaterally sponsored accreditation program for the following specialized health facilities: nursing homes, homes for the aged, and rehabilitation facilities; such proposal to be developed with appropriate recognition that there are other kinds of specialized health care facilities that may be included in such an accreditation program in the future.

MEETING OF STEERING COMMITTEE ON ACCREDITATION OF SPECIALIZED HEALTH FACILITIES

University of Chicago Center for Continuing Education, Chicago, Ill., February 20, 1964

ORGANIZATIONS AND REPRESENTATIVES

American Association of Homes for the Aging: William T. Eggers, chairman.
American Dental Association: Gerard J. Casey, D.D.S.
American Hospital Association: Mrs. Helen D. McGuire.
American Medical Association: Charle C. Edwards, M.D.
American Nurses' Association: M. Marian Wood.
American Nursing Home Association: Mrs. Eleanor B. Baird.
Association of Rehabilitation Centers, Inc.: Charles E. Caniff.
National Association of Social Workers: Edna Nicholson.

The meeting of the steering committee convened at 1:30 p.m.

A press release concerning the morning meeting of national organizations was approved. (See app. A.) It was agreed that the approved statement would be released to the press by the American Association of Homes for the Aging, and that no other information would be given to the press by the organizations represented.

ELECTION OF TEMPORARY OFFICERS

It was agreed that, in view of the fact that some organizational representatives to the steering committee have not yet been designated, it would be unwise to elect officers at this meeting. There is need, however, to designate someone to preside over this meeting and to act for the committee until the next meeting. It was decided to elect a temporary chairman and secretary to serve until the next meeting. The following were elected:

Chairman pro tem: Rev. William T. Eggers.

Secretary pro tem: Mrs. Helen D. McGuire.

March 6, 1964—Representatives of the above-mentioned steering committee met with the executive board of the National Council for Accreditation of Nursing Homes.

Invitation had already been extended by National Council for meetings with any other interested groups.

March 16, 1964—Board of Directors of National Council recommended to their parent organizations the expansion of the sponsorship of the National Council.

April 20, 1964—ANHA midyear governing council voted to expand the National Council.

NATIONAL COUNCIL FOR THE ACCREDITATION OF NURSING HOMES,
Chicago, Ill., May 7, 1964.

Mr. FRANK C. FRANTZ,
Staff Director, Joint Subcommittee on Long-Term Care, Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR MR. FRANTZ: The enclosed true copies of the letter sent to organizations listed are self-explanatory.

I would appreciate it very much if you would present this material to Senator Moss and his committee.

Sincerely,

H. CLOSE HESSELTINE, M.D.,
Chairman, Board of Directors.

The attached letter was sent to the following organizations:

Rev. William T. Eggers, chairman, Accreditation Committee of AAHA Home for Aged Lutherans, 7500 West North Avenue, Wauwatosa, Wis.

Lester Davis, executive director, American Association of Homes for the Aging, 49 West 45th Street, New York, N.Y.

Jerome Hammerman, Accreditation Committee of AAHA Drexel Home, Inc., 6140 South Drexel Avenue, Chicago, Ill.

Dr. Frank B. Kelly, M.D., American College of Physicians, 122 South Michigan Avenue, Chicago, Ill.

Dr. Reed M. Nesbit, M.D., American College of Surgeons, University Hospital, Ann Arbor, Mich.

Dr. John Paul North, M.D., American College of Surgeons, 55 East Erie Street, Chicago, Ill.

Dr. Gerard J. Casey, D.D.S., American Dental Association, 222 East Superior Street, Chicago, Ill.

Harold E. Goetsch, American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill.

Mrs. Helen D. McGuire, American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill.

Miss M. Annie Leitch, R.N., American Nurses' Association, 10 Columbus Circle, New York, N.Y.

Dr. Lest H. Rudy, M.D., American Psychiatric Association, 1601 West Taylor Street, Chicago, Ill.

Charles E. Caniff, Association of Rehabilitation Centers, Inc., 828 Davis Street, Evanston, Ill.

Frederick R. Wolf, Association of Rehabilitation Centers, Inc., 828 Davis Street, Evanston, Ill.
Miss Edna Nicholson, National Association of Social Workers, 86 East Randolph Street, Chicago, Ill.
Mrs. Etta B. Schmidt, National Federation of Licensed Practical Nurses, 1402 West University Avenue, Champaign, Ill.
Miss Helen Dunn, R.N., National League for Nursing Illinois Research Hospital, 840 South Wood Street, Chicago, Ill.
Chester L. Watts, secretary, American Academy of General Practice, 215 Volker Boulevard, Kansas City, Mo.

[True copy]

JANUARY 30, 1964.

(Addressees listed.)

DEAR ———: At the recent meeting of the National Council for the Accreditation of Nursing Homes, the board of directors discussed the interest of other organizations in the general area of nursing home accreditation.

As you know, the bylaws of this council were written to allow for the addition of other sponsoring organizations. The accreditation program of the council is underway and is progressing in a very satisfactory manner. With this in mind and because of the council's desire to make this accreditation body a group representative of all parties interested in this problem, we would like to extend to the American Association of Homes for the Aging an invitation to further discuss the general area of accreditation and specifically your interest in becoming a member of the National Council for the Accreditation of Nursing Homes.

The board of directors will be meeting on March 16, 1964, and again in June, and would like very much to discuss this matter with you on either of those occasions.

Very sincerely,

H. CLOSE HESSELTINE, M.D., *Chairman.*