CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

FIRST SESSION

Part 5.—New York City, N.Y.

AUGUST 2 AND 3, 1965

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

47-467 WASHINGTON : 1965

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C., 20402 - Price 60 cents

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MONDAY, AUGUST 2, 1965

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
New York, N.Y.

The subcommittee met at 10 a.m., pursuant to notice, in the auditorium, New York University Medical School, 550 First Avenue, New York, N.Y., Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Neuberger, and Williams.

Also present: Senator Robert F. Kennedy.

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

Senator Moss. Ladies and gentlemen, the hearing will now come to order.

We do not have a full panel here yet; we expect other members of the subcommittee to be with us later. However, we had better get underway because we have a lot of ground to cover this morning with the scheduled witnesses. We do not want to delay further.

I am very pleased to have the Senator from New York, Robert F. Kennedy, sitting with the subcommittee this morning. We are pleased to have you with us, Bob, and hope that you can stay through the hearing which will continue both today and tomorrow.

This is the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. We are opening this morning the fifth public hearing in a series which we are holding in cities throughout the country. Earlier in the year the subcommittee conducted hearings in the Midwest, the Mountain States, and on the west coast. In the next 2 weeks we will be in Boston, Mass., and Portland, Maine. We are delighted to be here today for the first of 2 days of hearings in New York City.

The Subcommittee on Long-Term Care was organized for the purpose of making a thorough and comprehensive study of the conditions and problems in the Nation's nursing homes, to review the operations of Federal and State programs in this field, and to reappraise the role of the Federal Government in assisting in the development of appropriate and high-quality services for the long-term patient.

Licensing and inspection of nursing homes and other health facilities is traditionally a function of State and local government. Progress in the development and improvement of services available to our infirm aged citizens must depend on leadership in the nursing home

field and the health professions. These roles must be preserved and strengthened.

At the same time, the Federal Government has become increasingly involved in the long-term-care field through programs to assist in construction of facilities and for the purchase of health care services. It is important that Federal activities be designed to complement and reinforce the efforts of those striving for improved health services for the aged.

Funds authorized in the Hill-Burton program for assistance in the construction of long-term care facilities has reached a level of $70 million. The Small Business Administration and the Federal Housing Administration assist in financing construction of proprietary nursing homes and the FHA program has recently been amended to include nonprofit nursing home sponsors.

Almost $400 million per year is being spent for nursing home care under the public assistance programs and more than half of this amount is in Federal funds. The so-called medicare program, which the President signed into law last Friday, includes a posthospital convalescent benefit. This part of the program provides a long-awaited mechanism for financing high-quality care in a nursing home following hospitalization.

Although the extended care part of the medicare program is a limited benefit—it is not intended to finance long-term care—it poses new demands upon nursing homes, State and local regulatory agencies, and the health care community in general, to provide the services for which financing is now available.

Our task is to inform ourselves on the present conditions and problems in nursing homes and in other institutions and agencies which offer health services to the long-term patient, to assess the impact on them of Federal programs and the capacity of these institutions to provide the services they call for, to identify the remaining gaps in the availability of services and quality of services, and to consider whether additional action in the Federal field is needed and appropriate to fill these gaps.

We have allotted 2 days of hearing time to New York City because of the great wealth of information that is available to us here. New York City is one of the Nation's great medical centers, and we are aware that there has been a great deal of effort and activity in recent years in the development and improvement of long-term care services here.

We understand that there have been extensive revisions and improvements in nursing home standards and that New York City now has one of the best nursing home codes to be found in the country. We also have been informed of innovations in programs to bring medical care and supervision into nursing homes on a regular and organized basis. We look forward to learning about these achievements in more detail.

This is an official hearing of the U.S. Senate and everything that is said here will be taken down by a reporter and made a part of the record of our subcommittee. This record will be used by committees and individual Members of Congress who must develop and act upon legislation affecting nursing homes and related health services.

We have a number of distinguished authorities on this subject who have agreed to appear here today and tomorrow and give us the bene-

fit of their experience and views. I am sure that the witnesses we will hear in the next 2 days will add greatly to the store of information which we are compiling. We look forward to their testimony.

Senator Kennedy, if you have any opening remarks, we would like to hear from you.

Senator KENNEDY. I just want to thank you, Senator Moss, for holding these hearings. I think the hearings that you have held around the country have been extremely valuable. I am particularly grateful to you for coming to New York City and the State of New York to continue your hearings. The list of witnesses you have scheduled will be very helpful in developing our own programs here in New York City and across the State.

I think that they will reveal where we have done well and I expect also they will reveal our deficiencies. I think also it is very important they will indicate where the city of New York and the State of New York, working with the Federal Government, can develop the programs which will be beneficial to all the people of the State as well as across the country.

I congratulate you personally for the leadership you have given in this important field in which you are the foremost authority in the Senate of the United States; and I congratulate also the committee for making this intensive effort on a very difficult problem.

Senator Moss. Thank you, Senator Kennedy. We are grateful that you have come to join with us in New York and we will depend on your counsel and assistance as we develop this record and later decide whether or not there are special areas which should be developed.

The Honorable Paul R. Screvane who is the acting mayor of the city of New York is our first witness.

STATEMENT OF HON. PAUL R. SCREVANE, ACTING MAYOR, NEW YORK, N.Y.

Mr. SCREVANE. Thank you very much.

Senator KENNEDY. Could I join the chairman in welcoming Mr. Screvane and commending him on his distinguished career and record in this city.

Mr. SCREVANE. Thank you.

It is an honor to welcome the distinguished members of this committee to New York City.

As acting mayor of New York City, I salute those here today who represent the Senate of the United States. I thank each one of them for the consideration they are giving to this subject—so long neglected and yet so deserving of attention and action by every level of government.

The problem of nursing homes for the aged calls for the cooperation of all levels of government and of the voluntary agencies, too. Such cooperation is essential to meet this problem in the proportions in which it must be met.

Some new thinking is called for. To meet the needs of the aged, it is not enough just to have more of what we already have—although that, too, is vitally needed. We also badly need some imaginative innovations and refinements.

First of all, we must keep in mind that the aged are people, with all the variations in their needs that exist among younger people. We need fully to recognize these variations in the care that must be provided. This is true of almost every aspect of the problems of the aging. It is surely true in the field of nursing homes.

We need intensive care nursing homes, and we need convalescent homes. There is a distinction between the two. We need more of each.

But this is just one illustration of the necessary refinements in our thinking in respect to the problems of the aging.

All of us are grateful for the fact that this committee is focusing attention on these problems.

I am going to report briefly today on some of the things we in New York City have done. I know you will be hearing from some of the experts. I am not an expert. But I am closely acquainted with the actions that have been taken and the improvements that have been made in our nursing homes in recent years.

I have joined in pressing for these improvements and in supporting them. We have a long way to go, and we must travel that long way.

As of 1960, according to the census of that year, one out of every seven New Yorkers was 65 years old or older. We know much less than we should about these particular New Yorkers. They are not a visible group in our city, nor in any city. We know, however, that they need hospital and convalescent facilities at a far greater rate than younger New Yorkers—four times the rate, in fact.

When an older citizen becomes feeble or sick, he must ask himself the question, "Where can I go?" The nature of city living often makes it difficult, if not impossible, for parents to move in with their children. If the elderly people are indigent and sick, regardless of the degree of their illness, almost invariably they must find a place in one of our city hospitals. Today, thousands of the elderly who could better be cared for in other facilities are occupying hospital beds—simply because the supply of nursing and convalescent facilities is inadequate—indeed, very inadequate.

Yet, New York City has always been proud of its health facilities, and with good reason. In fact, New York has been a pioneer in health and hospital care. But today we face a critical problem. How can we provide adequate care for the elderly and infirm and at the same time, adequately serve the rest of the citizens of New York?

Up to the present, the majority of our nursing homes have been privately owned. Today, we are beginning to have an increasing number of nursing care beds in municipal facilities. As examples, I might mention Bird S. Coler Memorial Hospital & Nursing Home, and the Sea View Hospital & Home. The Sea View Hospital & Home was formerly used for tubercular patients.

Up to the present, there has been a general lack of nursing home facilities under voluntary agency auspicies. There are some, but not enough.

This is the rough outline picture. Now let me fill in the outline.

Of our recent accomplishments, none has been more dramatic or gratifying than the raising of the standards of nursing home care.

We accomplished this by adopting a tough new nursing home code which has been in effect for the past 2 years. The formulation of this

new code, under the direction of the commissioner of hospitals, followed a comprehensive investigation conducted by the city's own commissioner of investigations.

We found shocking conditions in some of those nursing homes. We decided to move against those conditions. Over very strong opposition, we adopted the new nursing home code. Our new code—and our enforcement of it—is providing a model for many other cities throughout the Nation.

The new code prescribes standards for physical facilities for both new construction and existing institutions. It establishes quotas and ratios of personnel to patients, and describes the services and facilities that must be provided for the patients, ranging from occupational therapy to recreation.

We have not only developed and enacted a new code, we have also cracked down hard on those institutions which have refused to, or have been unable to, meet the new standards.

Those institutions which couldn't make the grade have been closed down. This, of course, has drastically cut down the number of beds. It has also cut down the number of horrors.

Consequently, we have been moving to increase nursing home facilities in the public sector, and to encourage a similar increase in the voluntary agency sector.

We have also started to make plans for the much greater increase in facilities that is critically necessary.

Today there are probably no more than 10,000 nursing home beds in the entire city. Many of these must be replaced in the years to come. At the present time, there are no halfway facilities between nursing homes and home care. Convalescence is often carried on in facilities ill equipped for it. Many of our nursing homes have been no more than storage houses for the elderly.

In general, however, I think it can be said that we in New York City have made substantial progress:

1. By raising the standard of nursing home care, so that those who are being cared for in the nursing homes are truly being cared for; and

2. By planning for future expansion of our nursing home facilities, and exploring in depth our future needs, not only in terms of nursing home beds, but in terms of other facilities which are adapted to the varying needs of our elderly citizens.

We view the progress made in this field with some satisfaction, compared to what was, and compared to the situation in many other cities and parts of the country.

But there is not much room for too much satisfaction. It is true that we have done away with the houses of horror of a few years ago, where aged men and women were kept in conditions which were shocking and almost medieval in their lack of respect for human dignity.

Those conditions in nursing homes seem to have been practically eliminated, as a result of our nursing home code and its enforcement. Yet, some of our aged live or rather exist in conditions of unspeakable squalor, not institutions, but in roominghouses, tenement flats, and private homes.

Many are in hospitals who should be in nursing homes. Slender lifesavings are being eaten up in quick gulps and relatives are being

impoverished, to support some of these aged people in hospitals and in suburban and other out-of-city private institutions, because insufficient facilities are available in New York City.

These facts ought to give us nightmares. These facts must move us to action with a minimum of delay. These facts must and will, I hope, if properly presented to the public over the next month, lead to the approval of the proposition that will be on the ballot in November, permitting the large-scale construction of nursing homes through low-interest loans.

This is not just something that is desirable to be done. This must be done. It must be done as quickly as possible.

The planning to which I referred earlier must be done at top speed.

Medicare is upon us. Its impact will be volcanic in many fields, and most certainly in health and welfare.

We must prepare ourselves to receive, absorb, and meet the impact. We must turn it all to the best advantage of our citizens, above all, our elderly citizens.

In 1962, it was officially estimated by the Hospital Review and Planning Council of Southern New York that New York City would need 15,000 additional nursing home beds during the 10-year period from 1962 to 1972. We are not providing them. In fact, we are falling behind in numbers because of the nursing homes we have closed down.

To overcome the shortage, we have met with the voluntary agencies and agreed that the municipal government would accept the obligation for half of the total need. The voluntary agencies accepted the obligation for the other half—7,500 beds apiece.

At the same time we are seeking Federal and State aid for the capital cost.

The result of our efforts to get State aid is a proposition which will be on the State ballot in the coming election. This will authorize low-interest loans for nursing home construction. This proposal was enacted by the State legislature at this year's session, and Governor Rockefeller signed it. For a number of years we have been urging legislation on this subject, although we have urged that nursing home construction be authorized under the terms of our middle-income housing law, the Mitchell-Lama Act. This proposal failed to receive Governor Rockefeller's support.

Now we need to secure statewide approval by majority vote in November of the proposition that was passed by the legislature. We are going to do our utmost to get that majority, and I hope that we will. This will enable the voluntary agencies to build nursing homes.

It is essential that the voluntary agencies get into the field of nursing home care and assume their share of the responsibility in this area.

Nursing homes should be an adjunct to the voluntary hospitals, in order that suitable medical care can be made available when needed. One of the most shocking facts we uncovered in our investigation of the proprietary nursing homes was the absence in some of them of any access to medical care. Of course, this situation does not exist in nursing homes which are associated with voluntary hospitals or with the city hospital system.

In short, I would define our needs as follows:

1. We need 15,000 more nursing home beds, to be operated both by the city and by voluntary agencies.

2. We need convalescent homes, likewise under the auspices of both the city and the voluntary agencies.

3. We need more home settings for older people who need to be cared for but do not need either convalescent or nursing home care.

4. We need substantial Federal assistance for nursing home construction along the lines of the Hill-Burton Act. We need a Hill-Burton Act for nursing and convalescent homes.

5. We need comprehensive and even radical planning to meet the physical and the manpower needs we will confront as a result of medicare.

Let me now turn to that subject.

The new medicare measure is one of the most important pieces of social welfare legislation in the history of our Nation. However, medicare must be considered a new beginning, rather than a consummation, in the field of geriatric medicine.

Countless thousands of elderly New Yorkers will now be able to afford the health care services they desperately need. In the past, we have not even been able to keep up with the health care demands of those who could afford such care. How shall we now provide for the additional people who now, through medicare, will be able to afford a convalescent facility when they need to?

We in the city government, under the direction of Mayor Wagner, recently established a special task force chaired by our city administrator, Dr. Connorton, to study the impact of medicare on our municipal facilities and on the facilities and capabilities of the voluntary agencies.

Of course, we will need to increase the utilization of our present hospital facilities. That is essential and unavoidable. I have already suggested some of the directions that must be taken in this respect.

This is not a problem that can be put off. Our senior citizens deserve better than they are getting. The medicare bill was a revolutionary step along a path that will lead to the eventual goal of complete care for the elderly infirm.

We live in an age of experimentation. Yet, we are not doing enough of this experimenting in services to the senior members of our society. The city of New York has not taken a back seat in serving the medical needs of the elderly. But we do need help, and unless the Federal Government can come to the aid of the city and State by providing help in the construction of infirmary facilities, voluntary nursing homes, and other facilities, we will be unable to meet the needs of our citizens.

Another innovation we must pursue is the provision of health care for the elderly where they live, rather than requiring them to come from their homes to where the health care is. Of course, this is only possible where there are concentrations of elderly citizens, as in some of our housing projects.

We have pioneered in such an undertaking at the Queensborough Bridge housing project. I am sure that your committee would find much interest in this fine demonstration program which has already proved itself. There should be an expansion of this program. Because of its cost, it will take Federal and/or State help to do so.

These days we have very many needs for which we are turning to the Federal Government. The need I have described today is certainly one of the most urgent. How can it be denied or turned aside?

The very presence of this committee here today indicates the national recognition of the need to act. There is very clear precedent in the Hill-Burton Act. It has worked wonders in helping to provide hospitals where they were needed.

There is ample reason and justification for a comprehensive program, generous in amount, of Federal aid for nursing home construction. This is certainly one of the needs that must be anticipated as a result of the medicare program. This need must be met without delay.

There are many other needs of the aged and aging which must be met. Your committee will, I am sure, explore them all in the course of its inquiries. This is a field in which, as I have said, we must all work together. Our senior citizens, increasing in number as the general lifespan increases, must be helped to lead lives of both comfort and usefulness.

This is the challenge confronting us. We must meet that challenge.

Thank you very much.

Senator Moss. Thank you very much for a comprehensive statement of the action that has been taken recently in the city of New York in the field of care for the aging.

Does the city of New York actually operate any nursing homes or simply provide the financing?

Mr. SCREVANE. We are operating them in connection with the two hospitals I mentioned, the Sea View Hospital and the Bird S. Coler Memorial Hospital. These, in addition to being hospitals, also have a nursing home facility, but we will under the new proposal be in it in a much larger way on the 50–50 basis. The voluntary agencies will be operating 7,500; we would be operating the balance in addition to what we are operating presently.

Senator Moss. The city would actually operate the 7,500 which you have projected?

Mr. SCREVANE. Yes, sir.

Senator Moss. I was interested also in your comment about the need to bring medical consultation to elderly citizens where they are. Many can continue to live in their homes or with family if it is available, providing they can get some medical assistance. That is a very forward-looking program and one that I am sure we need to emphasize greatly.

The total number of beds now in the city of New York seems rather small to me for a city of this size, and even the projection is not a great number of beds. A 15,000 increase is not a large number; is it?

Mr. SCREVANE. Well, it is 15,000 over the 10,000 that we have presently and perhaps with the other kinds of programs that might be developed with some medical consultation we may have some in-home care rather than institutional care.

I say this is the best projection the board came up with.

Now this is a 10-year program. As we proceed, I am sure evaluations will be made. If the need is indicated this could perhaps be increased substantially, but this is presently the planned figure for these 10 years.

Senator Moss. The voluntary agencies that you referred to, would they be primarily nonprofit organizations sponsored by religious or fraternal groups?

Mr. SCREVANE. They are all nonprofit agencies; yes, sir; Federation of Jewish Philanthropists, Catholic Charities, all the groups that presently operate voluntary hospitals in the city of New York.

Senator Moss. It is obvious that you have made some great steps forward in the last few years in the city of New York. I want to congratulate you and the city for moving in this direction. You say there is much yet to be done, but at least the movement is in the right direction and going very well.

Senator Kennedy, do you have any questions?

Senator KENNEDY. I have just a few questions. I thought your statement was excellent and will be very helpful to the committee.

You talked about the need of perhaps some Federal legislation to help in this area. Would you be prepared now or will the city be prepared prior to the time the hearings are completed, to furnish some specifics as to the kinds of legislation that would be helpful in the city?

Mr. SCREVANE. We would be delighted to do that for you, Senator. We won't draft the legislation obviously, but we would like to give you some thoughts we have on it.

Senator KENNEDY. That would be helpful.

The second point I want to ask you about is the role that the State should play in helping the city meet its needs. There has been reference to the Folsom committee which has made some studies of the hosptial situation in New York as well as across the State. They made some recommendations in the spring of this year.

Would you have any comment on that or the role that the State can play in connection with the city's needs and also in conjunction with the Federal bill?

Mr. SCREVANE. Well, this is a perennial battle that goes on between the city of New York and the State of New York. I would imagine this happens in most States. We think a great deal more can be done by the State. We think many of the recommendations in the Folsom report could be implemented. We realize most of them will mean money. We think the low-interest money for construction will be essential. We will act upon this in November.

I think the State aid, the reimbursement that we get for nursing home care and other types of medical care ought to be increased. I think there is a great number of areas where we can be helped by the State. It is unfortunate that most of these programs and examinations and reports have to be evaluated and reevaluated and studied and restudied time and time again while so many people are crying out for the help that the implementation could bring to them, so that I would certainly hope that we would be able to have rapid implementation in the Folsom report.

Senator KENNEDY. Thank you.

Senator Moss. Do any of the staff members have any questions?

Thank you very much.

Mr. SCREVANE. Thank you. I appreciate it.

Senator Moss. An excellent statement, we are glad to have it.

Our second witness is Dr. James G. Haughton, deputy medical welfare administrator, Bureau of Medical Services of the City of New York.

If you will come forward, Dr. Haughton, we will be pleased to hear from you.

STATEMENT OF JAMES G. HAUGHTON, M.D., DEPUTY MEDICAL WELFARE ADMINISTRATOR, BUREAU OF MEDICAL SERVICES, DEPARTMENT OF WELFARE, CITY OF NEW YORK

Dr. HAUGHTON. I am Dr. James G. Haughton. I am a graduate of the Loma Linda University College of Medicine, class of 1950, and a graduate of the Columbia University School of Public Health and Administrative Medicine, class of 1962.

I have been a practicing family physician in New York City since 1952 and a medical care administrator since 1962. At present, I have a dual appointment as director of medical care to the indigent and the aged in the New York City Health Department, and as deputy medical welfare administrator in the New York City Welfare Department. In this dual role, I plan medical care activities for the New York City Health Department and administer medical care programs for the welfare department.

When I was contacted by a staff member of this committee with respect to my appearance here today, I made it clear to him that I would not be party to any attempt to besmirch the image of the long-term care institution in New York City. This was already accomplished quite efficiently by a sensational series in the local press some 3 years ago. The scandalous conditions reported in that series were quite accurately described, but those conditions existed for a variety of reasons which I shall attempt to identify later.

I have been assured that it is the intent of this committee to inform itself with regard to local efforts which have been successful in improving conditions in the long-term care facilities of this city and to uncover any residual problem areas. To this end I have come today to participate in this hearing.

When, in 1944, the New York State Department of Social Welfare ruled that a nursing home was not a medical institution and that it would thenceforth be possible for local welfare departments to establish public assistance eligibility for persons residing in such institutions, there were only about 2,000 nursing home beds in this city. With the aging and disabled population increasing, the local welfare department welcomed the nursing home as a resource for the placement of these persons, and as a consequence, there are now 87 licensed private nursing homes in this city with approximately 8,800 beds, an increase of over 400 percent. Of this number, over 6,000 beds in 73 homes are occupied by persons sponsored by the New York City Department of Welfare. This is an excellent example of the effect that public policy can have upon an industry.

At this point, I would like to explore some of the reasons underlying the deplorable conditions which were widespread in private nursing homes a few years ago and which to much lesser extent still exist.

The sudden impetus to creation of nursing home beds in the fifties engendered by the change in State policy, led to the conversion of many buildings which were not structurally suited to this purpose. As a result, even the conscientious operator had difficulty deploying his staff to provide adequate supervision and care of the residents.

In addition, many persons became operators of nursing homes who had little or no training in institutional management, and, what was

worse, had no knowledge of the peculiar needs of the aging and disabled. Additional problems were the inclination of some operators to skimp on services in order to increase profits, and the inability of the New York City Department of Hospitals, which had and still has primary regulatory responsibility, to properly supervise these homes because its inspection staff had not grown with the industry.

To the credit of the city administration, it can be said that at the time of the newspaper series to which I made reference, these problems had already been recognized, and steps had been taken toward their correction. These included the appointment of a new commissioner of hospitals who, as one of his first official acts, began a strict enforcement of the existing proprietary nursing home code and a revision of this code to bring it into conformity with modern concepts of nursing home administration.

The new code became effective in February 1963 and, together with an expansion of the inspection staff of that department, has led to major improvements in the physical, administrative, and service aspects of nursing home care.

But, in my opinion, there was another even more overriding reason for the problems encountered in nursing homes. Happily or unhappily, depending upon one's point of view, teaching hospitals and university medical centers in large urban centers like New York City perceive as their major roles in our medical scheme of things the education of physicians and other paramedical personnel and major medical research. The patient's disease is used as a part of the apparatus in these processes.

If as a byproduct of these teaching and research efforts the patient obtains some medical care, it is quite fortuitous and certainly not by design. The patient, therefore, is seen not as a human being with a medical problem which is causing him suffering and which may affect his future as a productive member of society and as a member of his family constellation, but merely as a bearer of a disease which is to be subjected to exhaustive and intensive study. This may seem a rather harsh judgment of our medical establishment, but it is nonetheless a fact of life.

When this study is completed and the "case" has no more teaching value, the young hospital house officer begins his search for a resource for the disposition of this case. Yes, gentlemen—not careful discharge planning, but disposition. And herein lies the most serious cause of difficulty in the nursing home. Patients are often discharged to facilities which are not staffed nor equipped to provide the services they need.

In fairness to the hospital physician, I must point out that these misplacements are often not due to callousness on his part, but rather to his ignorance of what a nursing home is and what services can be rendered there. In many instances the physician is correct in his determination that the patient no longer needs acute hospital care, but neither is the nursing home as it traditionally exists the proper placement.

It seems to me, therefore, that our solutions lie in three directions:

1. We must restructure our concept of what services can and should be available in a nursing home.

2. We must find ways of educating physicians with respect to the care of patients in these institutions.

3. We must educate physicians who do not work in nursing homes with regard to the limitations of care in nursing homes and the alternatives to such care.

Happily, we in New York City have developed what we believe to be some solutions to the problems of nursing home care. Our activities have been based on the premise that, although a nursing home is a nursing—not a medical—institution, good nursing care cannot exist in a vacuum. Nurses are traditionally trained to expect and to respond to medical leadership. We have, therefore, made considerable effort to bring medical supervision and leadership to nursing home care.

To this end, we have developed three medical approaches to these institutions. One is based in group practice, the second is based in the hospital, and the third is based in the community.

The first began in September 1962 when the New York City Department of Welfare contracted with the Health Insurance Plan of Greater New York (better known in New York City as HIP) to provide comprehensive medical services to 13,000 recipients of public assistance in the old-age assistance and MAA categories.

Sixteen hundred of these recipients resided in private nursing homes. The six HIP medical groups involved in this program, therefore, set about to create a sound medical program for these persons. Each group has developed a nursing home staff of physicians who make medical rounds in each nursing home daily or as often as is dictated by the needs of each home, and are on call to each home for emergencies around the clock including holidays and weekends.

All the specialists and the supporting treatment and diagnostic resources of the groups are available to these patients in the nursing homes or in the groups' medical centers. More recently we have been able to create transfer agreements between these medical groups and local hospitals in order to facilitate the transfer of patients from one level of care to another with appropriate transfer of medical information between the groups and the hospitals.

Our second approach, hospital-based, began in October 1962, when the department of welfare contracted with the Lutheran Medical Center, a hospital in Brooklyn, to provide comprehensive medical services to 100 welfare recipients residing in a nursing home not far from the hospital.

This hospital has created a nursing home staff consisting of the medical residents of the hospital under the supervision of the hospital's director of clinics who is a senior member of the attending staff. This staff makes daily rounds in the nursing home and is on call to the home for emergencies at all times. All of the supporting services of the hospital are available to this nursing home population.

An exceedingly important feature of this program is that all patients who require hospitalization are admitted to the affiliated hospital whenever possible, with the result that there is complete continuity of care since the same staff provides the care in both institutions.

The third program was begun in November 1963, and organizes three private physicians in the community into a team which provides all the medical care to a group of 210 welfare recipients residing in a

large private nursing home. These internists, under the supervision of the senior member of the team, function in much the same way as has been described in the two previous programs.

They are supported by specialists of the welfare department's panel who provide consultations on request, by a private medical laboratory under contract to the department, and by a local hospital which provides X-ray services and electrocardiograms. Recently a transfer agreement between this nursing home and a nearby municipal general hospital has added the missing dimension to the program.

These programs have offered an approach to two of the solutions we seek. That is, they have provided a means of bringing medically supervised care into the nursing home, and have provided a means of training physicians in the care of the nursing home patient. We still need a means of informing physicians with regard to the limitations inherent in the nursing home context.

We are convinced that these three approaches are feasible financially and otherwise. They have created a professional milieu in the nursing home to which the nursing home staff is responding. The nurses welcome the medical leadership and as a result, the nursing care has improved and this improvement has filtered down through all levels of staff. The turnover in staff which was a constant problem to the administrators of the homes, has diminished dramatically. What is most important, the new sense of security which is engendered in the residents by having qualified physicians always available to them is reflected in the improvement in their morale and in their interest in the world about them.

We now have HIP programs in 31 nursing homes, hospital-based programs in 3 homes, and community programs in 2. We are negotiating with 4 hospitals for hospital-based programs in 10 additional homes. By September 1, 1965, we hope to have 5,200 of the 6,000 welfare recipients who reside in private nursing homes served by these 3 mechanisms for medical care.

Obviously, there are still problems. These relate primarily to social services in the homes and to activity programs related to recreation, diversion, and occupation. Several organizations in our community are addressing themselves to these facets of the problem, and we hope to have answers in the foreseeable future.

There are also difficulties related to the proper utilization of long-term-care facilities and the development of alternatives to intitutionalization. These are subjects which I suspect will be discussed by other witnesses before this committee and which I will be happy to attempt to discuss if the gentlemen of the committee would care to pose specific questions.

In this presentation I have tried to summarize for you some of the activities which have taken place in the nursing home field in New York City during the past 3 or 4 years.

We believe that much has been accomplished and that a great deal of credit is due the leaders of the local nursing home industry for the manner in which they have cooperated with the public agencies and have stimulated and supported their colleagues in bringing about these improvements.

Thank you.

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Senator Moss. Thank you, Dr. Haughton, for a very excellent statement. I would like to ask a few questions.

One question that I suggested to Mr. Screvane was whether the number of beds presently available seems abnormally low in the city of New York. What is your opinion on that?

Dr. HAUGHTON. If we consider all the long-term beds available in addition to the private nursing homes, there are an additional 5,000 or so in nonprofit homes for the aged with State-approved infirmaries and there are an additional 3,000 in nonprofit homes for the aged without a State-approved infirmary and an additional 844 in nonprofit nursing homes. This means that we actually then have some 15,000 or 16,000 long-term-care beds. It seems to me that if alternatives to institutional care could be provided, our needs for long-term beds would be decreased.

One of our problems has been that for the want of some other alternative to institutional care many people are in nursing homes. Once a resident becomes accustomed to a nursing home it is then very difficult to find ways of persuading him to leave the nursing home. For example, at the moment, as I mentioned we have some 6,000 persons in nursing homes. By "we," I mean the department of welfare.

I would surmise that there are some 10 percent of these persons who are physically capable of living outside of an institution but these people have been in institutions for 1 or 4 or 5 years. They have put down roots in these nursing homes, they have their friends there and they are loathe to leave the nursing home. Especially since we have good medical programs, they feel very secure in having the doctors available, having good nursing care available. They refuse to leave the nursing home so that our emphasis more recently has been to plan for the discharge of the resident who enters the nursing home at the time that he enters so that hopefully we can use the nursing home as a convalescent home rather than a long-term facility.

There will be, of course, people who cannot leave the nursing home, for whom this is the appropriate place. There are many aged persons who enter the nursing home after they leave the hospital simply because they cannot function alone at home. These people improve under good medical care and should be able to leave the nursing home later.

If we can let them know that that is not the end of the line when they enter, I think we can be successful in moving them along back into the community.

For example, we have a foster home program. Our foster home program is designed to create a family setting for an older person who can function out of the institution. These people must be fairly well when they enter a foster home since the foster home does not provided nursing care, it provides simply room and board and some personal services. For example, a proprietor of a foster home will accompany an older person to a church service or clinic or take him out for a walk in the park, help him dress and undress if he needs this, and provide even tray service at the bedside for a few days. If he becomes acutely ill and needs nursing care, he must be transferred to a hospital.

This is the type of service that a daughter would provide for her aging mother. We limit the number of these persons in these foster

homes to about four persons and we pay the proprietor $150 per month for each person housed in such an arrangement. This creates a very nice family setting for an older person.

We have some 200 vacancies in our foster homes in the Department of Welfare. Our problem is how to get these older people to accept this. In a foster home setting they must relate to the people they live with. In a nursing home, they can isolate themselves and not have to relate too closely to anyone.

These are some of the problems in the placing of the aging population.

Senator Moss. Do you find there has been actually a preference, then, for the nursing home care than the foster home care?

Dr. HAUGHTON. In many instances, this is true.

Senator Moss. Does your Department regularly review the appropriateness of the assignment of these elderly people as to whether they are appropriately placed in the nursing home or should go elsewhere?

Dr. HAUGHTON. Yes, this is part of our medical program. The doctors in our program review—as a matter of fact, the nursing home code of New York City requires that each patient's care be reviewed once a month and part of these reviews is the determination of the person's ability to function in some other setting.

Senator Moss. With the establishment of the present code here in New York City, would you say that the operation of nursing homes now is meeting the standard or is still falling short?

Dr. HAUGHTON. I would say in most of the nursing homes they are meeting the standards. The Department of Hospitals has provided considerable leadership in this regard. In addition to rewriting the code and enforcing it, the Department of Hospitals has attempted to help the proprietor of the home to meet the standards.

For example, Columbia University, School of Public Health, offered a course for nursing home administrators. The department of hospitals is now developing a series of films for the in-service training of nurses aids in the nursing home and so on.

So I feel that the services are improving for a variety of reasons, not the least of which is the new code.

Equally important are the efforts of the public agencies not to penalize the homes and the operators but rather to help them meet the standards.

Senator Moss. Roughly, what is the division between the proprietary nursing homes and the nonprofit nursing homes?

Dr. HAUGHTON. There is quite a disparity. There are 87 private nursing homes with 8,800 beds. There are only 3 nonprofit nursing homes with 844 beds.

Senator Moss. That is a great disparity.

Dr. HAUGHTON. Then, of course, there is the large group of nonprofit homes for the aged which are also long-term institutions. These homes are divided into two parts, the domiciliary section and the infirmary section. The domiciliary sections are for persons who are well when they entered the homes. The infirmary sections serve two purposes: one to provide acute medical care for short-term minor illnesses and the other to provide long-term care parallel to nursing home care.

This allows a person who enters a home of this type and then deteriorates to be moved from one level of care to another without having to leave the institution.

There are 17 of these nonprofit homes, as I mentioned which have infirmaries which are approved by the New York State Department of Social Welfare and these have 2,899 domiciliary beds and 2,680 infirmary beds. Now there are an additional 30 which have infirmaries which are not approved by the State and these have some 3,000 beds.

I mentioned altogether there are some 16,000 long-term beds of different categories, but in the private nursing home and the nonprofit nursing home, there are only the 8,800 private and the 844 nonprofit.

Senator Moss. In your testimony you touched on a question relating to medical education that has come up in a number of the other hearings; to wit, that the teaching of medicine is directed so much to the acute field and has neglected the medical problems of long-term care.

Has the program here in New York served to bring more emphasis to chronic or long-term care in medical training?

Dr. HAUGHTON. Yes. In our first hospital-based program the house staff of the hospital involved was used. At that time it was necessary for the hospital to order the residents into the homes. They felt this was not a useful activity for them, this was not a good learning experience. They soon learned that this was not so. The young residents began to find out that treating pneumonia in somebody who is 90 years old and has three or four other chronic illnesses is not quite the same as treating pneumonia in somebody who is 30 years old.

They have responded very well to this kind of experience.

One program that has been of great encouragement to us is one that was started more recently with the Lennox Hill Hospital here in New York City, which assumed care for a nursing home which has 250 residents.

Generally when we are able to encourage hospitals to take on this kind of program, it is to meet one of their needs, which is how to get rid of the chronically ill person who no longer needs acute care. This hospital does not have this problem; this is quite a plush hospital on Park Avenue, it does not have too many poor, older people in its wards. What they wanted was a means of teaching their residents the care of the aged. So they volunteered to take on this program for us for these 250 people.

The most encouraging part of this was that when the hospital informed the resident staff of its plans all of the medical residents came down and volunteered to take part in the program in addition to some of the other specialty residents.

This program has been functioning since January under the supervision of a senior member of the staff and most of the services are being rendered by the doctors in training.

This will serve, of course, as a resource for us for our future programs. These are gentlemen who will have had their training in the nursing homes.

Senator Moss. That is indeed encouraging. I am glad to have that report before us.

Also in a number of hearings we have held, we have encountered complaints about the shortage of trained nursing staff or trained nurses. What is your experience here on that?

Dr. HAUGHTON. Yes; there is a shortage and there probably will continue to be a shortage. However, it seems to me that what we need to do is to try to find better ways of using what we do have, find ways of increasing the productivity of the professional staff we can find.

Of course, one of the problems in private nursing homes in the past has been that because of the unprofessional milieu in the homes it was impossible to attract well qualified nursing staff in spite of the fact that they could pay better rates than city institutions or some voluntary hospitals.

However, we found in our programs that as medical leadership moves into the nursing home and a professional atmosphere is created, good nurses are then willing to work in the nursing home. In fact, we have had nurses write to us and say, "We are glad to tell you we feel like professionals again, we are working in a professional situation."

I think that we need to train more nurses in the care of patients in our nursing homes. One of our hospitals is now considering rotating nursing students through the nursing home in order to learn some of this long-term care. The care of geriatric patients is not the same in nursing homes as the care in the hospital. One is aimed at the acute flareups of chronic illnesses in the hospital while the other is aimed at the on-going day-to-day care of people who are unable to take care of themselves.

The nurses need training in this area. I think that any training for more nurses to meet these needs will have to be geared to some of this long-term care as well as to hospital care, because the hospital nurse is not quite the same thing as the nurse in a nursing home.

Senator Moss. Somewhat like the M.D.'s you were talking about, the R.N.'s also need more emphasis on this type of care in their training.

Dr. HAUGHTON. I think there should be some of this brought into the nursing curriculum.

Senator Moss. You think they are showing increased interest as the professional standards are raised in the nursing home?

Dr. HAUGHTON. Very definitely.

Senator Moss. Senator Kennedy, do you have any questions of Dr. Haughton?

Senator KENNEDY. First, let me congratulate you, also, Dr. Haughton, on all you have done in this city and the distinguished career that you have had.

Dr. HAUGHTON. Thank you.

Senator KENNEDY. I would like to ask you about these nursing homes which did not live up to the standards required.

What have you found has happened to them since then? Have they closed down or have they been turned into other kinds of institutions?

Dr. HAUGHTON. I think the people from the department of hospitals can tell you more of the details, but many of the nursing homes that were not able to meet the standards of the new code have closed. Some have closed because their licenses were revoked, others closed voluntarily because to do what was necessary to meet the standards would have been so costly that they would not have been able to accomplish it.

However, this closing of nursing homes has created another problem for us because what has happened is that some of the homes that could not meet the standards as nursing homes have closed and then reopened as hotels for senior citizens or residences for senior citizens. This is another problem that the city has to deal with.

Senator KENNEDY. Now, has it been found by the city that these residential hotels or boarding homes for the aged have serious deficiencies?

Dr. HAUGHTON. Yes. We did a study at the request of the city administration last year because we knew that some of these homes have converted and they were not being supervised. About 11 years ago, the State department of social welfare, which has regulatory jurisdiction over this type of facility which is referred to as a proprietary home for adults, delegated this responsibility to the New York City Department of Welfare.

At that time, the department felt that it did not want to take this responsibility because we had not used these homes as a resource for placing the aged on public assistance. The State department therefore said to us, "We will permit you to place your emphasis on the smaller homes which you use"—these are the foster homes that I mentioned. They did not say we were not responsible for the large ones.

Well, this was not too much of a problem at the time because not too many of these homes existed, but with the new code and homes closing, they began to convert themselves into this new kind of facility and we finally found that when we did the study we had 46 or so addresses reported to us.

Senator KENNEDY. How many?

Dr. HAUGHTON. Forty-six, but we found that only 22 of them were functioning as private homes for adults, the others have been converted into other things. We found something over 600 older persons living in these hotels for senior citizens or residence homes, they are called all kinds of things.

We found that a few of them were doing what they purported to do. They purport to provide room and board and personal care. Now, no one has really defined for us what they mean by "personal care." We define it ourselves to mean "room and board and help with moving about and with dressing, if necessary."

One of the things we discovered in these homes was that many of them had fire hazards, others were being run by people who had no understanding of what the needs of the aged and disabled were. We found that many disabled persons were living on upper floors in buildings which did not have adequate elevator service.

We found that none of these larger homes had adequate staff or adequately trained staff so that if an emergency occurred none of the homes that we visited would have had sufficient staff to help many of these disabled people leave the building.

Senator KENNEDY. How many homes were visited?

Dr. HAUGHTON. Twenty-two.

Senator KENNEDY. So all of these 22 that you referred to have deficiencies?

Dr. HAUGHTON. All but about four.

Senator KENNEDY. These deficiencies that you have outlined are serious deficiencies?

Dr. HAUGHTON. They are serious deficiencies. For example, we found an old lady, totally deaf, on the sixth or seventh floor of a building where she obviously never could have heard a fire alarm, and in this particular home there was not enough staff which would have been able to reach that floor to help her down.

We found another old person, wheelchair-bound, on an upper floor of a building where the elevator was so small that the wheelchair could not be wheeled into the elevator.

Senator KENNEDY. These are deficiencies that endanger, certainly, the health of the people that live there and possibly their lives?

Dr. HAUGHTON. Their lives, yes.

Senator KENNEDY. How many people are involved?

Dr. HAUGHTON. Slightly over 600.

Senator KENNEDY. When was the report made of the study?

Dr. HAUGHTON. This was done between February and June of last year.

Senator KENNEDY. Of what?

Dr. HAUGHTON. 1964.

Senator KENNEDY. What is being done now?

Dr. HAUGHTON. This study was done by a group representing most of the city agencies: health, hospitals, welfare, fire department, and department of buildings. When we submitted our report, the department of hospitals assigned this responsibility to their inspection staffs and many of these things have improved.

However, while we were doing this study, the State law was amended to give this responsibility back to the State department of social welfare. So as of January 1, these homes have become the responsibility of the State department of social welfare.

To my knowledge not very much has been done by the State. However, the department of hospitals continues to survey these homes and to make sure that some of the more serious deficiencies we discovered no longer exist.

Senator KENNEDY. Do they have jurisdiction over the homes?

Dr. HAUGHTON. Not now, the State department of welfare has.

Senator KENNEDY. Have they had jurisdiction since January?

Dr. HAUGHTON. The State department of social welfare has.

Senator KENNEDY. The New York City Department of Hospitals, they did not, as I understand it.

Dr. HAUGHTON. They don't have jurisdiction now.

Senator KENNEDY. So that the situation is that a number of these homes can continue to exist and there is no group or organization that is on top of the situation at the present time?

Dr. HAUGHTON. At the present time, I believe that the department of hospitals is still looking at these places as often as they can to make sure that nothing too serious develops but actually, they don't have the responsibility.

Senator KENNEDY. Do you know if the State has made an investigation or inspection of these 22 homes?

Dr. HAUGHTON. Not to my knowledge. I can't say that they have not, but to my knowledge they have not.

Senator KENNEDY. Are you concerned about the conditions in those institutions?

Dr. HAUGHTON. Very much so. As long as these homes are within our jurisdiction, that is, our geographical jurisdiction, we are concerned about the conditions in these homes.

Senator KENNEDY. Do you know why the State has not reviewed this situation?

Dr. HAUGHTON. Well, the last time we spoke to them about this was toward the end of 1964 and at that time they told us that they had other priorities at the moment and that they would soon do something about it. At that time, they were trying to rewrite the State nursing home code which would possibly have included this type of facility.

Senator KENNEDY. Well, now that was 6 or 8 months ago.

Dr. HAUGHTON. Yes. I don't know what the situation is now at the State level, I have not discussed it with them recently.

Senator KENNEDY. Before the hearings end, Mr. Chairman, perhaps we could find out what has happened insofar as each of these 22 homes is concerned. Could we obtain a copy of the report and the location of the homes and then find out what needs to be done in each one of those homes?

Senator Moss. I am sure we can.

Senator KENNEDY. Do you have a copy of the list?

Dr. HAUGHTON. Yes.

Senator KENNEDY. Does it give the addresses of these homes?

Dr. HAUGHTON. It does.

Senator Moss. Very good. We would like to have that, then, to append to our record.

Senator KENNEDY. Thank you very much.

Senator Moss. I think Mr. Miller has a question.

Mr. MILLER. Your comments about the foster home situation is most interesting, observing the existence of 200 vacancies at the moment. You also made the observation that apparently older people tended to prefer nursing homes and this raises several questions.

One, this rejection or nonapplication for these foster home situations, is this based on an awareness of the older person only of the existence of foster homes or does the older person have some idea when he makes this rejection of the particular kinds of homes and living situations that he is rejecting?

Dr. HAUGHTON. Well, actually, the older person's rejection of this kind of arrangement is only part of the situation. Actually, most of our referrals for long-term care comes from hospitals and in the past we have not received many requests for foster home placement.

We are told that the only resource that the doctor in the hospital is aware of is the nursing home, so that is what he requests.

We were also told by the social service departments in the hospitals that one of the reasons why they don't ask for this kind of placement is that they don't have any means to make the referral, they don't have a form that they can use for it. Recently we have revised our form in the welfare department, the form that was used for nursing home referral, so that it can also be used for foster home referral. We hope this will give us more referrals in this regard.

We have found at times that the older person who rejects foster home care rejects it because he does not know what it is. Our bureau of special services in the department of welfare has a group of caseworkers who will take a person who has been referred, to take him for a visit,

have lunch there, meet the proprietor, meet the other people in the home to persuade him, and in many instances they accept this when they find out where it is and what it is all about.

Mr. MILLER. Your response is very pertinent, it appears to me, because it seems to me that the possibility of cultural difficulties and the neighborhood and the activity pattern that might be available to the older person if he accepts the foster home, will be extremely important to him.

I gather from what you say this is where the social caseworker activity is helpful.

Dr. HAUGHTON. Yes. The social worker is usually the crucial factor. The older person must know where he is going and have a chance to evaluate it himself. We have to give them much attention in providing this kind of casework which would help the older person to see what this is all about.

Senator Moss. Thank you, Dr. Haughton. We appreciate your testimony and your response to the questions. It has been most helpful to this subcommittee.

I am pleased that the Senator from New Jersey, Mr. Williams, a member of this committee, has joined us on this panel. As the chairman of the Subcommittee on Frauds of the Special Committee on Aging and as a member of the committee, he has done an outstanding job, and we are happy to have him with us this morning.

Our next witness is Mr. Irwin R. Karassik, who is the executive director of the Nursing Home Association of Metropolitan New York.

We are pleased to have you with us, Mr. Karassik. Introduce the gentleman with you and proceed in any way you like.

STATEMENT OF IRWIN R. KARASSIK, EXECUTIVE DIRECTOR, METROPOLITAN NEW YORK NURSING HOME ASSOCIATION, INC.; ACCOMPANIED BY EUGENE HOLLANDER, PRESIDENT, METROPOLITAN NEW YORK NURSING HOME ASSOCIATION, INC.

Mr. KARASSIK. Mr. Chairman and committee members, I am Irwin R. Karassik, executive director of the Metropolitan New York Nursing Home Association, whose offices are located at 165 Broadway, in New York City.

I also am a member of of the New York State Bar, and a fellow of the American College of Nursing Home Administrators. With me here today is Mr. Eugene Hollander, president of our association who, with 17 years of experience in the nursing home profession, is prepared to answer any questions you may wish to ask.

The Metropolitan New York Nursing Home Assocation's membership consists of 67 out of the 86 licensed proprietary nursing homes in the 5 boroughs of this city.

I wish to state that we do not represent the 22 homes that Dr. Haughton mentioned. All of our members are proprietary nursing homes licensed by the city of New York as being in substantial compliance with the hospital code of the city of New York.

We thus represent approximately 7,700 out of 8,800 of the city's proprietary nursing home beds. An additional 7,100 nursing-home-type beds are provided by voluntary institutions (4,888) and the city

(2,255). Approximately 70 percent of the proprietary nursing home beds in our city are occupied by recipients of welfare payments. The members of our association also belong to the New York State Nursing Home Association which, in turn, is affiliated with the American Nursing Home Association.

I shall avail myself of this opportunity to address you—for which we are most grateful—to speak of the role of the proprietary nursing home in the medical care complex, and about some of our problems in the city which may be of interest to you when considering national legislation.

It is not my purpose to defend private proprietary nursing homes—no such defense is needed. We maintain that the concept of private enterprise in the United States is constitutionally established and requires no defense or justification from us.

Historically and practically, proprietary operation is more economical because of its incentive, its inherent competitive factor, its subjective interest, its constructive urge for progress, and its ingrained objection to waste. We claim an understanding of our responsibilities, a dedication to our tasks, and an accomplishment of our purposes, second to none.

Initially, the authority to regulate medical facilities within this State resided with the State department of social welfare. I shall make passing mention of the fact that, just last month, this authority was transferred to the State department of health. Perhaps the health commissioner, who is scheduled to address you, will speak on this subject. Since, however, the practical significance to us of such transfer is as yet unknown, I shall not now comment upon it.

The New York State Department of Social Welfare some time ago, delegated to the city of New York the authority to regulate proprietary hospitals and nursing homes within its geographical jurisdiction. The State, however, retained the authority to regulate all voluntary facilities and proprietary nursing homes outside of the city of New York.

The city board of hospitals has from time to time implemented this delegated authority by the promulgation of new rules and regulations amending the hospital code. We might productively pause here to view the situation that was thereby created.

A proprietary nursing home in New York City is governed by a different set of rules and regulations than a voluntary nursing home that may be just across the street and is required to provide additional staff and services that proprietary nursing homes in other counties in the State are not required to provide.

It cannot be disputed that the Hospital Code of the City of New York is one of the most stringent sets of rules and regulations governing the conduct of nursing homes in any part of this country. We do not complain of this fact. We take a measure of pride in it and vigorously endorse those portions of our code that pertain to standards of nursing care. We are impelled to wonder, however, why all patients in governmental, voluntary, and proprietary nursing homes in this State do not receive the benefit of such regulation. Why, we ask, should they not all be treated as first-class citizens?

We recommend the adoption of uniform minimum standards for nursing homes, both private and voluntary, not only for city and State,

but for the entire Nation. The National Council for the Accreditation of Nursing Homes, under the joint sponsorship of the American Nursing Home Association and the American Medical Association, is a far-reaching step in the right direction.

We urge that fuller recognition and, eventually, quasi-administrative legal status, be given to this program, about which future speakers will have more to say. Thirty-one proprietary nursing homes with 2,835 beds, have been accredited in New York City (13 of which, with 591 beds, have been classified as "skilled" facilities, and 18 of which, with 2,244 beds, have been classified as "intensive").

Aside from the dichotomy of standards in this State, additional problems have arisen with the hospital code in the city of New York. These problems arose as a result of the growth of the nursing home profession after World War II and they have national implications.

In order to meet a compelling demand, nursing home operators were forced to convert existing buildings, or build new ones, without the benefit of guidelines.

In 1950, only five States licensed nursing homes. Time and experience brought a revision in the kinds of facilities that were being constructed. This was reflected in the enactment of new codes and the amendment of existing codes. Today, every State has some form of licensure.

Physical structure, however, is not necessarily equated to standards of nursing care. Nothwithstanding the pressing need to effectively utilize every licensed facility, an inclination, at least, became apparent to eliminate the grandfather clause nursing home from the community of medical-health facilities in our city. Not only has the initiative and contribution of the older home been ignored, but its capacity to continue to render valuable and needed services in the future has been placed in jeopardy.

In 1954, the board of hospitals in our city amended the hospital code to require, among other things, certain physical changes in the building, plant, and equipment of proprietary nursing homes constructed or first commencing to operate as nursing homes after November 1, 1954.

Nursing homes licensed and in operation prior to November 1, 1954, were protected by what we have come to call grandfather clauses.

Among the physical changes were requirements that halls be at least 6 feet in width; that the floor area in single bedrooms be at least 100 square feet; that where patients are housed above the first floor, an elevator must be provided; and that doorways must be 3½ feet wide.

Effective November 1, 1960, however, the board of hospitals amended the hospital code by deleting the grandfather clauses, thereby placing all pre-1954 proprietary nursing homes in noncompliance for failure, among other things, to have halls which were at least 6 feet wide.

Further, those persons who had purchased pre-1954 nursing homes, in reliance upon the grandfather clauses in the 1954 hospital code, stood to lose substantial investments.

Having thus stated in 1960 that 6-foot corridors were essential, as a minimum, to the well-being of nursing home patients, the board thereupon reversed itself and purported to adopt guidelines in 1961 which required the grandfather clause homes to widen their corridors to 5 feet,

rather than 6 feet, and their doorways to 30 inches, rather than 42 inches, within 3 years.

In 1963, the board again amended the hospital code by adopting the structural provisions of the 1961 guidelines as part of the code, and requiring such additional structural changes as the installation of exercise rooms, additional entrances, entrance ramps, elevators, and special elevator equipment, additional and special toilet, bathroom, and shower facilities, modifications of sizes of doors and doorways, modification of sizes and arrangement of rooms, provision of additional space for dining facilities and storage areas, and other detailed and extensive basic structural changes in the building.

Not only were the pre-1954 nursing homes unprotected by grandfather clauses but the nursing homes built between 1954 and 1963 were also unprotected. In fact, when the 1963 hospital code became effective, every proprietary nursing home in New York City was in technical noncompliance.

The 1963 hospital code does make provision for modifications and exceptions upon application—what we have come to term "variances"—but we believe the procedure to be totally unsatisfactory for the following reasons:

First, there was, and is, no assurance that any requested variance would be granted; second, the granting or denial of any requested variance is a matter lying solely and exclusively within the discretion of the board of hospitals; and, third, in light of the elimination of the grandfather clauses from the 1954 code, and the ensuing history of the board of hospitals' vacillation and uncertainty, an owner or a prospective purchaser, of a proprietary nursing home could not state with certainty how long a variance from the 1963 hospital code would continue to be effective.

When the hospital code of 1963 became effective, the Board of Hospitals of the city of New York assumed the right to close down every proprietary nursing home in New York City for noncompliance with structural provisions which were being given retroactive effect. Corridors, for example, had to be widened to 5 feet and doorways to 30 inches.

Compliance with these and other similar arbitrary structural requirements is impossible, as a physical matter, for some homes, and would involve others in impossibly exorbitant expenses together with the loss of income.

None of these provisions have ever been approved by the Legislature of the State of New York, the City Council of the city of New York, or any other duly elected body or official of the government of the State or city of New York.

Of the group of private citizens appointed—not elected—to the board of hospitals, several are not physicians and several are neither expert nor specially trained in matters of public or private health, the care of the aged, or the administration of nursing homes.

Our association, therefore, on behalf of its members, has determined to test the constitutionality of the hospital code, and has instituted litigation toward that end. We claim that promulgation of the hospital code by the board of hospitals constituted an unconstitutional assumption of legislative power by an administrative agency; that the code unconstitutionally deprives owners of their property without

due process of law and without compensation; that the code constitutes an arbitrary and unreasonable exercise of the police power; that the code denies proprietary nursing home owners the equal protection of the laws. These matters are all presently before the courts.

In 1962, the Hospital Review and Planning Council of Southern New York stated that, as a conservative estimate, between 13,000 and 15,000 new long-term care nursing home type beds would be needed in New York City met by 1972. Let's take a look at how this need has been met.

In 1962, there were 94 proprietary nursing homes with a licensed bed capacity of 8,719 beds. Three years after such estimate, there were but 86 additional beds and 7 less proprietary nursing homes.

In 1962, there were 161 voluntary, governmental, and proprietary institutions with a total nursing home type bed capacity of 15,294 beds. In 1965, there were but 654 additional nursing home type beds and a total of 9 fewer institutions.

In Manhattan alone, where approximately 208,000 citizens over the age of 65 represent over 12 percent of the borough's population, there has been no new nursing home licensed since 1958.

Why hasn't the dire need been met for nursing home beds in New York City?

Some of the causes of lack of nursing home construction are directly attributable to the hospital code. I have personally witnessed a reluctance on the part of prospective builders and operators, as well as lending institutions, to become entangled in the uncertainties and vicissitudes of existence under the rule of a hospital code where the value of the property as an operating nursing home, for lack of grandfather clause protection, may some day be destroyed.

Also, the code contains provisions which materially increase the cost of construction, while adding luxurious but impractical spatial requirements. Examples of such extravagance may be found in the code's requirements for treatment and examining rooms, and excessive storage areas and dining room facilities.

Standards imposed by the Federal Government have also tended to stray from the practical to the luxurious, as evidenced by the recent FHA-supported nursing home failures.

One ignominious example is to be found in Queens County, where a fully constructed and equipped 116-bed nursing home facility remains vacant because no knowledgeable operator would undertake to absorb its high carrying charges while providing high standards of nursing home care.

Senator WILLIAMS. Whose project was that?

Mr. KARASSIK. It started as a private nursing home with FHA funds, guarantees, and because of some of the requirements imposed by FHA—for example, one area is in the parking space that is required. With the high cost of land acquisition in New York State, the operating and maintenance charges for that property just came too high to carry. No one will take that home over now.

Senator WILLIAMS. The individual who started failed?

Mr. KARASSIK. It never opened as a nursing home.

But neither the hospital code nor FHA standards are solely at fault for the lack of nursing home construction in our city. We must also

recognize the high cost of land acquisition, of construction, of financing, and of operation.

I might here note that our accountants have advised us that current welfare payments do not take into account between $40 and $50 per month per bed of recently incurred increased labor costs in our city.

In the light of the high cost of financing and operating new construction, it is apparent that our primary efforts must be directed toward an attempt to appropriately utilize all of the facilities which have heretofore been licensed, and which have continued to be licensed, under our hospital code.

These nursing homes have provided superior nursing care in the past, and are in a position to continue to do so—and at a lesser cost than that which newly constructed homes can afford. They are safe structures in which to house the aged and chronically ill, and they are sufficiently staffed by personnel who have achieved adequate educational levels.

There is another element, often ignored, but which should not be overlooked, when considering the status of the older nursing home. The structural requirements of modern-day codes tend toward the establishment of nursing institutions—hospitals for the chronically ill and convalescent—and the elimination of a homelike atmosphere. There is a measure of sadness in the thought that nursing homes are destined to become cold and insensitive to the needs of many of our senior citizens.

There is also a need to encourage the building of relatively small neighborhood, or community, nursing homes, where the patient can be close to his family, relatives, and friends. The nursing home should be brought to the patient as an integral part of community planning, rather than requiring the family to make long trips to visit a nursing home patient in a hospital-like atmosphere.

What, then, is there to encourage new nursing home construction? Every prospective proprietary nursing home owner will give you the same answer: The reimbursement rate to the nursing home operator must be reasonably related to the level of services rendered.

The new nursing home will not be built in our community if it is to receive the same rate of reimbursement as an older home which cannot, for structural reasons, provide the expanded facilities and services required, by code, of new construction.

The basic and very minimal welfare reimbursement rate should be supplemented where a facility is equipped and prepared to offer additional required services.

The new nursing home will not be built in our community if, because of lack of uniformity in the law, it is to receive the same rate of reimbursement as nursing homes in nearby communities which are not required to maintain the same stringent staffing requirements.

The more one studies the nursing home profession, the more one is irresistibly compelled to the conclusion that in order to obtain rates of reimbursement reasonably related to the level of services rendered, to fully utilize existing and qualified nursing home facilities, and to encourage new construction to meet the need set forth by the Hospital Review and Planning Council, a system of classification of nursing home fascilities should be established according to the nature and extent of the services they are equipped and prepared to render—prefer-

ably on a national level—and reimbursement should be equated to the the level of classification. Connecticut is one State that has made significant headway in this area.

At this point, I would like to emphasize that we do not take exception to the nonstructural provisions of our code. We have undertaken to implement all of the provisions relating directly to nursing care and safety, such as the staffing requirements (at least 2 registered nurses for the first 60 licensed beds or part thereof, and 1 additional registered nurse thereafter for every 60 beds or part thereof; an additional director of nursing service for homes with over 120 beds; at least 1 practical nurse for every 20 beds or part thereof; and at least 1 attendant for every 5 beds or part thereof); the development of special programs for the prevention of fire and the protection of patients; obtaining admission medical histories and examinations; development of a treatment and discharge program for each patient within 30 days after admission; the adoption of uniform forms and records; and many similar items.

We have worked closely with the Department of Welfare to upgrade the standards of medical care received by welfare recipients. I understand that some representatives of the health insurance plan (HIP) are scheduled to speak to you on this subject.

It is in the field of education that we face some of our most serious problems. First, there is a notorious and dramatic shortage of professional nursing personnel. Our association, in cooperation with Local 144 of the Hotel & Allied Service Employees' Union, has committed itself to the expenditure of substantial sums of money for the establishment of scholarships to enable aids and orderlies to become licensed practical nurses, and to enable the practical nurses to become registered nurses. But a more massive effort is needed, and it is in this area that the State and Federal Governments should take a more active role.

Secondly, we have met our obligation to maintain an adequate educational level for our present staff by lending financial and other assistance to the department of hospitals' series of TV training programs for aids and orderlies.

Our association was primarily responsible for the establishment of an approved course in nursing home administration by the School of Public Health and Administrative Medicine of Columbia University, and the approval by the department of hospitals of a series of workshops in nursing home administration given by the Center for Continuing Education of Northwestern University.

The united hospital fund, with financial assistance from the U.S. Public Health Service and from our association, has undertaken a 3-year project to determine the manner in which the social worker may be most effectively utilized in our member homes. Similar projects are planned for our recreation, rehabilitation, and dietetic programs.

While we have recognized our responsibility and have responded to its demands, in its broader aspects the care of the elderly is the moral responsibility of every citizen in every community.

In the final analysis, it is the Government that should play a greater role of leadership in the establishment of educational programs and in the recognition, or promulgation, of uniform, achievable, nonwasteful standards, of both construction and care.

Thank you.

Senator Moss. Thank you, Mr. Karassik. We appreciate your very fine statement. We are glad to have the president of your association, Mr. Hollander, here, too.

I understand from your testimony that you believe we have reached the point where we ought to have national standards for nursing homes.

Mr. KARASSIK. Yes, I do. As a matter of fact, as I read the medicare legislation, there is reference to two national accrediting agencies and we believe that these agencies have taken a long stride toward the establishment of such uniform methods throughout the country and should receive eventual quasi-legislative power—that they should be looked to as the accrediting agencies throughout the country.

I see no reason why a nursing home, to just pick an example, in your home State of Utah, should be any different than a nursing home, and the standard of treatment given to it, in New York State.

I think we should treat all of our senior citizens in the same way.

Senator Moss. Now your only objection, as I understand it, to the code here pertains to the physical requirements for the nursing homes themselves.

Did your association appear before any legislative committee or board before those standards were set?

Mr. KARASSIK. Yes; we had an opportunity to speak. Mr. Hollander could tell you more about that. I was not with the association at the time. I would like to first mention the fact that we do not object necessarily, although we do think there are some wasteful items in the prospective building of nursing homes.

The provisions of the current hospital code of the city of New York have been given retrospective effect. At the time the code was promulgated in 1963, every single existing proprietary nursing home in New York City was in technical noncompliance and as a matter of law, if not for the protection of the courts, could have been put out of business.

It is to the retroactive effect of these provisions that we take greatest exception. As to the prospective effect of these provisions we take exception only insofar as we think they have strayed from the practical nursing home to a more luxurious concept which makes it too expensive to run.

Senator Moss. Was this fully presented at the hearing, Mr. Hollander?

Mr. HOLLANDER. Yes, Senator Moss, it was presented as another fact that our organization was invited and we have been sitting in as Mr. Karassik mentioned. We are not fighting progress. We have agreed practically to most of the changes in the code.

What we object to is existing facilities. We stated that those facilities have been here for years, they were approved. Any nursing home in this city was approved once by the department of hospitals and we felt those homes which were built and were approved by the hospitals should have the right to continue and stay in business inasmuch as there are no fire hazards or no safety hazards to their patients.

Inasmuch as the home has the 4-foot corridor, that home can still operate and provide very excellent care for the patients. This was our biggest objection to the new code, I mean as far as the old nursing homes, the "grandfather" nursing homes are concerned.

Senator Moss. Well, is there any length of time that a "grandfather clause" should protect an institution, a building? Would you want an indefinite "grandfather clause"?

Mr. HOLLANDER. No. As a matter of fact, we were told by the department of hospitals at certain meetings that approximately 30 "grandfather" homes which don't comply only by structural facilities, those homes will have approximately 3 years and after 3 years, they will be out of business.

Senator Moss. Well, I understand from your testimony, Mr. Karassik, that 70 percent of the patrons of your proprietary nursing homes are welfare patients at this time. What is the limit the department of welfare will contribute for the care of these welfare patients?

Mr. KARASSIK. The limitation is set, of course, by the welfare department after investigations of our cost patterns and proposed cost of operating the home, and the rate was supposed to be reasonably related to our costs.

However, there is a lag as can be understood, between costs and reimbursement. For example, as I pointed out, we have new labor contracts just this year and there are other labor contracts in the process of being worked out right now which have increased our costs approximately $50 per bed per month.

Our current rate in effect does not cover the cost of our welfare patients, and if it were not for the fact that there were private patients paying a higher rate in a great many of the nursing homes, they are in effect subsidizing many of the welfare recipients in our private homes.

Senator Moss. Are you telling me that the welfare people do have some leeway in the amount of payment; in fact, that they can do some of this classification which you recommend ought to be established for care in the nursing home?

Mr. KARASSIK. I think the legislature would have to approve it, but I think it could be done; yes.

Senator Moss. At the beginning of your statement, you indicated that you thought the proprietary nursing home was probably the best type because of its inherent seeking of economy, eliminating waste, and so on.

Isn't this somewhat inconsistent with what we are talking about now, where the majority of the patrons are on welfare and therefore restricted in the amount that they can pay, inasmuch as the proprietary, of course, has to make a reasonable profit to stay in business?

Mr. KARASSIK. I don't think it is inconsistent at all, Senator Moss. To begin with, the rate in New York City now for a welfare recipient in a private institution is $355 per month. The voluntary institution is getting $420 a month.

I think experience has proved that the proprietary nursing home can render better nursing home care than any other institution and at a lesser cost. I don't think anybody who will speak to you today can question the fact that the proprietary institutions render better nursing care than our own municipal hospitals which are under the same jurisdiction that we are.

Mr. HOLLANDER. Senator Moss, may I add to that that the private proprietary nursing homes are providing approximately 100 percent of the staff required where the city or other voluntary agencies I don't think come near to what we are providing as far as health is concerned.

Mr. KARASSIK. The Reader's Digest in the August issue has a statement that the department of hospitals was able to obtain less than one-half of the nursing staff it had received funds to employ.

The proprietary nursing homes on the other hand, are virtually 100 percent staffed in accordance with the code and we are compelled at all times to explain a one shift shortage even in an emergency situation. That is one of the reasons we believe we give a very high standard of nursing home care in our city.

Senator Moss. Senator Williams?

Senator WILLIAMS. Just one or two questions.

I do not understand why your welfare rate is fixed so much lower a month than the voluntary and other institutions.

Mr. HOLLANDER. May I answer that question?

The voluntary rates are fixed based on cost and our rates are not based on cost.

Senator WILLIAMS. Who fixes the rate?

Mr. HOLLANDER. The city. First of all, the department of welfare.

Senator WILLIAMS. I also do not understand why you come under the State-delegated authority to a city which, in turn, was delegated to a board, is that right?

Mr. KARASSIK. That is right, sir.

Senator WILLIAMS. You come under this and the others do not. I do not understand that.

Mr. KARASSIK. Senator Williams, I don't understand that either.

Senator WILLIAMS. Do you believe the enactment of the medicare legislation will stimulate more interest in creating nursing homes?

Mr. HOLLANDER. May I answer that question?

Senator, that new code which places the old nursing homes in jeopardy, if that would not have been done there would be today many more nursing homes. Anyone going into this field takes immediately quite a big risk because his investment is so risky that it becomes a white elephant.

Many nursing homes cannot be sold. The department of hospitals would not transfer a license so any nursing owner who has a nursing home is stuck with it. If those regulations have been changed today, I assume there would be at least 5,000 more proprietary beds available in this city.

Senator WILLIAMS. You are just talking now about the situation in New York City?

Mr. KARASSIK. Yes, we are. We will have a representative here from the State that might be in a better position to answer.

Senator Moss. Senator Kennedy, do you have any questions or comments?

Senator KENNEDY. In connection with the standards applied here in the city of New York, would you be in favor of applying these standards across the country?

Mr. KARASSIK. The standards enacted in the city I think are doing a superlative job. I don't know if I would be prepared to state that

necessarily the same exact provisions would have to be enacted across the country in order to accomplish a similar job, but I think that certain minimum standards in any event, should be applied on a national basis.

Senator KENNEDY. As I understand from your answer, you still disagree with some of the provisions that are in effect here in the city of New York.

Mr. KARASSIK. Yes. Yes; on some of the prospective features I do disagree.

Senator KENNEDY. Do you disagree with features other than the ones dealing with the physical makeup?

Mr. KARASSIK. In some minor ways. If you care for specifics, I could give you some.

Senator KENNEDY. No; I don't want to take the committee's time. Do you have them written out here?

Mr. KARASSIK. No, but I will prepare a statement for you. I will be very happy to.

Senator KENNEDY. Did you testify in opposition to some of the standards that were put into effect here?

Mr. KARASSIK. Our association did. I was not personally present at that time.

Senator KENNEDY. Did you testify, or your association testify, in opposition to some of the standards other than the physical standards that were established here in the city?

Mr. KARASSIK. Most of care standards we went along with and even advocated some of our own.

Senator KENNEDY. Were there some requirements, other than the physical standards, with which you disagreed when you testified in opposition?

Mr. KARASSIK. No.

Senator KENNEDY. There were not any?

Mr. KARASSIK. Right now we have accepted and worked toward the fulfillment of all these with dedication to——

Senator KENNEDY. I understand that. I was just asking whether you testified in opposition to any of them when they were first considered?

Mr. HOLLANDER. No; we did not, only as far as physical structure of nursing homes.

Senator KENNEDY. The previous witness testified in detail about some of the horrors which exist in homes now.

Are any of those homes members of your organization?

Mr. KARASSIK. Our association is but 3 years old now. There were some predecessors, split organizations in the past, but none of those could have belonged to our association.

Senator KENNEDY. Did any of them belong to any of the associations that became part of your association?

Mr. HOLLANDER. Some did, very few.

Senator KENNEDY. Since the code has been in effect, how many of the nursing homes that were members of these associations have lost their licenses?

Mr. HOLLANDER. Senator, there were all together 132 nursing homes in existence; today there are about 87. The balance of the nursing homes that were not in existence, most of them did not belong to any

organization, either smaller homes which when the new code was promulgated, they realized they have no chance to stay here, they were homes between 11 and 25 beds. Most of those homes closed. Most of them closed because of their structural facilities. Their facilities were not able to comply with the new code at all.

Senator KENNEDY. Do you have the figures on how many of those homes that had to close or decided to close because they could not meet the standards were members of your association?

Mr. KARASSIK. I would be happy to furnish that to you We don't have it at this time.

Senator KENNEDY. Do you have the approximate number?

Mr. HOLLANDER. About seven.

Senator KENNEDY. About seven of them?

Mr. HOLLANDER. About seven of them.

Senator KENNEDY. I would be interested to see the basis on which they closed.

Mr. HOLLANDER. We will be glad to furnish that.

Mr. KARASSIK. If I may add, our association is now in the process of forming an effectively operating self-regulating standards committee because up to now the supervision has been solely within the department of hospitals.

This is not to replace the supervision that we now receive by the department of hospitals but we would like to go into our own homes and see for ourselves what is going on and perhaps make recommendations to our own members, all in an effort to elevate the standards of care we give here in New York City.

Senator KENNEDY. Would you not agree that the efforts that Dr. Trussell and those associated with him have made to establish standards here in the city of New York are highly worth while?

Mr. KARASSIK. They are highly worth while. We are 100 percent in favor. We commend them on their job. We are most pleased with the results that have been achieved in the city. It is only to the structural provisions that we take exception.

Senator KENNEDY. Some question has been raised as to the bases or the reasons upon which those who were members of Dr. Trussell's committee came up with recommendations or suggestions as to standards.

You are not suggesting to this committee there was anything but good faith by the group that was associated with Dr. Trussell?

Mr. KARASSIK. The good faith we don't quarrel with. We believe that a code of this sort should get a legislative type of approval through either the city council or the State legislature rather than a board of private citizens who I may say, if they were not as honorable as the people we did have on the board could have resulted in some very serious destruction of property and could have been very harmful throughout the industry.

Fortunately, we did have a man of high honor.

Senator KENNEDY. I suspect that would be something for the city itself or the State rather than Dr. Trussell's committee.

Mr. KARASSIK. Either that or the courts where we are now.

Senator KENNEDY. Thank you.

Senator Moss. We are most pleased to have our colleague and member of this committee, the Senator from Oregon, with us. I do not know whether she would have any questions at this point.

Senator NEUBERGER. No.

Senator Moss. Thank you. We are pleased to have you here, Senator Neuberger.

Do you have any questions Frank?

Mr. FRANTZ. Yes.

The FHA home which you mentioned; was this the home sponsored by two doctors who also are associated with a proprietary hospital in Queens?

Mr. HOLLANDER. No, there was a builder—as far as I know, it was a builder—who has built a new home with FHA money and when he was ready to lease it to someone there was no one who was able to take it and there is a very simple explanation. He felt that the new code in the city and the code or the requirements by the FHA at the time being were so high that the prevailing rates cannot cover the cost of such a building.

This is why no one is willing to operate such a new home. The interest and amortization for an FHA home today, the cost is about $10,000 per bed. We have to figure to maintain the interest and amortization is $1,000. Today, no nursing home makes a thousand dollars per patient a year so therefore it is impossible that with the prevailing rate somebody should operate the new home.

Mr. FRANTZ. The builder or his company is the sole sponsor, as far as you know?

Mr. HOLLANDER. That is correct.

Senator Moss. Thank you very much, gentlemen. We appreciate your being here to testify before us and we are glad to have your knowledge and experience.

We have one more witness to hear this morning. We will call Dr. Trussell at this point.

Dr. Trussell is director of the School of Public Health and Administrative Medicine, Columbia University.

We are very glad to have you, Dr. Trussell, and look forward to your testimony.

STATEMENT OF DR. RAY E. TRUSSELL, DIRECTOR, SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE, COLUMBIA UNIVERSITY

Dr. TRUSSELL. Thank you, Senator.

I have submitted this statement to the members of the committee so that I will try to go over some of the highlights.

Senator Moss. Thank you. The entire statement will appear in the record and you may highlight it for us.

Senator KENNEDY. Mr. Chairman, before he begins, could I just welcome Dr. Trussell before the committee. Of all the public officials in the State of New York, nobody has contributed more than he has. I think we all owe a great debt to him, not only the city of New York but the country, for the leadership he has given us.

Senator Moss. Thank you, Senator Kennedy.

Dr. TRUSSELL. Thank you.

I propose to limit my factual statements to what has happened in the nursing home field in New York City in the past few years in terms of facilities for and standards of care.

I wish also to voice some concern and to offer a few recommendations. Naturally, I am available for questions from your distinguished committee.

First, I will give a line item summary of events in the proprietary nursing home field beginning in 1961 which was when I became commissioner of hospitals.

I might say parenthetically that the department of investigations had been working on some of the abuses in this field for at least 3 years prior to my coming into the department, and that a good deal had already happened.

Furthermore, there was a mayor's commission on health services of which I was executive director. We did an audit of medical care in proprietary nursing homes and found some substandard conditions which was background for the efforts that Dr. Haughton described this morning to improve care in proprietary homes.

As you can see from running over this list, for example, we have been busy closing out substandard facilities. To upgrade care we also provided training for administrators; we developed a TV program on the local television station for aids and attendants. We had faculty in the field visiting the nursing home after each TV demonstration.

We increased our own special investigator staff so that we could visit every nursing home at least once a month which is quite by contrast with the surveillance in most regions in the United States. If we had complaints, we would visit them much more frequently.

The concentration on fire safety has been especially important in our opinion. We had one situation in which a proprietary nursing home went out of business. We required that they discharge every patient even though they wanted to keep some, because the licenses were going to convert the business to a hotel for senior citizens. All of our patients for whom we were responsible were discharged. The facility reopened as a hotel and had a fire and one inmate was burned to death. I was very glad to have the attention brought out this morning to the problem of these institutions that are converting to senior citizens facilities not requiring skilled nursing care.

The new code which was adopted for the regulation of proprietary nursing homes has been the subject of some discussion this morning. I think for the record I would like to say that the board of hospitals can be likened to a board of health. The members are appointed by the mayor, one physician, and one layman each year, for staggered terms of 5 years. They are outstanding public servants and outstanding physicians, no one has ever challenged their ability or integrity. They have, under the city charter, without reference to any other provision of law, the right and the responsibility to establish standards in the hospitals which are operated by the department of hospitals, which are licensed by the department of hospitals and in any institutions with which the city of New York does business.

We have promulgated standards through the board of hospitals in all three of these types of institutions. I might say that the board and its authority have been attacked in the courts several times and has been upheld in every decision so far.

I would like to go over the matter of facilities. You have heard different numbers this morning and I have probably a different set of numbers but they are roughly the same. We indicate at the present time there are 86 proprietary nursing homes in New York City, a considerable decrease over the last few years.

We then indicate why they closed. Now I might say that I made an error in writing this up. I substituted numbers for names so that that 1, 2, 3 means three different institutions, not three that were required to close for falsification of records. This was an error on my part.

You will note there are three essential reasons why the nursing homes have closed at our order, (1) either unsatisfactory operation which meant lack of cleanliness, or personnel shortages or safety problems or structural requirements, (2) those who could not comply after having been given the maximum amount of time to comply with the code requirements and (3) those who falsified records.

It has been a source of amazement to me that in spite of the fact that this field has been investigated since about 1959 that even as late as last year, we had one situation of falsification of records.

You will notice that a number of the institutions have voluntarily closed. Part of this is because they could not afford to comply with the new code. A substantial number, as has been brought out here, deliberately converted to senior citizen facilities which were not under our jurisdiction, which theoretically were under the jurisdiction of the local department of welfare. Actually, only part of them were actually supervised and all now are totally under the jurisdiction of the State department of social welfare.

The construction situation is an interesting development. If we start off with 8,805 proprietary nursing home beds as of January of this year, we have in the city under construction an additional 706 proprietary nursing home beds which indicates that those people who said that a strong code would stop proprietary hospital building were wrong.

The next category of beds summarized for you are those for which plans have been filed with the building department but have not yet been started under construction. These 1,497 beds, if the plans had been filed with the building department, are very likely to be constructed because very few people go to that expense and difficulty if they are not about to build.

The questionable figure which I will discuss later is 6,178 beds which are under the heading "Plan Still Being Reviewed by the Department of Hospitals."

The city has been brought into this problem over the years. At the present time, in addition to the two very large facilities which the acting mayor mentioned, there are other smaller facilities which are called public-owned infirmaries which are really taking care of nursing home patients. These are units both within general hospitals and also units which are free standing.

I would point out that with the exception of one of these, the Sea View unit, every one is now operated or is about to be operated, by a medical school or by a very strong teaching hospital and I would categorically challenge the comments about the proprietary nursing homes being better than the others in New York City.

The Elmhurst unit is staffed by the Mount Sinai Hospital. Goldwater Memorial is just in the process of being taken over by New York University Medical School which is your host institution today. Queens Medical is staffed by Long Island Hospital, which is the finest hospital in Long Island. The Sea View Hospital will be taken over by St. Vincent's Hospital on Staten Island beginning next spring. They are now studying the situation. Bird S. Coler is staffed by the New York Medical College, et cetera.

So in our existing facilities, we have provided for very high professional care. There is no question about the nurse shortage and this everybody knows is a municipal problem which needs a lot of attention.

The city has already placed in the capital budget, at my request, funds for 2,350 additional public home infirmary beds as a part of the crash program which Mr. Screvane discussed this morning. The agency which certifies to the Federal Government and to the State government as to needs for beds, namely, the State health department, has indicated that in New York City we have fulfilled about 69 percent of the estimated needs for suitable beds and that we need another 8,400 beds.

Now if you added up all those figures I have just given it would appear that we were overbuilding, but actually the figure of 6,178 beds listed for the proprietary field is a very "iffy" figure representing feelers but not so many firm commitments.

The fact is that long-stay patients are backlogged in voluntary and municipal hospitals to an alarming degree and at a very high cost. This is a cost which will be felt by medicare as well as by all other sources of payment to hospitals.

I might inject the fact that we have another research study made by Columbia University to which I have not alluded in which we drew a sample of voluntary general hospitals and a sample of general municipal hospitals and said anybody who had been there 30 days or longer was a "long stay" patient.

We studied those patients with a team of consultant internists, nurses, and social workers. We found in voluntary hospitals about 26 percent of those patients who had been there 30 days or longer did not need to be in the general hospital; they needed to be somewhere, home-care program, or foster home or nursing home, but they didn't need to be in a high-cost general hospital. In the municipal hospitals which receive all of the unwanted long-term patients in New York City, the figure was 50 percent. This study was directed by Prof. Frank Van Dyke.

In addition to my comments on physical facilities, I wish to state that our major concern has been with standards of care—a concern which I am sure you share and a problem which is aggravated by the Medicare Act.

In New York City, with the help of a very large and distinguished committee, the department of hospitals developed, over a long period of time, after much consultation, a public hearing and against great resistance, a very strong code for nursing home care which is systematically being implemented home by home.

I have provided the committee staff with copies of this code and will not take more of your time in discussion at this point.

Looking ahead one can continue legitimately to express concern about the standards of care in certain types of nursing homes. While we have a very strong code in New York City which will be protected by an amendment to the Medicare Act introduced by Senator Kennedy from New York, there are not comparable codes in the rest of the State nor across the Nation.

Fortunately, the responsibility for supervision of nursing homes other than those licensed by the commissioner of hospitals has been transferred to the State department of health by the last legislature and the stage is now set for strengthening standards of care for the thousands of elderly and often defenseless patients throughout the State.

It is regrettable that the Medicare Act does not speak out strongly on this issue, but I hope that the intent of the Congress and the President to finance care only in facilities where reasonable standards are required and enforced will be made abundantly clear to those charged with policymaking and program administration.

I also am concerned about the disproportionate share of nursing home facilities now operated or being constructed by proprietary interests whose motives by definition are a profitable return on an investment, and by Government which is driven into the field to meet a need which cannot be financed by the voluntary agencies.

New York City is in the process of designing for construction 2,350 beds at an estimated cost of $47 million. This is 60 percent of the entire Federal appropriation for nursing homes for the Nation, yet it is being met as a 100-percent local taxpayer expense. No Federal funds which come into New York City are earmarked to assist the city administration in meeting this crushing burden.

One can only hope that now the Congress has provided a badly needed mechanism for financing care in nursing homes, attention can be turned to the pressing problem of creating enough modern facilities to meet the need by both voluntary agencies and Government.

Insufficient nursing homes result in patients staying in acute general hospitals at a much greater cost. In New York City an indigent patient in a municipal general hospital receives care at an average cost of $48 a day. The same patient placed by the department of welfare in a proprietary nursing home at the rate of about $11.80 per day and protected by a strong code is obviously less expensive. To this latter figure must be added the cost of physician services and drugs.

Nevertheless, the overall potential for savings is enormous, and real thought should be given to the savings which might be demonstrated over the years if a crash building program of modern nursing homes under voluntary and governmental auspices financed by Federal and State funds were mounted forthwith. A saving of $20 a day for 1,000 days is approximately the cost in New York City of one nursing home bed in a modern facility with a complete range of services.

In other words, an investment equal to 3 years of savings will produce a facility good for 30 years which will go right on generating savings to medicare and to all forms of public assistance programs for the elderly in nursing homes.

I have deliberately limited my remarks, Mr. Chairman, because there are a number of us who are going to speak on different aspects on the problem, so I will stop at this point.

Senator Moss. Thank you, Dr. Trussell. We appreciate this very much. Your full statement will be included in the record.

(The statement referred to follows:)

STATEMENT BY DR. RAY E. TRUSSELL

I am Dr. Ray Trussell, director of the School of Public Health and Administrative Medicine of Columbia University. For the past 4 years and 4 months, ending on June 30, I also served as commissioner of hospitals of New York City. In that capacity I was responsible for the care of several thousand long-term patients in municipal facilities and I licensed proprietary nursing homes subject to a code promulgated by the board of hospitals.

Since several of my colleagues will be speaking also on related topics, I propose to limit my factual statements to what has happened in the nursing home field in New York City in the past few years in terms of facilities for and standards of care. I wish also to voice some concerns and to offer a few recommendations. Naturally I am available for questions from your distinguished committee.

First, I will give a line item summary of events in the proprietary nursing home field beginning in 1961:

NEW YORK CITY PROPRIETARY NURSING HOME PROGRAM DEVELOPMENTS 1961–65

In 1961

Seven unsatisfactory homes closed.

Initiation of course for administrators at Columbia University, staff of Institutional Review Service included.

In 1962

1. Appointment of physician as director of proprietary hospitals, nursing homes, and home care services.
2. Elimination of 13 substandard or marginal nursing homes by December 31, 1962.
3. Gradual change of focus of staff from purely regulatory to regulatory and educational.
4. Addition of 2 supervising institutional inspector positions, 13 inspection positions, position of 1 administrative assistant, 1 clerk, and 1 stenographer.
5. Increase in total number of inspections to proprietary institutions and increase in number of night inspections.
6. Initiation of a training program for nursing home nurses' aids.
7. Improvement in medical care program for welfare client-patients in nursing homes—contracts with hospital insurance plan and 2 voluntary hospitals—affecting 23 homes which house 2,406 patients will probably result in better care for all patients in these homes.
8. Improvement in nursing home operation as of December 31: one home without a license and four with restricted licenses. Previous years—average of unlicensed homes 15 to 20 on any day.
9. Issuance of restricted licenses for nursing homes and order that nursing homes may not admit private patients during periods of unlicensure and restricted licensure. This was instrumental in effecting improvements.
10. Four elevatorless homes removed patients from the third floor.
11. Concentration on fire safety; cooperation between fire department and hospitals to assure installation of sprinkler systems in nonfireproof homes and fireproof homes where fire department believed such homes should be sprinklered.
12. Engagement of part-time dietitians by some homes.
13. Extension of consultant services by community mental health board to three more homes, making it a total of six which receive such services.
14. Assignment of a consultant from community mental health board to meet regularly with institutional inspection staff.
15. Amendment to hospital code provides for chest X-ray of patients prior to admission to nursing homes.
16. Revision of the nursing home section of the hospital code completed.
17. Progress on a diet manual being developed by the food and nutrition council.

In 1963

New code adopted for nursing homes.
TV faculty appointed for education of nursing home personnel.
Bed capacity reduced in some homes.
Grant for study of role of social worker in nursing homes received and implemented.
Medical care programs of welfare department extended.
Guidelines established for existing homes as to how far they must go to meet new code.

In 1964

Evaluation of structure and services of existing homes, followed by hearings by department and final decision of board as to what "homes" must do to stay in business.

The numerical picture of facilities and beds can be summarized in several categories as follows:

Proprietary nursing homes in New York City

Year	Total number of institutions	Total number of beds
1959	119	9,350
1960	113	9,329
1961	107	9,420
1962	94	8,839
1963	87	8,551
1964	87	8,805
1965 as of Feb. 28, 1965	86	8,785

The reasons nursing homes closed can be itemized as follows:

Nursing homes closed

IN 1961

Ordered to close:	
Unsatisfactory operation	1
Unsatisfactory operation	2
Falsification of records	3
Voluntary closings	4

IN 1962

Ordered to close:	
Unsatisfactory operation	1
Unsatisfactory operation	2
Falsification of records	3
Unsatisfactory operation	4
Unsatisfactory operation	5
Unsatisfactory operation	6
Could not comply	7
Unsatisfactory operation	8
Could not comply	9
Falsification of records	10
Voluntary closings	3

IN 1963

None ordered closed.
Voluntary closings: Seven (five could not afford to comply with the new code).

IN 1964

None ordered closed.
Voluntary closings: Two could not afford to comply.

IN 1965

Ordered to close: One.
Voluntary closings: Two.

The situation regarding proprietary home construction projected for the future is tabulated below:

Proprietary nursing home bed situation as of Jan. 21, 1965

Licensed homes	87
Total bed capacity	8,805
Homes which accept welfare patients	70
Bed capacity	7,828

	Homes	Beds
Homes under construction:		
Manhattan	0	
Bronx	1	120
Brooklyn	2	440
Queens	1	116
Richmond	0	
Additions under construction:		
Queens	1	30
Total		706
Homes for which plans have been submitted to building department but which have not started construction:		
Manhattan	1	200
Bronx	7	1,157
Brooklyn	0	
Queens	2	140
Richmond	0	
Total		1,497
Proposed homes—Plans still being reviewed by department of hospitals:		
Manhattan	10	[1] 3,741
Bronx	3	[2] 320
Brooklyn	1	114
Queens	6	[2] 1,004
Richmond	5	999
Total	25	6,178

[1] Plus 5 sites, capacities not available.
[2] Plus 1 site, capacity not available.

The municipal contribution to the needs of the community now and for the future follows:

Public home infirmary care

	Beds
Existing:	
City Hospital at Elmhurst	120
Bird S. Coler	807
Coney Island	101
Goldwater Memorial	360
Queens	72
Sea View	668
Total	2,128
Projected over next 5 years:	
Bronx Municipal	400
Manhattan Beach	200
Bronx Hospital	200
Brooklyn	200–300
Metropolitan	50
Queens General	300
Lincoln	200
Greenpoint	200
Fordham	100
Kings County	400
Total	2,250–2,350

The estimated needs for the city, as projected by the State department of health, are summarized below:

	Estimated population	Estimated number of suitable beds needed			Existing long-term care beds		Unsuitable
		Total	Chronic hospital	Nursing home	Total	Suitable	
	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Total	17,541,565	57,316	14,522	42,794	51,121	33,756	17,365
New York City	7,913,317	27,160	8,560	18,600	20,845	18,698	2,147

	Percent of estimated needs met by existing suitable beds	Net additional suitable beds needed (col. 4 minus col. 8)
	(10)	(11)
Total	58.89	23,560
New York City	68.84	8,462

Theoretically, New York City is overbuilding. Actually, the figure of 6,178 beds listed above for the proprietary field is a very "iffy" figure representing many feelers but not so many firm commitments. The fact is that long-stay patients are backlogged in voluntary and municipal hospitals to an alarming degree and at a very high cost.

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THE CITY OF NEW YORK

BOARD OF HOSPITALS

HOSPITAL CODE—PART 1
PROPRIETARY NURSING HOMES

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THE HOSPITAL CODE OF THE CITY OF NEW YORK AND REGULATIONS

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BOARD OF HOSPITALS

Filed with the City Clerk on January 23, 1963 and Published in THE CITY RECORD on February 4, 5 and 6, 1963

Amendments to the Hospital Code

Resolved:

1. Articles III and IV of the Hospital Code of the City of New York as amended are hereby renumbered to be Article XI and Article XII respectively.
2. Articles I and II of the Hospital Code of the City of New York are hereby repealed.
3. The Hospital Code of the City of New York is hereby amended by the addition of new Articles I through X inclusive to read as follows:

ARTICLE I TITLE, PURPOSE AND GENERAL DEFINITIONS

Section

1.01. SHORT TITLE.
1.02. PURPOSE AND IMPLEMENTATION.
1.03. GENERAL DEFINITIONS.
1.04. MODIFICATIONS AND EXCEPTIONS.

§ 1.01. **Short Title**

This code shall be known and may be cited as the Hospital Code of The City of New York.

§ 1.02. **Purpose and Implementation**

The purpose of this code is to state the requirements adopted by the Board of Hospitals of The City of New York relating to the protection and general welfare of patients in proprietary nursing homes and proprietary hospitals in order to exercise the jurisdiction conferred upon it by the New York City Charter. The implementation of this code shall be in accordance with a schedule to be determined by the Commissioner.

§ 1.03. **General Definitions**

When used in this code, unless otherwise expressly stated or unless the context or subject matter requires a different interpretation, the following shall apply:

(a) "Charter" shall be held to mean the New York City Charter.

(b) "Administrative Code" shall be held to mean the Administrative Code of The City of New York.

(c) "Board" and "said Board" shall be held to mean the Board of Hospitals of The City of New York.

(d) "Home" shall be held to mean a proprietary nursing home.

(e) "Hospital" shall be held to mean a proprietary hospital.

(f) "Department" shall be held to mean the Department of Hospitals of The City of New York.

(g) "Commissioner" or "Commissioner of Hospitals" shall be held to mean the Commissioner of Hospitals of The City of New York.

§ 1.04. **Modifications and Exceptions**

(a) Notwithstanding any other provision contained in this code, where there are practical difficulties or unnecessary hardships in existing homes in complying with the strict letter of the provisions of this code, the Board shall have the power in a specific case to modify any provisions thereof in harmony with the general purposes and intent of this code.

(b) The Commissioner shall license all existing homes which comply structurally with the minimal standards established by the Board in the "guidelines" which were adopted by it and became effective May 24, 1961 following the repeal of the "grandfather clauses" of the Hospital Code provided that such homes comply with the other requirements applicable thereto.

The Board may establish additional guidelines as a basis for application of this code to existing homes which do not comply structurally with the provisions of this code.

(c) Applications for modifications and exceptions provided in this session shall be heard by a board established by the Commissioner. The recommendations of the hearing board shall be submitted to the Board of Hospitals.

PART I—PROPRIETARY NURSING HOMES
ARTICLE II LICENSURE

Section

Introductory Notes

Nursing homes provide a sheltered environment for the residential and protective care of patients who are incapacitated, chronically ill, chronically disabled, convalescent or suffering from the infirmities of old age, who cannot remain in their homes and who in the judgment of their physicians do not require active treatment in a hospital. Such homes provide skilled nursing care, access to medical care services and other necessary and essential services such as physical therapy, social service, podiatry and recreation.

Nursing homes provide a suitable environment in which every reasonable effort is made to help restore patients to the maximum degree of physical and emotional independence and self help possible and to maintain them at such optimum levels of function. Whenever possible, patients shall be helped to return to their homes or other residential living arrangements.

§ 2.01. **Specific Definitions**

When used in this code, unless otherwise expressly stated or unless the context or subject matter requires different interpretation, the following definitions shall apply:

(a) A proprietary nursing home (home) shall be held to mean any institution which provides for profit, lodging, board, certain ancillary services as provided for in this code, and skilled nursing care for twenty-four (24) or more consecutive hours for three (3) or more persons not related to the licensee by blood or marriage within the third (3rd) degree of consanguinity.

(1) A new home shall be held to mean:
  (a) A home which was never licensed prior to January 16, 1963.
  (b) A home which was licensed and in operation prior to January 16, 1963 but whose license has been finally revoked.
  (c) A home which discontinued its operation for any reason whatsoever prior to January 16, 1963.

(2) An existing home shall be held to mean:
  (a) An operating home whose license has not been revoked by the Commissioner by January 16, 1963.
  (b) A home which is under construction according to plans reviewed by the Commissioner and approved by the Department of Buildings prior to January 16, 1963, provided that such construction is completed prior to January 16, 1964.

(b) "License" shall be held to mean a license duly issued by the Commissioner of Hospitals to operate a nursing home.

The following licenses shall be issued as indicated:

(1) Temporary license is a license issued for a period of ninety (90) days to a new home.

(2) Annual license is a license issued for one year to a home found on inspection to be in substantial compliance with this code.

(3) Provisional license is a license issued for not more than ninety (90) days, when a home is not in complete compliance but has demonstrated improvement and evidences potential for compliance with this code.

(4) Restricted provisional license is a license issued for not more than ninety (90) days to a home which has neither a provisional nor an annual license, and which has not evidenced compliance as directed. During the existence of the restricted provisional license, the licensee shall be afforded the opportunity to indicate that he is entitled to receive a provisional or annual license.

The home receiving such a license shall not admit patients but may continue in operation until the expiration or revocation of its license.

(c) "Licensee" shall be held to mean the person or persons who operate and are responsible for a home and to whom the Commissioner has issued a license to operate a nursing home.

(d) "Applicant" shall be held to mean a person or persons who intend to operate and be responsible for a home and who submit to the Commissioner an application for a license to operate a nursing home. The applicant may not be a corporation.

(e) "Registered professional nurse" or "registered nurse" shall be held to mean a nurse who holds a current license issued by the Department of Education of the State of New York to practice as a registered professional nurse and who has registered with such department, in accordance with the provisions of the Education Law.

(f) "Licensed practical nurse" or "practical nurse" shall be held to mean a nurse who holds a current license issued by the Department of Education of the State of New York to practice as a licensed practical nurse and who has registered with such department, in accordance with the provisions of the Education Law.

(g) "Patient" shall be held to mean any person receiving care in a nursing home.

(h) "Sponsor" shall be held to mean the person, persons or agency legally responsible for the welfare and support of a patient.

(i) "Qualified nutritionist" or "nutritionist" shall be held to mean any person who has been graduated with a bachelor's degree in home economics from an institution of learning approved by the Department of Education of the State of New York, including major studies in foods, nutrition or institutional management, and has had at least two (2) years experience as a nutritionist in a health or welfare agency, or who has received a masters degree in nutrition from such an institution and has had at least one (1) year of experience as a nutritionist in a health or welfare agency; or who has had the equivalent of such post-graduate training and experience as approved by the Commissioner.

(j) "Qualified dietitian" shall be held to mean any person who has been graduated with a bachelor's degree in home economics from an institution of learning approved by the Department of Education of the State of New York, including major studies in foods, nutrition or institutional management, and has had an internship as a dietitian in an institution approved by the American Dietetics Association, or the equivalent of such post-graduate training and experience as approved by the Commissioner.

(k) "Licensed physical therapist" shall be held to mean any person who holds a current license issued by the Department of Education of the State of New York to practice as a physical therapist and who has registered with such department in accordance with the provisions of the Education Law.

(l) "Qualified social worker" shall be held to mean any person who has a master's degree or certificate after successfully completing a two year course of study at a graduate school of social work accredited by the Council on Social Work Education or an equivalent as accepted for membership in the National Association of Social Workers and accredited by the Department of Education of the State of New York.

(m) "Recreation leader" shall be held to mean any person who holds a baccalaureate degree issued by an accredited college or university including or supplemented by eighteen (18) credits in recreation or group work; or an equivalent combination of education and experience approved by the Commissioner.

§ 2.02. **Licensure—General Provisions**

(a) No person or persons shall maintain or operate a home without a current license.

(b) The bed capacity of each home shall be approved by the Commissioner and so indicated on the license.

(c) A license issued by the Commissioner to operate a home is issued to a particular individual or individuals and for the designated place of business mentioned in the license. The license shall not be valid for use by an other person or persons, or at any place other than that designated in the license. Any transfer as to person or place shall cause an immediate forfeiture of such license.

(d) A license issued by the Commissioner shall expire one (1) year from the date of issuance or upon such dates annually as he may prescribe. Notwithstanding, any provision of this code the Commissioner may issue a provisional or restricted provisional license for a period not exceeding ninety (90) days when in his opinion the issuance of an annual license is not warranted.

(e) The license shall be posted conspicuously on the licensed premises.

(f) Before an initial temporary license will be issued, each home shall file with the Commissioner a copy of its current certificate of occupancy.

(g) Each applicant shall be over the age of 21 years; a citizen of the United States or a person who has declared his intention of becoming a citizen, a resident of New York

State; of reputable character, financially responsible, and who has not had a license to operate a nursing home revoked or whose license has not been renewed for cause. Each applicant shall furnish such other and further pertinent information as is indicated in the application or required by the Commissioner. Each applicant shall authorize the Commissioner to investigate and verify the information submitted to support the application for licensure.

(h) The Commissioner or his designated representative shall, at all times, have the right to inspect and investigate a home and all records pertaining thereto. They shall, at all times, have the right, under appropriate professional safeguards, to examine patients, inspect patients' medical records and conduct medical audits on any or all patients in a home.

(i) The Commissioner shall be notified in writing not less than thirty (30) days before changes in the ownership, physical plant or name of a home and immediately on change in bed capacity or any known or pending change in management. Such changes shall not be made until receipt of written approval from the Commissioner.

§ 2.03. **Application for an Initial Temporary License**

(a) An applicant for a license to operate a nursing home shall file with the Commissioner an application on an official form which will be furnished by the Commissioner. The application shall contain the name, address and occupation of each person, persons, entity or entities who will receive or who will be entitled to receive directly or through a designee, any pecuniary profit from the operation of the home, other than compensation for services rendered.

(b) In addition, the applicant shall submit the following:

(1) A complete set of preliminary floor plans and preliminary specifications for the building, and such portions of the working drawings as the Commissioner may require. In the case of an existing building, a complete set of floor plans showing present conditions and proposed alterations plus preliminary specifications for proposed alterations.

(2) Plans and specifications required herein shall be accurate and detailed and shall show dimensions of the square footage of usable clear space, location and specifications of the fixed equipment (Group I), beds and other non-fixed equipment (Group II). Subsequent requests for changes shall be submitted in writing to the Commissioner for his approval. Any revisions required by the Department of Buildings shall be resubmitted to the Commissioner for approval. All building plans and specifications required to be submitted to the Commissioner shall be prepared by an architect or a professional engineer duly licensed by the State of New York.

(3) A plan of organization which shall include the staffing pattern, the duties and the qualifications of all personnel including the administrator, the director of nursing service and their assistants.

(4) The maximum bed capacity.

(5) The name by which the home shall be known.

(c) The applicant shall furnish proof of compliance with all existing laws and regulations applicable to nursing homes.

(d) Plans for the construction of a home filed with the Department and approved by the Department of Buildings prior to January 16, 1963 shall be void unless construction has completed by January 16, 1964. Such plans shall comply with the minimum standards of this code applicable to existing homes. As Amended by the Board of Hospitals June 19, 1963.

(e) The Department will render information services to prospective applicants.

§ 2.04. **Licensed Bed Capacity**

Each home shall apply for a license to operate a specified number of beds. This will be known as the licensed bed capacity and shall be approved by the Commissioner. If at any time the licensee wishes to reduce the licensed bed capacity, he may advise the Commissioner that he will operate with a bed complement of a specified reduced number and maintain a patient-personnel ratio applicable to that number of beds. The bed complement shall mean either the licensed bed capacity or the number of beds approved by the Commissioner.

All beds or part thereof which represents the difference between the licensed bed capacity and the reduced bed complement may be retained in readiness, according to a plan approved by the Commissioner. If the home has an annual or provisional license, patients may be admitted at any time to those beds held in readiness subject to the following conditions:

(a) Employment of additional personnel so as to maintain patient-personnel ratios as set forth in this code.

(b) Written notification to the Department postmarked within twenty-four (24) hours of admission of patients in excess of the previously stated reduced bed complement, giving the names of such patients and the location of their beds in the home.

NOTES: Group I refers to equipment which is usually included in the construction contract, i.e. cabinets, counters, etc.
Group II refers to equipment which has a life of five (5) years or more and which is not normally purchased through the construction contract, i. e. bedroom furniture, examination tables, etc.

§ 2.05. **Application for Modification of an Existing Home**

Proposed changes in existing homes, such as changes in the physical plant, name of the home, bed capacity, staffing pattern or extent of services provided shall be submitted in writing on forms supplied by the Commissioner. Such changes shall not be made until the receipt of written approval from the Commissioner.

§ 2.06. **Issuance of License to a New Home**

After it has been determined that the applicant has complied with the requirements of the Department, the Commissioner may in his discretion issue a temporary license which shall expire not more than ninety (90) days from the date of issuance. If the home has been maintained and operated during this period of temporary licensure in compliance with the provisions of this code the Commissioner shall issue a regular annual license.

§ 2.07. **Renewal of License**

Two months prior to the expiration date of the annual license, an application for a renewal thereof shall be submitted to the Department on forms supplied by the Department. Upon receipt and review of the application and determination of the extent of compliance with the requirements of the Department, the Commissioner may issue:

(a) A regular annual license, or
(b) A provisional license, or
(c) A restricted provisional license.

§ 2.08. **Revocation or Non-Renewal of a License**

The Commissioner may revoke a license after a hearing and determination thereon.

(a) Grounds for revocation or non-renewal:
  (1) Failure to comply with federal, state and municipal laws, ordinances, standards, sanitary codes, and other codes, rules and regulations and orders applicable to nursing homes.
  (2) Conduct of a home in a manner deemed by the Commissioner to be detrimental to the health, safety or welfare of patients or employees.
  (3) The commission of immoral or illegal acts in the home.
  (4) Misrepresentation of a material fact by the licensee or his authorized representative.

(b) Notice of revocation or non-renewal. The Commissioner may revoke or refuse to renew a license for cause only after the licensee has been given an opportunity to be heard on the proposed revocation or non-renewal. The licensee shall be given notice in writing of such proposed revocation or non-renewal and the reasons therefor.

(c) The notice of hearing of proposed revocation or non-renewal of license shall be given at least ten (10) days before the hearing. The notice shall contain the date, time and place of said hearing. The notice shall be personally served on the licensee or when sent in writing by certified or registered mail to the licensee at the home or delivered there personally shall be deemed to be sufficient service of such notice.

(d) Revocation or non-renewal. Upon revocation or non-renewal of the license, written notice thereof shall be given to the licensee by personal service or sent to the home by registered or certified mail.

(e) Review of revocation or non-renewal by the Board. The licensee may upon revocation or non-renewal of a license, within ten (10) days after such decision, file in writing with the Secretary of the Board a request that the Board review the Commissioner's action. The Board shall, as soon thereafter as possible, review the facts and the Commissioner's decision. The Board's determination shall supersede the Commissioner's decision. The licensee shall be informed in writing of the Board's action.

(f) Notice of revocation or non-renewal when it becomes final, may be given to the Medical Society of the county in which the home is located and/or to the public through the press or otherwise. However, the patients, their nearest of kin or sponsors may be informed of revocation or non-renewal immediately after determination by the Commissioner.

§ 2.09. **Return of License**

Upon the revocation or expiration of a license, it shall be immediately removed from public view and promptly surrendered to the Department.

§ 2.10. **Relocation of Patients Upon Closure of a Home**

When the Commissioner has directed after a hearing that a home discontinue operation or an immediate forfeiture of license as provided in Section 2.02 (c), the patients in residence shall be transferred to other appropriate facilities not later than the date set by the Commissioner. Such transfers shall be effected by the licensee in consultation with the patients, their nearest of kin or sponsors, their physicians and the Department.

ARTICLE III STAFF ORGANIZATION AND QUALIFICATIONS

Section

§ 3.01. **Staff Organization**

(a) The licensee of each home, irrespective of the size of the home and number and type of patients admitted, shall provide a staff having satisfactory qualifications and the ability to carry out its responsibilities as defined in this code.

(b) The Commissioner shall review with each licensee and approve for each home the minimum number of personnel in all categories to be employed and the staffing pattern for each shift.

(c) The number of personnel in each category shall be based on the bed complement, the physical layout of the home and the types of services offered therein.

(d) The minimal ratio of nursing personnel to bed complement is set forth in Article VII Section 7.03.

(e) Provision shall be made for relief personnel during days off, vacations, sick leave and periods of emergency.

(f) All persons shall be on active duty at their respective stations during their tours of duty, unless relieved.

§ 3.02. **Selection and Training of Personnel**

All personnel shall be selected for their experience, ability and interest in working with chronically ill, disabled, infirm and aged persons. They shall receive an orientation to their jobs and to the operation of the home. On-the-job training shall be the responsibility of the appropriate department head.

§ 3.03. **Licensee**

The licensee shall be responsible for the care and safety of the patients, the provision and maintenance of the physical plant and equipment, the personnel policies and practices and the business management. The licensee shall not be a corporation.

§ 3.04. **Administrative Officer**

Each home shall be under the supervision of a qualified administrative officer. He shall be capable of directing the activities of the home to insure compliance with all applicable federal, state and local laws as well as the rules and regulations of city and state departments and the standards established by the Department. He shall devote his full time to the administration of the home. The administrator may be a licensee.

During periods of prolonged absence of the administrator, the licensee shall provide equivalent administrator coverage.

The administrator shall be an individual who is in good health; of good moral character; shall have successfully completed a high school education or its educational equivalent; and shall have successfully completed courses in hospital administration, nursing home administration, or other health service administration or their equivalent as approved by the Commissioner. The Commissioner may waive this last provision for those administrators who are employed in licensed homes at the time this code is adopted and who shall within a period of two (2) years complete such courses in hospital administration, nursing home administration or other health service administration.

§ 3.05. Director of Nursing Service

A registered professional nurse, who shall be known as the director of nursing shall be in charge of the nursing and personal care of all patients. Such nurse shall have appropriate training or experience in nursing administration satisfactory to the Commissioner and shall function under the general direction of the administrator. Such nurse shall be employed by the home on a full time basis. When the director of nursing finds it necessary to leave the premises, he or she shall, in consultation with the administrator, designate some other qualified registered professional nurse to act during such absence. During periods of absence of the director of nursing service, the administrator shall provide equivalent supervisory coverage.

The director of nursing service shall be responsible to the administrator for typical duties such as the following:

(a) Seeing that all patients receive proper nursing care.

(b) Reviewing the nursing requirements of prospective patients in terms of nursing services available in the home.

(c) Developing and having accessible in writing, clearly defined nursing service objectives.

(d) Developing and supervising the carrying out of the nursing procedures as set forth in the home's nursing procedure manual.

(e) Selecting, assigning, supervising and evaluating nursing personnel in the performance of their duties.

(f) Developing a job indoctrination program and a continuing in-service educational program for all nursing personnel.

(g) Developing job descriptions for all nursing personnel.

(h) Planning and budgeting for nursing personnel, equipment and facilities.

In addition to the foregoing, the Commissioner may require other responsibilities of the director of nursing service.

§ 3.06. Dietitian or Nutritionist

In all homes, the dietary service shall be under the regular supervision of a qualified dietitian or nutritionist whose training and experience shall be acceptable to the Commissioner. This dietitian or nutritionist may be employed part time or full time by an individual home or employed on a cooperative basis by two (2) or more homes. The frequency and timing of the supervisory visits and the number of homes which may be supervised by one (1) dietitian or one (1) nutritionist must be approved by the Commissioner.

In homes which do not employ a full time dietitian or nutritionist, the dietary service shall be under the supervision of a person who has had training and experience, acceptable to the Commissioner, in the handling, preparation and serving of food and in the supervision and management of food handlers.

§ 3.07. Social Worker

The social workers required by this code shall provide casework service or access to casework service to patients and their families requiring help in the resolution of their personal and social problems; participate in developing and carrying out the treatment program for each patient; assist patients to make a satisfactory adjustment to group living; enlist the cooperation of community agencies in rendering needed services to patients. The home shall make it possible for the patient to consult with the social worker in privacy.

§ 3.08. Recreation Leader

The recreation program in all homes shall be under the regular supervision of a recreation leader whose training and experience shall be approved by the Commissioner. The recreation leader may be employed part-time or full-time by an individual home or on a cooperative basis by two (2) or more homes. The frequency and timing of the supervisory visits and the number of homes which may be supervised by one (1) recreation leader must be approved by the Commissioner.

§ 3.09. Personnel Policies

Every home shall have personnel policies which shall be provided in writing to all employees. These policies shall specify or otherwise indicate the provisions which govern the condition of employment.

(a) Health of Personnel. The personnel employed in the nursing home shall be free from communicable diseases. Medical examinations of all personnel shall be made upon employment or within one (1) week thereafter. Repeat examinations shall be required annually and whenever necessary to ascertain that they are free of communicable diseases and are able to perform their assigned duties. The initial examination and subsequent annual examinations shall include a chest x-ray. There shall be pro-

vided in each home a first-aid kit for the emergency use of the employees. The control and maintenance of the first-aid kit shall be the responsibility of the director of nursing service or her designee.

(b) Dressing rooms and lockers, toilets, lavatories and dining facilities shall be provided in proportion to the number of personnel employed as set forth in this code.

(c) Personnel who reside in the home shall be provided with suitable living quarters separate and apart from patient areas.

ARTICLE IV ADMINISTRATION AND MANAGEMENT

Section

§ 4.01. Name of the Home

The words "Hospital" or "Sanitarium" shall not be used in the name of the home. The home shall use the name as it appears on the license for all listings, advertising and stationery. The name of the home shall not be changed without notification to and written approval from the Commissioner.

§ 4.02. Admission and Transfer Policies

The Commissioner shall have the right to determine the suitability of the placement of patients in homes and the need for their relocation. This relocation shall be accomplished in consultation with the patients, the nearest of kin or sponsors and the patients' physicians.

(a) Patients under sixteen (16) years of age shall not be admitted unless separate facilities are provided. These facilities shall conform to the requirements of the state and other city agencies.

(b) Maternity patients in pre-natal, intra-partum or post-partum period shall not be admitted.

(c) Patients suffering from the following diseases and conditions shall not be admitted:

(1) Patients who are harmful to themselves or to others.
(2) Patients whose usual behavior is so disturbing as to interfere with the care and comfort of other patients.
(3) Known active drug addicts, except patients suffering from terminal illnesses whose physicians have prescribed narcotic drugs.
(4) Reportable communicable diseases, including active tuberculosis.
(5) Any illness or condition which requires hospital care.

(d) Patients requiring diagnostic study, medical care or treatment of a level that cannot be performed in the home shall be transferred to a hospital or other appropriate health care facility. Such transfers shall be effected in consultation with the patient, his nearest of kin or sponsor and the patient's physician.

(e) The patient, the nearest of kin or sponsor shall agree as part of the admission agreement to a physician visit at least once every thirty (30) days and more often when medically indicated. The cost of these visits is to be paid to the physician by the patient, the nearest of kin or sponsor. If the patient's personal physician or alternate is not available, the administrator shall see that another physician visits the patient within thirty (30) days from the last examination.

§ 4.03. Location of Handicapped Patients

Legally blind and non-ambulatory patients shall not be housed above the street level floor unless the building is of fireproof class I construction and equipped with elevators and means of egress as provided for in this code and as approved by the Commissioner. For the purposes of this code, a non-ambulatory patient shall mean a person who, unaided, is physically or mentally not capable of walking a normal path to safety, including the ascent or descent of stairs.

§4.04. **Identification of Patients**

All patients shall be provided with identification bands of a type approved by the Commissioner.

§ 4.05. **Personal Life and Welfare of Patients**

The dignity and individuality of the patient shall be respected at all times. The home shall assist patients to maintain contact with family and friends. It shall permit each patient as much freedom of choice and opportunity to participate in activities in the community or in the home as is consistent with his safety and capabilities. The administrator and his staff with the direct help of the social worker shall become familiar with the services offered by local social agencies and voluntary organizations, establish working relationships with them, acquaint patients and their famililes with these services, and encourage their use.

(a) Patients shall be permitted as much personal freedom as their physical condition and the orderly management of the home permit. Patients, able to do so, shall be permitted to come and go at reasonable hours.

(b) Provision shall be made for maximum ambulation commensurate with the patient's condition. Unless a patient is bedfast by his physician's order, he shall be up and out of bed each day as much as his condition shall permit.

(c) Visiting hours shall be prominently posted. As a minimum, visiting shall be permited six (6) days a week from twelve (12) noon to eight (8) p.m. On the seventh (7th) day, visiting hours shall be confined to two (2) hours in the evening to permit general and heavy cleaning. Patients shall not be denied visitors unless so ordered in writing, by there personal physicians. In the case of critically ill patients, and at the discretion of the patients' physicians visiting shall be as often as the patients' conditions warrant.

(d) The home shall provide individual and group activities suited to the patients' needs and interests. These activities shall be supervised by a recreation leader. Each home shall have suitable recreational areas as defined in this code, and patients shall have free access to these areas. Activities shall be provided for the bedfast. The personnel of the home shall encourage all patients to participate in these activities to the extent of the patients' interest and capabilities. Homes shall make every effort to enlist the participation of outside social and recreational groups and contract or otherwise arrange for their services when desirable.

(e) Patients' spiritual needs shall be provided for as requested. Members of the clergy shall be permitted to see patients at all reasonable hours. The home shall make it possible for patients to practice their religious beliefs and to consult with their clergymen in private. Patients shall have the right to attend religious services as they choose.

(f) Patients shall not be locked in their rooms at any time.

(g) Patients' mail and packages shall be delivered intact and promptly. Patients' incoming or outgoing mail shall not be opened unless otherwise authorized in writing by the patient or his authorized representative.

(h) Patients' clothing and personal effects shall be appropriately marked and properly cared for.

(i) The home shall take care of and be responsible for all patients' monies and valuables. A written record of such monies and valuables shall be kept in the patients' personal folder and a written receipt for the same shall be given to the patient or his sponsor. Patients' monies and valuables shall be appropriately safeguarded and released at the request of the patient or his sponsor.

§ 4.06. **Notice to Nearest of Kin or Sponsor**

(a) A patient's nearest of kin or sponsor shall be immediately notified in the event of:

(1) Any accident which is reportable to the Department.
(2) Any sudden serious change in the patient's condition.
(3) Death of a patient.

(b) Except in emergencies, patients shall not be transferred out of the home or discharged for any reason without prior notification to the nearest of kin or sponsor. When the nearest of kin or sponsor cannot be reached or refuses to cooperate, proper arrangements must be made for the patient's welfare before transfer or discharge.

§ 4.07. **Fire Prevention, Fire Drills and Evacuation**

Each home shall consult with the Fire Department and comply with its rules, regulations and orders in the development of special programs for the prevention of fire and the protection of patients in the event of fire or other catastrophies. These programs shall include evacuation plans, establishment of fire brigades and frequency of fire brigade drills. Each home shall have a written record of the program so developed and shall maintain such other records as are required by the Fire Department.

It shall be the responsibility of the licensee to see that all personnel are oriented to and regularly participate in the carrying out of the fire prevention program, fire drills and evacuation plans of the home.

§ 4.08. **Telephone Service**

There shall be at least one operational, unlocked non-coin telephone installation on each floor of the home. In addition, there shall be coin operated telephones accessible to all non-bedfast patients.

§ 4.09. **Undesirable Occupancies or Activities in the Home Prohibited**

No occupancies or activities undesirable to the welfare and care of the patients shall be located in the building or buildings of a home.

§ 4.10. **Notice of Rate Schedule**

Every home shall exhibit to all persons applying for admission a complete statement enumerating in detail all charges, expenses and other assessments, if any, for services, materials, equipment and food, which shall or may be furnished or supplied to such patients during the period of residency. Such statement as herein provided shall be annexed to the application for admission provided by the home. No additional charges or expenses may be assessed against such patients in excess of that contained in such statement, except:

(a) Upon express approval and authority of the patient or his sponsor, if any, or

(b) Upon the express order of the attending physician of the patient, or

(c) Upon ten (10) days notice to the patient and to his sponsor, if any, of additional charges and expenses due to increased cost of maintenance or operation.

(d) However, in the event of any emergency affecting such patients, additional charges as are reasonable and necessary may be assessed for the benefit of such patients for services, material, equipment or food.

Notwithstanding the foregoing, rates for public assistance patients shall be determined by the Department of Welfare after negotiation with appropriate representatives of the home.

§ 4.11. **Prepayment and Refunds**

Prior to admission, the home shall inform or make known in writing to all prospective private paying patients or their sponsors, the refund policy of the home. When payment for care has been made in advance, a full refund shall promptly be made of the excess amount of the pre-payment in the event of death or when a patient is compelled to leave the home for reasons beyond the patient's control.

Contracts for the life care of patients are prohibited.

§ 4.13. **Rebating Prohibited**

Licensees or their representatives shall not pay any commission, bonus or gratuity in any form whatsoever to any physician, surgeon, organization, agency, or to any person, either directly or indirectly, for patients referred. Licensees or their representatives shall not receive from vendors, suppliers or others, any commission, bonus or gratuity in any form for services rendered to or for their patients.

§ 4.14. **Voluntary Closing of an Operating Home**

An operating home which closes voluntarily shall maintain a standard of service in compliance with the provisions of this code and shall not discontinue its operation until such time as provision has been made for the proper disposition of the patients therein.

ARTICLE V RECORDS AND REPORTS

Section

§ 5.01. **Filing and Accessibility of Records**

All homes shall keep complete and accurate records in a manner approved by the Commissioner. They shall be filed in accessible fire-resistant containers and be available for inspection at all times.

§ 5.02. **Maintenance of Records**

The licensee shall be responsible for the maintenance of all records which the home is required to keep.

§ 5.03. Length of Time for Records to be Kept

Except as otherwise provided in this code, all records shall be kept readily accessible for a period of at least six (6) years. In the event that a home discontinues operation for any reason whatsoever, the licensee shall notify the Department in writing where the patients' medical records will be stored for the length of time required herein. In the event of the transfer of a patient to another health care facility, a copy of the patient's medical record or an abstract thereof shall accompany the patient.

§ 5.04. Confidential Nature of Records

Information contained in patients' medical records is privileged and confidential. Disclosure of such information to unauthorized persons without the consent of patients or their sponsors is prohibited.

§ 5.05. Records to be Kept

The following records shall be kept:

(a) Chronological Admission Register which shall include for each patient at least the following:

(1) Nursing home admission number.
(2) Date of admission.
(3) Name, age, sex and marital status.
(4) Admitting diagnoses.
(5) Date of transfer, discharge, or death, including the name and address of the institution to which transferred or discharged.

(b) Patient's individual, Non-Medical Record, which shall include the following:

(1) Admission number
Sponsor's case number, if any.
Name and location of hospital from which patient was transferred and the in-patient number.
Name and location of hospital clinic and the out-patient number.
(2) Date of admission.
(3) Name, age, sex and marital status.
(4) Home address.
(5) Nearest of kin or sponsor—name, address, phone number, relationship.
(6) Referring person or agency or other interested party.
(7) Place from which patient was received.
(8) Religion.
(9) Personal physician, alternate, or alternate plan for coverage—names, addresses, phone numbers.
(10) Diagnoses on admission.
Diagnoses on discharge or death.
(11) Date of discharge or death.
(12) Name and address of physician who pronounced patient dead.
(13) Disposition of body.

(c) Patient's Personal Folder which shall contain the following:

(1) All agreements between the home and the patient or his sponsor.
(2) All account records.
(3) List of the patient's personal property and clothing received at any time by the home and for which a receipt has been given to the patient or his sponsor.
(4) Record of all monies and valuables belonging to the patient and for which a receipt has been given to the patient or his sponsor.
(5) All non-medical correspondence and papers concerning the patient.

(d) A Medical Record shall be kept for each patient. Such a record shall be a chronological history wherein the attending physicians, nurses and other paramedical personnel shall record the medical history, admission diagnoses, examinations, treatments, observations, therapeutic diets, orders and progress notes. Every entry shall be dated and signed at the time the examination, treatment, observation or order is effected. This record shall be kept, until the patient's discharge, at the nurses station adjacent to the patient's nursing unit. All parts of the current medical record shall be kept together in one folder or binder. However, the doctor's order sheet may be kept in a separate loose-leaf binder at the nurse's station. When a new doctor's order sheet becomes necessary, the preceding sheet shall be placed in the patient's medical record folder or binder. When a patient's current medical record becomes voluminous and unwieldy, the nurse's notes may be removed and placed in a separate folder or binder marked with the patient's name. This folder or binder shall be available when requested. The medical record shall contain all forms prescribed by the Department.

(e) Accident Register. In addition to the completion of the Accident Form in the patient's medical record, each home shall keep a chronological Accident Register which shall contain the following:

(1) Date, time and place of accident.
(2) Name of patient, employee or visitor involved.
(3) Nature of the accident.
(4) Disposition.
(5) Date on which accident report is completed and sent to the Department.

(f) Daily census record. This record shall be kept for at least one (1) year.

(g) Death Register.

(h) Dietary Record, containing copies of menus and corrected menus of food served during the preceding thirty (30) day period.

(i) Food Purchase Record, which shall contain the receipted invoices of the food and supplies purchased and received during the calendar month. This record shall be substantiated by monthly inventories and monthly food cost reports. This record shall be kept for six (6) months on forms approved by the Department.

(j) Narcotics Register, which shall be kept in conformity with the rules and regulations of the federal and state regulatory bodies.

(k) Fire Drill Record which shall have recorded in it the date, hour, description of the drill and the names and titles of the participants. This record shall be kept for at least one (1) year.

(l) Personnel Records. Complete, current personnel records shall be maintained on forms approved by the Department. Such records shall be kept separately for each employee, including the administrator, and shall contain the following:

(1) Employee's hours of duty and record of attendance in accordance with the requirements of the Department.
(2) Employee's Health Record which shall include the pre-employment and all subsequent physical examinations.

(m) Personnel Policies. Each home shall have a written record of its personnel policies and job descriptions of all its positions approved by the Commissioner.

(n) Financial Records shall be maintained and audited not less than annually by a certified public accountant.

§ 5.06. **Reports to the Department**

(a) Annual Report. Each home shall submit before January 31st of each year, on forms supplied by the Department, an annual report for the preceding calendar year.

(b) Accident Reports. Whenever an accident or an unusual incident occurs to a patient or employee, the responsible person on duty in the home shall complete an approved accident report in duplicate; the original shall be made a part of the patient's medical record and the copy shall be sent to the Department within seventy-two (72) hours.

(c) Other reports as the Department may require from time to time.

ARTICLE VI PATIENTS MEDICAL CARE

Section
6.01. Designation of a Personal Physician.
6.02. Qualifications of Physicians, Dentists and Podiatrists.
6.03. Admission Medical History and Examination.
6.04. Treatment and Discharge Program for each Patient.
6.05. Physician Visits.
6.06. Medications and Treatments.
6.07. Emergency Medical Care.
6.08. Isolation of Patients.
6.09. Restraints.
6.10. Social Service.
6.11. Dental and Ophthalmology Service.
6.12. Diagnostic Services.
6.13. Physical Therapy.
6.14. Podiatry Service.

§ 6.01. **Designation of a Personal Physician**

Each patient, at the time of admission to a home, shall designate a personal physician and alternate, or have a physician and an alternate plan for coverage designated by the sponsor or individual responsible for the patient. Medical care shall be provided by the patient's personal physician or the physician assigned by the sponsor or individual

responsible for the patient. It shall be the responsibility of the administrator to see that the patient receives such care as and when prescribed by the patient's physician. It shall be the responsibility of the administrator or his designee to see that a physician is promptly called at all times when a physician's services are required.

Notwithstanding the requirements contained herein, the medical, dental or podiatry services rendered to public assistance patients shall be provided by the sponsor.

§ 6.02. Qualifications of Physicians, Dentists and Podiatrists

All physicians, dentists and podiatrists who treat patients in homes shall hold a current license to practice in the State of New York.

§ 6.03. Admission Medical History and Examination

(a) Every patient admitted to a home shall undergo a complete physical examination by a physician within twenty-four (24) hours of admission unless he has had such an examination by his personal physician within five (5) days prior to his admission. This admission examination shall include vision and hearing screening and an inspection of the patient's mouth and dental structures. Within twenty-four (24) hours after admission, each patient's physician shall have completed in writing the proper medical history and physical examination forms indicating the date of the patient's physical examination, diagnoses and a course of treatment.

(b) The admission history shall contain a report of a chest X-ray taken within ninety (90) days prior to the patient's admission to a home.

(c) Every patient shall receive, within fourteen (14) days prior to or following his admission, a blood examination consisting of a hemoglobin or hematocrit and a white cell count. If indicated, a white cell differential shall be done. Every patient shall receive within fourteen (14) days prior to or following his admission, a complete urinalysis. Every patient shall routinely receive such a blood examination and urinalysis once a year and more frequently, if indicated. The administrator shall see that the results of the chest X-ray, of the blood examination and of the urinalysis are entered in the patient's medical record.

(d) There shall be a yearly review of each patient's dental and ophthalmological status with an appropriate entry made thereof in the medical record.

§ 6.04. Treatment and Discharge Program for Each Patient

An assessment of each patient's condition shall be made at the time of admission or within thirty (30) days after admission. This assessment shall be the basis for a comprehensive treatment and discharge program which shall be developed in writing for each patient. Such a program shall include plans for the patient's medical, nursing social and maintenance rehabilitation needs and length of stay. The patient's nearest of kin or sponsor, his physician, the administrator, the director of nursing service and the social worker on the staff of the home and/or from the sponsoring or other interested social agency, if any, shall participate in developing such a program. The administrator shall be responsible for seeing that this program is developed; that it is recorded in the patient's chart; implemented; and reevaluated at least once every six (6) months.

§ 6.05. Physician Visits

(a) Following each visit the physician shall enter a progress note in the patient's medical chart. He shall write legible orders for any changes in the patient's management involving medications, nursing care, treatment, diet, laboratory tests, X-ray examinations, medical referrals and consultations which are indicated. Orders concerning medications and treatments shall be in effect for the specified number of days indicated by the physician, but in no case shall they exceed a period of thirty (30) days, unless reordered by the physician.

(b) Every physician, who attends patients in a home, shall arrange for medical coverage for his patients during his absence or illness. He shall enter a note to that effect in his patients' records and notify the administrator of these arrangements.

(c) When a home receives reports of tests, consultations or treatments, the licensed nurse in charge and on duty shall immediately advise the appropriate physicians by telephone of these reports and make entries to that effect in the patients' charts. These entries shall include the recommendations of the physicians.

(d) The physician shall follow up all patient referrals for treatments, tests or consultations outside of the home. The patient's physician at the time of his next visit shall see that the results of these referrals are entered in the patient's medical record and acknowledge this by an entry in the progress notes.

§ 6.06. Medications and Treatments

(a) No medication or treatment shall be given except on the written and signed order of a physician, dentist or podiatrist, except that in an emergency telephone orders

may be accepted and acted upon by the licensed nurse in charge. The physician, dentist or podiatrist shall confirm these orders in writing within twenty-four (24) hours.

(b) Identification of medications. Medications individually prescribed for a patient shall be used for no other patient; medications shall be plainly marked with the name of the patient, the prescribed drug and dosage, the prescription number, the date of issue, the name of the prescribing physician, and the name, address and telephone number of the dispensing pharmacy.

(c) All drug reactions and medication errors shall be immediately reported to the patient's physician and an entry thereof made in the patient's medical record.

(d) Unused medications. Medications left in the home after the discharge or death of a patient for whom prescribed shall be destroyed except that all unused narcotics must be disposed of in accordance with appropriate federal and state laws.

§ 6.07. **Emergency Medical Care**

(a) Notification of patient's physician. In an emergency, including accidents reportable to the Department, or when there is a significant change in the patient's physical or mental condition, the patient's physician shall be called. If the patient's physician or alternate is not available, it shall be the duty of the person in charge of the home at the time to secure the services of another physician. When a physician does not respond within a reasonable time or the patient's condition deteriorates, the person in charge shall call for an ambulance.

(b) Roster of physicians and dentists on call. Each home shall maintain and post conspicuously in the nursing office, a roster of nearby physicians and dentists who can be called in emergencies. Physicians and dentists on the attending staffs of nearby hospitals, if available, should be included in this roster. The home shall not arrange for medical care except to the extent set forth herein.

(c) There shall be available at all times, an approved emergency tray containing essential medications, supplies and equipment.

(d) There shall be available at all times, at least one (1) tank containing eighteen-hundred (1800) liters (H size tank) of oxygen together with a functioning face mask, regulator and a flow meter. Every home shall have at least one (1) oxygen tank truck with a webbing strap for securing the tank to the truck.

§ 6.08. **Isolation of Patients**

(a) Any physician, nurse or administrator, upon discovering a patient affected with or suspected of having a communicable disease, shall secure the immediate isolation of such person and shall take such other action as is required by the Department of Health of The City of New York.

(b) The space and equipment provided for isolation care shall meet the requirements of this code.

(c) The director of nursing shall be responsible for the institution of proper isolation procedures and for the training and supervision of all personnel in carrying them out The procedures shall be those outlined in the New York City Health Code and shall be in keeping with the consultative advice of the Department.

§ 6.09. **Restraints**

A physical restraint is any apparatus, article, device or garment which interferes with the free movement of the patient and which the patient is unable to remove easily by himself. Restraints shall be of a type which can be removed promptly in the event of a fire or other emergency. Restraints shall not be applied unless required to prevent injury to the patient or to others, and shall be used only when alternative measures have failed to accomplish these purposes. They shall be applied only on the physician's written order which shall indicate the type of restraint, the reason therefor and the period during which the restraint is to be applied. In case of an emergency, a restraint may be applied temporarily pending the arrival of the patient's physician. No form of restraint shall be used or applied in such manner as to cause injury to the patient. A patient in physical restraints shall be visited by a member of the nursing staff at least once every half hour.

§ 6.10. **Social Service**

Every home shall on or after a date fixed by the Commissioner, employ at least one (1) qualified social worker or shall enter into an agreement with a recognized social agency or social service department of a hospital or other health agency to provide patients with direct access to casework services. The social worker may be employed part time or full time by an individual home or employed on a cooperative basis by two (2) or more homes. The amount of social work service in each home and the number of homes which may be serviced by one (1) social worker must be approved by the Commissioner.

§ 6.11. Dental and Ophthalmology Service

The nursing personnel shall be aware of the patients' needs for dental and ophthalmology services and shall bring these needs to the attention of the director of nursing service and/or the administrator, who shall notify the patients' nearest of kin, sponsors and physicians.

§ 6.12. Diagnostic Services

Clinical laboratory services other than those tests which can be properly performed in the home shall be expeditiously provided at the request of the patients' physicians by duly licensed laboratories. X-ray services shall be provided at the request of the patients' physicians.

§ 6.13. Physical Therapy

The administrator shall make arrangements to provide patients with physical therapy on the prescription of the patients' physicians. The physician shall prescribe what treatments and exercises are to be carried out by licensed physical therapists.

Every home shall have an exercise room for the carrying out of ambulation, elevation and other therapeutic exercises. The exercise room shall be of sufficient size to accommodate and permit the use of one (1) each of the following equipment:

Parallel bars
Shoulder wheel
Steps with a rail
Hand rail around the walls
Posture mirror

The physical therapy treatments shall be given either in the exercise room or the treatment room of the home. The minimal equipment shall consist of:

Treatment table if the exercise room is used for this purpose
Heat lamp
Hydrocollator
Leg exerciser (bicycle type may be attached to chair)

§ 6.14. Podiatry Service

The administrator shall make arrangements to provide patients with podiatry service at the request of the patient, the patient's nearest of kin or sponsor, physician or nurse.

Following each visit the podiatrist shall enter a progress note in the patient's medical chart.

ARTICLE VII NURSING SERVICE

Section
7.01. Provision of Nursing Care
7.02. Criteria for Nursing Care
7.03. Required Nursing Personnel
7.04. Handling of Medications

Introductory Notes

Skilled nursing care includes those procedures employed in caring for the sick which require some technical nursing skill beyond that which the ordinary untrained person can adequately administer. These may include full bed baths, enemas, irrigations, catheterizations, application of dressings or bandages, administration of medications by whatever method the physician orders (oral, rectal, hypodermic, intra-muscular), and other treatments prescribed by the physician.

The personnel of a home shall cooperate with physicians in programs designed to reduce or prevent incontinence and reduce bedfastness by encouraging activity, ambulation, self help and maintenance of range of motion to prevent or reduce physical disabilities.

§ 7.01. Provision of Nursing Care

The nursing service shall, at all times, provide for every patient such skilled nursing care and supervision as will protect his physical and emotional well being.

Such nursing care shall be carried out consistent with the treatment program developed for each patient following admission but shall be adaptable to changes in the patient's condition.

Proper nursing care includes but is not limited to periodic observation of each patient by members of the nursing staff throughout the day and night; visiting, at least once an hour, bedfast patients who are unable or unwilling to use the nurses' call system; recording of pertinent observations in the nurses' notes at least once during each nursing shift; accompanying physicians when they visit their patients.

§ 7.02. Criteria for Nursing Care

(a) Evidence of good personal hygiene.
(1) Baths—for ambulatory patients—at least once weekly; for bedfast patients—

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at least twice weekly; for incontinent patients—in addition to routine baths —body to be cleansed after each voiding or bowel movement.
Nursing personnel shall assist in the bathing of those patients who cannot do so by themselves.

(2) Clean skin.
(3) Clean mouth, teeth and dentures.
(4) Absence of dried, cracked lips.
(5) Clean, trimmed finger and toe nails.
(6) Clean, well groomed hair.
(7) Freedom from offensive odors.

(b) Proper care to prevent decubitus.
(c) Shaves when indicated.
(d) Protection from and prevention of accident and injury.

§ 7.03. **Required Nursing Personnel**

Every home shall have sufficient nursing personnel, including at least one licensed nurse on duty and working in the home at all times, to assure complete, safe and efficient nursing care for all of its patients. Such personnel shall be available at all times to respond promptly to patients' needs and requests. The nursing personnel shall not be assigned duties other than those associated with giving care to patients.

The following nursing personnel shall be the minimum who shall be on duty daily:

(a) At least two (2) registered nurses for the first sixty (60) beds, or part thereof, and one (1) additional registered nurse thereafter for every sixty (60) beds or part thereof which the home is maintaining as its bed complement. The registered nurses required herein shall be assigned to one (1) eight (8) hour tour of duty during each twenty-four (24) hour period.

(b) The registered nurses required herein shall be assigned so that at least one (1) registered nurse shall be on duty during the morning tour of duty and one (1) registered nurse shall be on duty during the night tour of duty. When more than two (2) registered nurses are employed, at least one (1) registered nurse shall be assigned to the afternoon tour of duty.

(c) The director of nursing service shall not be included in this minimum staffing pattern in homes having more than one-hundred-twenty (120) beds.

(d) In addition, practical nurses shall be employed in a ratio of one (1) to every twenty (20) beds or part thereof which the home is maintaining as its bed complement. In no event shall the home have less than two (2) practical nurses unless it provides facilities for less than ten (10) patients in which case it shall provide at least one (1) practical nurse in addition to the requirements set forth in paragraph (a).

(e) The home shall provide at least one (1) attendant for every five (5) beds, or part thereof which the home is maintaining as its bed complement.

(f) The Commissioner, after a hearing, may require any home to provide such additional nursing personnel as he deems necessary.

(g) On or before the tenth (10th) day of each month the licensee shall file with the Department a report on a form prescribed by the Department, which shall list the names and titles of the persons employed in the nursing service, together with their attendance records for the preceding month. The licensee shall sign the report and certify under oath to the accuracy of the information contained therein.

(h) Private duty nursing personnel shall not be included in the above quotas.

§ 7.04. **Handling of Medications**

(a) The handling and safeguarding of all medications in current use shall be assigned to the licensed nursing personnel.

(b) They shall administer medications only from containers that are legibly marked by securely attached labels; are in their original containers and kept separately for each patient except for such bulk medication which the home is permitted to keep with the approval of the Department.

(c) Medications which require refrigeration shall be kept properly refrigerated in clearly marked locked containers which are kept separated from food.

(d) Medications, other than those which must be refrigerated, shall be kept in locked cabinets. These cabinets shall be well lighted. The key to these cabinets shall be in possession of the nurse in charge or the administrator. Medications shall not be left unguarded at any time.

(e) Narcotics shall be stored in a locked box which is securely fastened inside a locked, stationary medicine cabinet.

(f) Barbiturates and other habit forming medications shall be stored in a locked box separate and apart from narcotics.

(g) Poisons and medications marked for "External Use Only" shall be kept in a locked cabinet separate from general medications and narcotics.

(h) No medication shall be left in patients' bedside tables except that such items as dusting powder and skin lotion may be retained by patients in their bedside tables.

(i) Medications shall be destroyed if the label becomes indistinct or mutilated. If the medication shows signs of deterioration, or the medication has reached the expiration date, it shall be discarded.

(j) Medication shall not be transferred from one container to another nor shall a container be relabeled.

ARTICLE VIII DIETARY SERVICE

Section
8.01. General Requirements
8.02. Evaluation of the Dietary Service.
8.03. Diet.
8.04. Menus.
8.05. Dietary Procedures.

§ 8.01. General Requirements

All food service personnel shall have clean hands and fingernails; they shall wear clean washable outer garments; be free from communicable diseases and open infected wounds. They shall observe all food handling requirements of the Department of Health.

The home shall provide its patients with well-planned, attractive and satisfying meals which shall meet the patients' nutritional needs.

The home shall encourage the regular use at meal time of the dining room facilities by all patients who can come or be assisted to the dining room. These dining room facilities shall be separate and apart from the dining room facilities for the home's personnel, except as otherwise provided in this code.

§ 8.02. Evaluation of the Dietary Service

The Department shall evaluate the operation of the dietary service of each home by periodic inspections; consultations with the dietitian or nutritionist; and by examination of the records and reports of the dietary service.

§ 8.03. Diet

Patients' food and nutrient needs shall be met in accordance with the current Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity.

(a) All food shall be served to patients in a palatable and attractive state and at the proper temperature.

(b) Each patient shall be served a minimum of three meals a day. Meals shall be served approximately five (5) hours apart with not less than ten (10) hours between breakfast and a substantial evening meal. No more than fourteen (14) hours shall elapse between the evening meal and breakfast.

(c) Nourishments shall be served between supper and the time when patients retire for the night when the evening meal is served before five (5) p. m.

(d) Where patients have problems of mastication, foods shall be prepared and served in a form which such patients can eat.

(e) Patients with poor appetites shall be served small quantities of easily eaten and nourishing food at regular intervals in order to insure an adequate intake.

(f) Service shall be provided for patients who need to be fed or who need help with eating.

(g) Therapeutic diets, ordered by physicians, shall be served as prescribed.

§ 8.04. Menus

(a) All menus shall be planned and written at least one week in advance.

(b) Menus shall be different for the same days of consecutive weeks and adjusted for seasonal changes.

(c) Menus shall be reasonably adapted to the food habits of the patients.

§ 8.05. Dietary Procedures

Adequate space and equipment shall be provided for the sanitary and efficient storage, preparation, handling and serving of food, and for the washing, sanitizing and storing of dishes, utensils, trays and food carts. Location, space allocations and equipment for the dietary service shall be approved by the Commissioner and shall conform with the requirements of the Department of Health.

(a) All perishable food and drink shall be properly refrigerated as provided for in this code.

(b) All kitchen equipment used in the home shall be kept clean and free from dust, dirt, insects and other contaminating materials.

(c) Dish and cooking utensil washing areas shall be separate and apart from food preparation and serving areas.

(d) All eating and drinking utensils and trays used in the preparation and the serving of food and drink shall be cleaned and sanitized after each usage.

(e) Hand washing facilities, including hot and cold running water, soap and individual towels, preferably paper towels, shall be provided in kitchen areas and pantries.

(f) The ceiling, walls and floors of all rooms used in the food preparation areas shall be constructed of material that is easily cleaned and shall be kept clean. Floors and walls to a height of five (5) feet from the floor shall be waterproof, nonporous, and grease resistant. Floor surfaces shall be of materials which can be easily maintained in a safe and non-slippery condition. The rooms shall be properly ventilated and lighted according to the provisions of this code.

(g) Storerooms shall be clean and well ventilated. All food shall be stored above the floor and shall be protected from unnecessary handling and from dust, flies, rodents, vermin, droplet infection, overhead leakage or other sources of contamination.

(h) All garbage shall be placed in watertight garbage receptacles with tight fitting covers. Every receptacle shall be kept covered except when being filled or emptied. Immediately upon emptying, such receptacles shall be properly cleaned. All garbage and other waste material shall be removed from the premises daily except Sunday and shall not be permitted to become a nuisance.

ARTICLE IX HOUSEKEEPING SERVICE

Section
9.01. Personnel.
9.02. Duties.
9.03. Linen and Laundry.

The interior and exterior of the nursing home shall be maintained in a clean, safe and orderly manner using accepted practices and procedures.

§ 9.01. Personnel

Housekeeping personnel shall be on duty in accordance with the staffing pattern approved by the Commissioner. Nursing personnel shall not be assigned to regular housekeeping duties.

§ 9.02. Duties

(a) The housekeeping personnel shall keep the home neat, clean, free of accumulations of dirt, rubbish and dust and keep the home free from offensive odors and safety hazards.

(b) The housekeeping personnel shall be responsible for the storage, in properly designated areas, of patients' possessions, unused furniture and equipment, bed clothes, linen and similar items.

(c) Only employees who are trained to do so shall be permitted to manually operate the elevators in a home.

§ 9.03. Linen and Laundry

(a) A home shall have at all times in use and in the laundry a quantity of patient linen essential for proper patient care equal to at least twice its bed capacity. In addition, a home shall have in reserve at all times a quantity of clean, essential patient linen equal to at least one-half (½) its bed capacity.

(b) Clean linen and clothing shall be stored in areas approved for such purposes by the Commissioner. Soiled linen and clothing shall be stored separately in suitable bags or containers in properly located areas approved for such purposes by the Commissioner.

(c) Soiled laundry shall not be sorted, laundered, rinsed or stored in bathrooms, patient rooms, kitchens or food storage areas.

(d) Soiled laundry shall not be permitted to accumulate in the home so as to create unsanitary conditions.

(e) The drying of laundry shall be permitted only in areas approved for such purposes by the Commissioner.

ARTICLE X PLANT AND EQUIPMENT

Section
10.01. General Requirements.
10.02. General Building Provision.
10.03. Entrance to the Home.
10.04. Halls, Ramps and Stairs

10.05. Doors and Doorways.
10.06. Windows.
10.07. Surfaces.
10.08. Elevators.
10.09. Heating.
10.10. Ventilation.
10.11. Lighting.
10.12. Communications System.
10.13. Sprinklers and Fire Alarms.
10.14. Toilets, Baths and Showers.
10.15. Janitor Closets.
10.16. Patient Rooms.
10.17. Special Care Rooms.
10.18. Treatment and Examining Rooms.
10.19. Nurses Stations.
10.20. Utility Rooms.
10.21. Day Rooms.
10.22. Office of Director of Nursing Service.
10.23. Dietary Department (see also Article VIII).
10.24. Recreation and Diversional Facilities for Patients.
10.25. Office Space and Equipment.
10.26. Laundry Facilities.
10.27. Storage Areas.
10.28. Delivery and Receiving Areas.

§ 10.01. **General Requirements**

Homes shall be so located, designed and operated as to furnish at all times a safe, sanitary and pleasant environment for all patients. Proximity to sources of noise greater than street level, such as airports, railroads, and factories, shall be avoided. Homes shall be located in areas accessible to public transportation and reasonably free from noxious and hazardous smoke and fumes. Suitable walks or space for outdoor recreation shall be made available to all ambulatory and wheel chair patients.

§ 10.02. **General Building Provision**

(a) Every home shall be of Class I fireproof construction as defined by the Administrative Code and shall be constructed throughout in accordance with the Administrative Code except as modified herein.

(b) Each floor occupied by thirty (30) or more patients shall be divided into at least two (2) fire sections by "Fire Partitions" as defined by the Administrative Code. At least thirty (30) square feet per patient shall be provided on each side for the total number of patients on the floor. Partitions shall be continuous through any concealed space such as between ceilings and floor or roof above. Openings in such fire partitions shall occur only in public rooms or corridors, and shall conform to the requirements of the Administrative Code.

§ 10.03. **Entrance to the Home**

Every home shall have at least two (2) entrances. At least one (1) of these entrances shall provide access from the street or sidewalk level to the entire street floor of the home without traversing a stair either inside or outside the entrance.

§ 10.04. **Corridors, Stairs and Ramps**

(a) Corridors

(1) Existing homes shall have until May 17, 1964 to provide corridors which are at least sixty (60) inches in width.
(2) New homes shall provide corridors which are at least ninety-six (96) inches in width.
(3) There shall be no dead end corridors.
(4) All corridors shall have alternate means of egress remote from each other.
(5) No corridor shall extend more than one hundred (100) feet without a fire partition as required in Section 10.02 (b). Additional fire partitions may be required by the Commissioner.
(6) No corridor shall extend more than one hundred and fifty (150) feet without a legal means of exit.
(7) Handrails shall be provided on both sides of all corridors. These shall be firmly anchored and shall not project more than three and one-half (3½) inches into the required minimum width. They shall be thirty (30) to thirty-six (36) inches above the floor.

(b) Stairs
(1) All stairways shall be not less than forty-four (44) inches in width unless a greater width is required by the Department of Buildings.
(2) Surfaces of treads and landings of stairs shall be constructed and maintained in such a manner as to prevent slipping thereon.
(3) Handrails shall be provided on both sides of all stairs. These shall be firmly anchored and shall not project more than three and one-half (3½) inches into the required minimum width. They shall be thirty (30) to thirty-six (36) inches above the floor.

(c) Ramps
(1) Existing homes shall have until May 17, 1964 to provide ramps where required which are at least sixty (60) inches in width.
(2) New homes shall provide ramps which are at least ninety-six (96) inches in width.
(3) Ramps shall have a maximum slope of five (5) per cent except that with the specific approval of the Commissioner, the maximum slope may be not more than ten (10) per cent.
(4) Ramps with slopes greater than five (5) per cent shall not be used by unattended patients.
(5) Surfaces of ramps shall be constructed and maintained in such a manner as to prevent slipping thereon.
(6) Handrails shall be provided on both sides of all ramps. These shall be firmly anchored and shall not project more than three and one-half (3½) inches into the required minimum width. They shall be thirty (30) to thirty-six (36) inches above the floor.

§ 10.05. **Doors and Doorways**

(a) Width of patient area doorways
(1) Existing homes shall have until May 17, 1964 to provide doorways which shall accommodate a door of not less than thirty (30) inches in width to community dining rooms, recreation rooms and patient bedrooms.
(2) New homes shall provide doorways to rooms and areas used by patients which shall accommodate a door of not less than forty-four (44) inches in width.

(b) Width of other doorways. Doorways to toilets in patient bedrooms and to all other spaces shall accommodate doors of not less than thirty-six (36) inches in width.

(c) Height of doorways. All doorways shall be not less than eighty (80) inches in height.

(c) Thresholds. All doorway thresholds shall be flush with the floor.

(d) All doors shall swing into spaces served except for individual toilet rooms and except as otherwise required by the Administrative Code; all swing doors shall open to at least ninety (90) degrees.

(e) Locks. No locks or hooks which prevent entrance or egress shall be installed on doors to spaces used by patients.

(f) Vision panels shall be provided in all double action doors. Panels shall be of wired or tempered glass. The top of each panel shall be not less than five (5) feet from the floor and the bottom of each panel shall be not more than four (4) feet from the floor.

(g) Outside doors, except fire doors, shall be screened from May 1st to November 1st with sixteen (16) mesh wire screening or its equivalent.

§ 10.06. **Windows**

Windows in all patient areas shall provide a minimum area of natural light of twelve and one-half (12½) square feet per one-hundred (100) square feet of floor area or major part thereof. All windows shall provide a minimum area of five (5) square feet of ventilation per one-hundred (100) square feet of floor area or part thereof unless mechanical ventilation is provided as required in this code. Window sills in areas used by patients shall be low enough so that the view of wheel chair and bedridden patients is not obstructed. All windows with sills less than three (3) feet from the floor shall be provided with readily removable window guards or special safety screens. Operable windows shall be installed and maintained so as to be easily opened and closed. From May 1st to November 1st, operable windows shall be provided with removable screens with sixteen (16) mesh wire screening or the equivalent for the full area of the operable sash.

§ 10.07. **Surfaces**

(a) Interior finish surfaces shall have a flame spread rating as established by the American Society for Testing Materials Standard E 84-61 not in excess of seventy-five

(75) except that in corridors, exit ways, storage rooms and rooms of unusual fire hazard the flame spread rating of interior finish surfaces shall not exceed twenty (20).

(b) All interior surfaces shall be of materials which are easily maintained in a sanitary condition. All floor surfaces shall be of materials which are easily maintained in a safe and non-slippery condition. All surfaces, finish, trim, etc., shall be simple in profile, easily kept clean and approved by the Commissioner. Cove bases shall be provided at the junction of all floors and walls. Cove bases shall not project more than one-eighth (⅛) inch beyond the surface of the floor or wall.

§ 10.08. **Elevators**

(a) Homes with patients housed on other than the street floor shall have at least one elevator.

(b) Homes with a bed capacity of sixty-one (61) to two-hundred (200) beds above the street floor shall have not less than two (2) elevators. Homes with a bed capacity of more than two-hundred (200) beds above the street floor shall have at least three elevators. The Commissioner shall determine the need for additional elevators by reason of the plan of the home, the patient activities and the patient services.

(c) Platforms of all required passenger elevators shall be not less than five (5) feet four (4) inches by eight (8) feet clear area, with cab and shaft doors not less than three (3) feet ten (10) inches in width.

(d) All elevators shall be equipped with automatic floor leveling devices and self closing doors.

§ 10.09. **Heating**

(a) Every home shall be equipped with a central heating system which is adequate to maintain a minimum temperature of seventy-five (75) degrees Fahrenheit throughout the home when the outside temperature is zero (0) degrees Fahrenheit.

(b) Portable room heaters are prohibited.

(c) Heating fixtures shall be shielded for the safety of patients.

(d) Each heating source shall be equipped with hand controls unless an individual automatic room control is provided.

(e) Each patient room shall be maintained at a temperature of seventy-two (72) degrees Fahrenheit when the outside temperature is less than fifty-five (55) degrees Fahrenheit. No exception shall be made unless otherwise ordered by a patient's physician.

(f) Each patient room shall have an accurate room thermometer securely mounted at bed level on the wall furthest from the heating unit.

§ 10.10. **Ventilation**

Rooms and spaces which do not have outside windows, and which are used by patients or personnel, shall be provided with forced or other approved ventilation to change the air at least once in six (6) minutes.

§ 10.11. **Lighting**

(a) Electric lighting shall be provided throughout the home in accordance with the latest recommended levels of the Illuminating Engineering Society. The use of candles, kerosene oil lanterns, or other open flame methods for illumination is prohibited.

(b) Lighting shall be designed for comfortable and efficient seeing. Maximum brightness ratios between tasks and adjacent surroundings shall be three (3) to one (1).

(c) In addition to the general lighting, night lighting shall be provided in corridors, toilets and similar areas to provide a lighting level of not less than five (5) foot candles; night lighting in patients' rooms shall be not less than one (1) foot candle.

(d) All spaces used by patients shall have the light switches located within reach of wheel chair patients unless the lights are on continuously.

(e) Emergency lighting shall be provided for boiler room, exits, stairs, patient corridors and nurses' stations. Such emergency lighting shall be supplied by an automatic emergency generator or a battery, and shall have a capacity sufficient to supply and maintain the total emergency lighting load for a period of at least four (4) hours. This emergency lighting shall be immediately available when required and continuously maintained in proper working order.

§ 10.12. **Communications System**

(a) An electrical call system, approved by the Commissioner shall be provided at each patient's bed. This system shall register above the door to the room where the call originates and at the nurses' stations, utility rooms and floor pantries.

(b) In addition, there shall be provided an emergency electrical call system from all toilets, baths and shower enclosures. In these locations, the activating device shall be accessible to patients. This emergency call system shall register at the nurses' stations a signal distinctly different than that of the signal from patients' rooms.

§ 10.13. **Sprinklers and Fire Alarms**

(a) All new construction shall be protected throughout with an approved automatic wet-pipe sprinkler system equipped with approved sprinkler alarms connected directly to Fire Headquarters through an approved Central Station.

(b) Existing homes

(1) All existing homes in other than Class I construction shall be protected throughout with an approved automatic wet-pipe sprinkler system equipped with approved sprinkler alarms connected directly to Fire Headquarters through an approved Central Station.

(2) All existing homes in Class I construction shall be inspected by the Fire Department which will make appropriate recommendations to the Commissioner.

(c) Every home shall be protected throughout with an approved local electric interior fire alarm system, installed in accordance with the Administrative Code and Interior Fire Alarm Rules of the Board of Standards and Appeals.

(d) Every home shall provide a watchman or a watchman service satisfactory to the Fire Department who shall visit all portions of the premises at regular and frequent intervals and an approved system of time detectors to properly record the movements of the watchman.

(e) The installation and types of all sprinkler and fire alarm systems shall be approved by the Department of Buildings and the Fire Department.

§ 10.14. **Toilet, Bath and Shower Facilities**

Toilet and washing facilities for staff and visitors shall be separate from those used by patients.

(a) Facilities for patients.

(1) If centralized toilets are provided, there shall be on each patient floor at least one (1) water closet and one (1) lavatory for each eight (8) beds on that floor.

(2) Of this number there shall be provided on each floor at least one (1) water closet and one (1) lavatory designated for each sex if both sexes are to be accommodated on the same floor.

(3) In new homes, there shall be provided close to all patient areas other than nursing areas, at least one (1) water closet and one (1) lavatory for patients of each sex. In other than new homes existing toilet facilities close to these areas may be approved by the Commissioner.

(4) Of the total patient toilets, at least one (1) toilet per sex per floor shall be built for use by patients confined to wheelchairs; the toilet enclosure shall be at least five (5) feet wide by six (6) feet deep and shall have a curtain instead of a door. The lavatory basin shall be at least two (2) feet ten (10) inches from the floor and shall be wall-hung to provide for easy access. The front edge of the lavatory shall be set not less than twenty-two (22) inches from the wall to which it is attached.

(5) There shall be provided on each floor at least one (1) bathtub or shower for each ten (10) beds on that floor.

(6) Where bathtubs are provided, at least one (1) bathtub per floor shall be accessible from three (3) sides and shall be installed with the tub bottom at least twelve (12) inches above the floor.

(7) Where showers are provided, at least one (1) shower enclosure shall be at least four (4) feet square. The shower stall shall contain a rust-proof, sturdy chair with openings for the bathing of a patient's rectal and back areas. The shower floor shall be flush with no curb and may be slightly sloped to drain. Mixing valve and controls shall be outside the shower stall.

(8) All tubs, showers and toilet enclosures shall be equipped with grab bars at least one (1) inch outside diameter, mounted with at least five (5) inches clearance between bar and wall.

(a) Each water closet shall have grab bars on each side approximately one (1) inch to one and one-half (1½) inch outside diameter by twenty-four (24) inches long, mounted approximately thirty-two (32) inches above and parallel to the floor.

(b) Each tub shall have a grab bar at one end approximately thirty-two (32) inches above and parallel to the floor.

(c) Each shower shall have one (1) grab bar approximately thirty-two (32) inches above the floor, easily accessible to patients while stepping into the shower. Each shower shall also have one (1) grab bar fourteen (14) inches long and mounted approximately thirty-two (32) inches above and parallel to the floor on the wall with the shower controls.

(9) All exposed heating pipes, hot water pipes and drain pipes shall be covered or insulated.

(10) All hot water outlets shall be supplied with water which is thermostatically controlled to provide a maximum water temperature of one hundred ten (110) degrees Fahrenheit at the fixture. The thermostat control shall be locked.

(b) Facilities for staff:

There shall be provided at least one (1) water closet and one (1) lavatory for each fifteen (15) persons or part thereof working at any one time. Where feasible, these should be located close to the following facilities:

Nurses Station	Laundry
Kitchen	Administrative Offices
Employees Dining Room	Employees dressing rooms and lounges

(c) Every home shall have at least one (1) conveniently located public water closet and lavatory for each sex. In larger homes, the Commissioner may require additional public toilet facilities.

§ 10.15. **Janitor Closets**

(a) There shall be at least one janitor's closet for each floor and such additional closets as the Commissioner may direct.

(b) The closet shall contain a service sink equipped with hot and cold running water and facilities for the storage of cleaning equipment and materials.

§ 10.16. **Patient Rooms**

(a) Nursing units. No nursing unit shall comprise more than forty (40) beds unless additional facilities are provided for them as may be required by the Commissioner, nor shall it encompass beds on more than one (1) floor.

(b) Size of rooms. The minimum floor area of patient rooms, exclusive of closets and/or lockers, toilet, bath, shower and entry ways, shall be as follows: one hundred (100) square feet for private rooms; eighty (80) square feet per bed for other rooms. All rooms shall have a ceiling height of at least eight (8) feet. Each bed shall be at least three (3) feet from any other bed and two (2) feet from any lateral wall. All beds shall be approachable from two (2) sides and one (1) end. If the head or foot of a bed is placed against an exterior wall, it shall be placed at least three (3) feet from any window. An unobstructed passageway of at least three (3) feet shall be maintained at the foot of each patient bed.

(c) Number of beds. In new homes patient rooms shall contain no more than four (4) beds.

(d) Location. The floor level of all patient rooms shall be above the legal curb level of the street front or above grade level adjacent to the building, whichever is higher. All patient rooms shall be outside rooms and shall have windows in accordance with the provisions of this code. All patient rooms shall be directly accessible to a main corridor. Patients rooms shall not be used for passage from one part of the home to another.

(e) Equipment

(1) Each patient room shall have a lavatory with hot and cold running water except where a lavatory is provided in adjoining bathroom or toilet facilities. There shall be an eye level mirror which can be angled downward.

(2) In rooms accommodating more than one patient, flame proof curtains or other approved means shall be provided to permit temporary privacy to each bed.

(3) At least one (1) duplex electrical outlet per bed shall be provided at each patient's bedside. There shall be not more than twelve (12) feet between duplex electrical outlets, measured around the circumference of each patient room. These outlets shall not be used for cooking appliances.

(4) A reading light shall be provided for each patient.

(5) Patient rooms shall be conspicuously identified by numbers rigidly fastened or plainly painted on the door or next to the entrance to the rooms.

(f) Furnishings. Each patient shall be provided with the following:

(1) Bed. A Gatch-spring type hospital bed which shall be at least seventy-six (76) inches long and thirty-six (36) inches wide; it shall be substantially constructed; equipped with a headboard and swivel lock casters or glides and shall be maintained in good repair. When necessary, variable height beds should be provided. Cots or folding beds are prohibited.

(2) Mattresses. Each bed shall be provided with a clean, comfortable mattress, at least five (5) inches thick, thirty-six (36) inches wide, and seventy-six

(76) inches long. When foam rubber is used the mattress shall be at least four (4) inches thick. The mattress shall have at least four (4) handles strong enough to permit the carrying of a person weighing at least two-hundred (200) pounds. Each mattress shall be protected by waterproof non-combustible material which shall cover the top surface of the mattress, but not cover the carrying handles.

(3) Pillows. Each bed shall be provided with a minimum of one (1) clean, comfortable pillow of standard size, unless otherwise requested by the patient or his physician.

(4) An approved hospital-type bedside cabinet.

(5) A hospital-type overbed table for all non-ambulatory patients.

(6) A comfortable straight chair with arms.

(7) Foot stools, when provided, shall be not less than ten (10) inches by fourteen (14) inches wide and eight (8) inches high; tip proof and equipped with floor gripping rubber feet and with rubber tread cemented to the top of the step.

(8) A washable and non-combustible waste basket.

(9) Other. In addition to the above, there shall be provided:

(a) Bedside equipment consisting of a bed pan, a wash basin, a urinal for male patients, an emesis basin and a glass or cup.

(b) Bedside rails when ordered by a patient's physician.

(c) At least one (1) easy chair per patients' room.

(10) Clothes storage shall be provided in accordance with the provisions of this code.

§ 10.17. **Special Care Rooms**

(a) Number required. There shall be provided for each forty (40) beds at least one single bedroom, available for immediate occupancy by a patient suspected or diagnosed as having a communicable disease or for a patient, from a multi-bed room, who is in the terminal phases of illness.

(b) Location. Special care rooms shall not communicate directly with any other patient rooms.

(c) Equipment.

(1) Every such room shall be fully equipped to carry out isolation techniques as established by the Department and in conformity with the New York City Health Code.

(2) Every such room shall be provided with private toilet and lavatory facilities. Lavatories shall be equipped with other than hand controls.

(3) Every such room shall be provided with a bed pan cleaning facility.

(d) Except as specified above, such rooms shall conform to all provisions of this code.

§ 10.18. **Treatment and Examining Rooms**

(a) Number required. At least one treatment room shall be provided for every forty (40) beds or part thereof. This room can be used by physicians as an examining room.

(b) Location. The treatment room shall be centrally located with respect to patient rooms.

(c) Size. The treatment room shall have a clear area of at least nine (9) feet by eleven (11) feet.

(d) Equipment. Each treatment room shall be provided with the necessary equipment, including but not limited to:

(1) A sink with hot and cold running water equipped with other than hand controls.

(2) A soap dispenser and towel rack.

(3) An examining table.

(4) An instrument table.

(5) An instrument sterilizer unless this operation is performed elsewhere.

(6) A waste receptacle with self closing lid.

(7) Storage cabinets.

§ 10.19. **Nurses' Stations**

(a) Number required. At least one nurse's station shall be provided for each nursing unit.

(b) Location. Each nurse's station shall be an integral part of its nursing unit and shall be so located as to provide adequate supervision of corridors outside all rooms. Nurses' stations shall not be located in a manner to create a fire hazard or interfere with the movement of patients or equipment.

(c) Equipment. Each nurse's station shall be provided with the necessary equipment including but not limited to:

(1) A sink with hot and cold running water.
(2) An instrument sterilizer unless this operation is performed in the utility room.
(3) Cupboards and work counter space for the dispensing and storage of medicines and nursing supplies; and the preparation and storage of patient records and reports.
(4) Medicine cabinets and closets which shall be well-lighted and can be kept locked.
(5) Refrigerator unless one is provided in the utility room.
(6) Sectioned medication trays as needed.

§ 10.20. **Utility Rooms**

(a) Number required. At least one utility room shall be provided for each nursing unit.

(b) Location. Each utility room shall be located close to the nurse's station.

(c) Equipment.

(1) The utility room shall be designed and constructed to provide for the separation of clean and dirty work areas. Size and location of all equipment shall be approved by the Commissioner.
(2) Each utility room shall be provided with counter space and cabinets consistent with the size of the nursing unit it services. Size and location shall be approved by the Commissioner.
(3) Each utility room shall be provided with a double compartment sink with drainboards and with hot and cold running water.
(4) Each utility room shall be equipped with a sterilizer for the proper sterilization of bedside equipment. This sterilizer shall be no smaller than sixteen (16) by twenty-four (24) inches in size.
(5) Each utility room shall be provided with an instrument sterilizer unless this procedure is performed elsewhere in the home.
(6) Each utility room shall be provided with a refrigerator.
(7) Each utility room shall be provided with a sanitary self-closing waste receptacle.

§ 10.21. **Day Rooms**

There shall be at least one (1) day room for each nursing unit. The size of the day room shall be consistent with the number of patients it serves.

§ 10.22. **Office of Director of Nursing Service**

The director of nursing service shall be supplied with an office which shall be equipped with a desk, chairs and files or cabinets sufficient for the preparation and storage of necessary records and reports.

§ 10.23. **Dietary Department**

(a) Ventilation. Kitchens shall be ventilated by mechanical systems adequate to change the air once every six (6) minutes and to discharge the air above the main roof or fifty (50) feet from any window. Exhaust air intakes shall be located at cooking and dishwashing centers.

(b) Refrigeration.

(1) Adequate mechanical facilities shall be provided to store all perishable foods and perishable beverages at or below fifty (50) degrees Fahrenheit.
(2) Thermometers shall be attached inside all refrigerators, freezers, frozen food compartments and refrigerated rooms. Thermometers in refrigerated rooms shall be readable from outside these rooms.
(3) Freezers and frozen food compartments of refrigerators shall be maintained at or below zero (0) degrees Fahrenheit.

(c) Dining Facilities.

(1) Patients' dining rooms shall provide not less than twenty-five (25) square feet of floor area per bed for seventy-five (75) per cent of the total number of beds.
(2) In homes having less than forty (40) beds, staff may eat their meals in the patient's dining area.
(3) If the dining area is to be used for recreational purposes, then it shall not be the sole recreational area in the home.
(4) The total square footage for the dining and recreation facilities, including day rooms, shall be not less than fifty (50) square feet of floor space per bed for seventy-five (75) per cent of the total number of beds.

(5) Location and allocation of this space shall be approved by the Commissioner.

(d) Floor Pantries.

(1) Number. At least one (1) pantry shall be provided for each patient floor in homes where patients are housed on a different floor from the kitchen.

(2) Equipment shall include but not be limited to:

(a) Refrigerator with trays for ice cubes.

(b) Covered, insulated box for ice cubes if ice is manufactured elsewhere or bought.

(c) Sink.

(d) Stove or heavy duty hot plate.

(e) Can, waste, with foot lever.

(f) Toaster, electric, two (2) slice, heavy duty.

(g) Other equipment depending upon the type of food service used in the home.

§ 10.24. **Recreational and Diversional Facilities for Patients**

(a) In addition to the day rooms, each home shall provide at least one (1) recreation and sitting area. This area may also be used for occupational therapy. If these areas are located adjacent to patient dining rooms, movable partitions or doors may be used so that these areas can be combined for group activities.

(b) Storage space for equipment required for recreational, diversional and/or occupational therapy shall be provided adjacent to these areas.

(c) The lobby of the home shall not be used to meet any part of the required recreational and diversional space.

(d) Location and allocation of this space shall be approved by the Commissioner.

§ 10.25. **Office Space and Equipment**

Space and equipment shall be provided for the business activities of the home and the preparation and storage of medical and other essential records. This space and equipment shall be approved by the Commissioner.

§ 10.26. **Laundry Facilities**

Laundry facilities where provided on the premises of a home shall conform to the following requirements:

(a) The laundry shall have sufficient capacity to process seven days' laundry in a work week.

(b) Laundry equipment shall be provided with all necessary safety appliances.

(c) All laundry dryers shall be equipped with removable lint traps.

(d) Surfaces shall conform to the requirements of this code.

(e) Floors and walls to a height of five (5) feet from the floor shall be waterproof.

(f) Ventilation shall be by mechanical systems, adequate to change the air once in six (6) minutes. This system and the vents from the drying equipment shall discharge the air above the main roof or fifty (50) feet from any window. Air circulation in the laundry shall not draw air from dirty linen areas through clean linen areas.

(g) Location, space allocation, equipment and operation shall be approved by the Commissioner.

§ 10.27. **Storage Areas**

(a) General storage. In addition to other storage facilities required, there shall be provided general storage space amounting to twenty (20) square feet per bed.

(b) Patients' clothes storage. In addition to other clothing storage facilities, there shall be provided, in each patient room, a closet, wardrobe or locker space at least thirty (30) inches wide, eighteen (18) inches deep and sixty (60) inches high for each patient housed in that room. This storage area shall also include some shelf space.

(c) Wheelchair and stretcher storage. Storage space shall be provided close to each nurse's station, for wheelchairs, stretchers and walkers. This equipment shall not be stored in corridors.

(d) Clean bed linen storage. There shall be provided, on each nursing unit, a cupboard or closet in which the linen required by that unit shall be stored. The key shall at all times be in the possession of the nurse in charge of the nursing unit.

§ 10.28. **Delivery and Receiving Areas**

Delivery and receiving of bulk supplies and equipment shall not be effected through the lobby or patient areas of the home.

(Note—Article XI, which refers to Proprietary Hospitals, has not been changed and is still in effect, is not being printed herein.)

ARTICLE XII—MISCELLANEOUS

§ 60. **Inconsistent Rules and Regulations Repealed.** All rules and regulations heretofore promulgated by the Commissioner which are inconsistent with the provisions of this code are hereby repealed.

§ 61. **False or Misleading Advertising Prohibited.** No licensee shall use any false or misleading advertising or permit the use of any false or misleading advertisement by any employee.

§ 62. **Interfering With or Obstructing Department Representative.** No person shall interfere with or obstruct any duly authorized representative of the Department when making inspections or examinations required by said Department or when executing its orders.

§ 63. **Modifications and Exceptions.** Where there are practical difficulties or unnecessary hardship in carrying out the strict letter of the provisions of this code and these regulations, the Board of Hospitals shall have power in a specific case to modify any provisions thereof in harmony with the general purposes and intent of the Code.

§ 64. **Smoking Prohibited Except in Designated Areas.** No person may smoke or carry a lighted cigar, cigarette, pipe or match or use any spark, flame or other fire-producing device in any municipal or proprietary hospital or nursing or convalescent home, except in areas designated by the Commissioner of Hospitals of The City of New York. (Enacted April 8, 1953, effective, April 18, 1953.)

§ 65. **Spitting Prohibited.** Spitting upon the floor of any institution under the jurisdiction of the Department of Hospitals is forbidden. The licensee shall keep permanently and conspicuously posted throughout the institution a sufficient number of notices forbidding spitting upon the floors and calling attention to the provisions of this section.

§ 66. **Violations, Penalties.** Any person who violates, refuses or neglects to comply with any of the provisions of the Hospital Code and the Regulations shall be guilty of a misdemeanor and shall be punished in accordance with Section 583-d of the New York City Charter.

Senator Moss. We will have an opportunity for brief questioning now but I may have to ask if you could return also this afternoon.

Dr. TRUSSELL. I will be very glad to.

Senator Moss. I think Senator Kennedy had a question he wanted to ask at this point.

Senator KENNEDY. Doctor, we talked this morning about some of these homes where perhaps the standards are inadequate and we have also gone into considerable detail as to the effort you made and the committee made to propose standards for these homes here in the city of New York in behalf of the welfare and the safety of those who are residents in these institutions.

Was there opposition or did you find that there was opposition to these standards when you began to develop them?

Dr. TRUSSELL. We had considerable concern expressed from a variety of quarters, Senator Kennedy.

Senator KENNEDY. Was that in connection with the physical make-up of the homes?

Dr. TRUSSELL. At the outset. I might say we handled this code development for and through the board of hospitals with the aid of a very large advisory committee, perhaps 80 people who were deeply concerned, including officers and legal counsel of the various associations of proprietary nursing homes.

In the beginning there was considerable resistance to some of the standards that we were driving for in terms of actual care of the patients. I think, however, now that the testimony given by the previous witness is correct, that those people who are now in the business to stay in the business are making an effort to meet the code.

There are always a few homes that we have to keep an eye on, they have difficulty with personnel shortages and so on. The greatest concern expressed by the owners has been about the issue of physical standards.

In some States the approach has been to say, "All right, any facility that was in business prior to adoption of the code will continue to be in business." This ignores the fact that there are some facilities throughout the Nation, and there were some in New York and there probably still are a few, that have not gone out of business yet, that cannot really be considered suitable for modern care of patients.

The board of hospitals has bent over backward to be reasonable in this matter. For example, in a new nursing home the code calls for corridors in patient-care areas which are 8 feet wide, yet the board of hospitals will grant a blanket variance to all homes that have corridors 5 feet wide.

You might say how did the 5-foot figure come about? Very simple. We estimated how much room you needed to get a wheelchair and a food cart by each other. If a fire breaks out, and we can have fires even in steel structures, and you have a very narrow corridor and personnel want to get to where that fire is, you can have a real interference with efforts to protect those patients.

We have used rough rule-of-thumb approaches to trying to grant reasonable variances to the new code. The Board of Hospitals felt it would be better to eliminate the grandfather clause approach and then to survey each home in totality, tell them what they would need to do to meet a permanently granted set of variances and how much time they would have, sometimes 3 years, even longer.

The home is entitled to hearings; we also have been taken to court on occasion. By and large, the homes have either gone out of business, changed their way of life, or have come up to conformity.

Senator KENNEDY. Was there much need at the time this code was put into effect for such a code here in the city of New York?

Dr. TRUSSELL. I think we all felt that the proprietary nursing home field was in need of scrutiny and certainly the wholehearted interest and cooperation we had of a great variety of community interests would demonstrate this. When we had our public hearing not only were there people who were opposed to certain aspects of the code (I will say in defense of the prior witness that the better elements in the profession did take a moderate position in this field) but we had a large number of important community agencies who came and testified to the need for this code and in complete support of its adoption in totality.

Senator KENNEDY. What are the chances or possibilities of having this kind of code adopted throughout the State?

Dr. TRUSSELL. I see no reason why this code could not be adopted throughout New York State providing the State health department faces the problem of regional variations with some reasonable approach.

Nationally, there is a very real problem because the availability of personnel, such as nurses, creates difficulties. A magnificent social breakthrough like medicare; that solves one problem, creates a whole series of other problems.

I would say that there are three most pressing problems. One is the issue of standards across the Nation and in upstate New York. Your amendment has protected standards in New York City. The other is the provision of other facilities because now that these elderly people will become private patients, their doctors, whom they will be able to get on a private patient basis, will admit them to voluntary and proprietary hospitals. This will lead to an unknown amount of crowding and will create great pressure to move out patients as soon as possible.

One of the obvious places that the chronically ill patient gets moved out to is a nursing home. In certain areas of the country there are real shortages of nursing homes, including New York City. So that we are concerned with facilities, we are concerned with standards and we are concerned with the availability of enough nurses.

Senator KENNEDY. What is your feeling, based on your experience with them, about the private proprietary homes? Do you think that they have a role to play, a major role?

Dr. TRUSSELL. I think that one of the other witnesses is going to testify to this question in a philosophical manner, namely, Professor Thomas from our faculty at Columbia University. As the commissioner of hospitals, recently resigned, I was confronted with the fact that these institutions are legal and are here to stay. Nationally, about 75 percent of the nursing-home beds are in proprietary institutions, and they are here to stay.

Since this is a fact and it has been engendered much by the Government through the FHA mortgage program, the issue before us is to see to it that the care received in these proprietary facilities meets reasonable standards so that patients are protected.

If you did away with proprietary nursing homes by a wave of the hand, you would not have 75 percent of your nursing-home beds today in the country.

Senator KENNEDY. What about in the city of New York and the State of New York? What is your feeling toward proprietary nursing institutions?

Dr. TRUSSELL. In New York City we have made a lot of progress. There are things yet to be done. I feel that in upstate New York the effort of the State department of social welfare to emulate our efforts in New York City have gradually worn out to be nothing. The State health department now has this function assigned to them as of next February and I am hopeful for a revitalized effort.

The State department of welfare worked with us very closely on the development of our code, they approved it before we adopted it. They then set up their own committee to set up an upstate code but every draft became weaker and weaker. Finally, it came to a halt. Upstate they have to start all over again.

Senator KENNEDY. Your feeling generally is that these homes are in existence now and that we should just learn to live and work with them?

Dr. TRUSSELL. They are legal, and I will say honestly that many of the owners are seriously trying to do a good job. There are others, which while legal, will still cut a corner if you give them the opportunity to cut a corner. This is an inherent conflict between the profit producing proprietary approach to providing health care and the necessity for giving an adequate service.

Senator KENNEDY. Do you think it would be well if we make a study here in the city of New York and State of New York as to whether these kinds of institutions should continue to exist?

Dr. TRUSSELL. I think a medical audit and a fiscal audit would be a very interesting type of activity to carry out. It takes time, it is not simple, but we have done this type of thing in hospitals; and we have done one in nursing homes and it could be repeated.

Senator KENNEDY. I want to end up with the issue of the 22 homes that were inspected and found deficient. I have the report that now belongs to the committee. I looked through it rather quickly and it is a rather ghastly account of what is going on in some of these homes, at least as of several months ago.

Do you know if the situation has improved with respect to the people living in these homes or houses?

Dr. TRUSSELL. The reason that the interdepartmental health council went into a survey of these institutions was that we became increasingly concerned about the fact that certain proprietary nursing homes were converting themselves intentionally into homes for senior citizens. In the past it, has been brought to our attention from time to time that such institutions would actually be rendering nursing-home-type care but without a license. Whenever that has happened the department of hospitals has issued a warning that if they do not desist from this type of activity they will be subpenaed.

At the present time, as Dr. Haughton testified, under the new legislaion these 22 institutions are the responsibility of the State department of social welfare. These homes should be followed closely and that is why we at the department of hospitals have sort of been doing it as a voluntary activity, to keep an eye on them so we can suppress any really serious situation.

There should be established for this group of institutions a State code and there should be regular inspections, because when people

go into these homes feeling perfectly well and saying, "This is where I am going to live the rest of my life," they are elderly and sooner or later they are going to have a heart attack or diabetes or glaucoma or arthritis or a stroke and they should be under more surveillance than they now are.

Senator KENNEDY. Is there anything being done about this?

I was just looking at the section of the report on homes of 7 to 12 residents. There were six homes in this category in which the ages run from 41 to 97 years of age. In two of these the residents were well aged persons who received adequate services and who did not appear to need nursing care. In the others there were residents who were mentally disoriented, physically disabled and in some cases, wheelchair-bound or bedfast. In many instances the residents are found to be dirty and unkempt, in dire need of services but are not receiving them.

There are some, I gather, where the situation is even worse. Is anything being done about them at the present time, that you know?

Dr. TRUSSELL. At the present time, to my knowledge, Senator Kennedy, the State is not doing anything about these but I may be wrong because I have not been in conversation with them in the last few weeks.

Senator KENNEDY. I hope, as a result of the hearings of this committee, that someone will begin to accept his responsibility and investigate and report on the situation in these homes.

Thank you very much.

Senator Moss. Thank you, Senator Kennedy.

Dr. Trussell, we are going to have to take our noon break. If you will be available at 2 o'clock when we reconvene, I am sure there will be some additional questions.

We will now be in recess until 2 o'clock.

(Whereupon, at 12:30 p.m. the subcommittee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m., Senator Frank E. Moss, chairman of the subcommittee, presiding.)

Senator Moss. The hearing will come to order.

Dr. Trussell was on the stand. If you would return, we would appreciate it, Doctor. Senator Neuberger has a question or two and I have one or two.

Senator Neuberger, you may proceed if you would like.

Senator NEUBERGER. I would like to ask Dr. Trussell are there specific provisions in the Nursing Homes Code for taking care of psychiatric patients?

FURTHER STATEMENT OF DR. RAY E. TRUSSELL

Dr. TRUSSELL. Here in New York City, Senator?

Senator NEUBERGER. Yes.

Dr. TRUSSELL. There is not a provision as such. Those facilities that are licensed to take care of patients who are mentally ill in this State happen to come under the State department of mental hygiene which licenses this particular health care function so that a patient who de-

veloped obvious psychiatric problems in all likelihood would probably be transferred to one of these licensed facilities, whether it be private or voluntary or to a State institution.

Senator NEUBERGER. But under the health care bill there is a 190-day lifetime limitation on psychiatric services.

This person might be ambulatory or should not be in an expensive hospital bed; yet he could be a self-care patient in many places outside of New York City. So shouldn't there be some kind of new provision in any standards or codes for the psychiatric patient?

Dr. TRUSSELL. I didn't think that the New York City Code would preclude a nursing home from taking care of a patient who was not disruptive, not obviously ill enough to be in a hospital. The code does require that a patient who is sick enough to be in a hospital must be transferred. This is in the interest of the patient.

I am sure that if you visited the nursing homes here you would find a good many patients who have some evidence of what is called chronic brain syndrome—early senility—and some with fairly advanced problems but who are not causing difficulty or who are not harmful to themselves.

I don't believe that there is any preclusion against the care of such patients in the nursing homes in New York City. On the other hand, the nursing homes would not be obligated to take such patients if they were obviously ill, in fact, they would have to see to it that they went somewhere else.

Senator NEUBERGER. Is there anything in the code that effects advertising of these proprietary homes?

Dr. TRUSSELL. I don't think there is anything that directly relates to advertising. We do require in the code that they make available to the patient and to his family or sponsor a list of charges so that the patient and the patient's family know exactly what they are getting into from a financial point of view.

Senator NEUBERGER. The code does not specify, then, that they may not advertise?

Dr. TRUSSELL. No.

Senator NEUBERGER. It just does not refer to it?

Dr. TRUSSELL. There is nothing that prohibits advertising. Usually this advertising is found in professional journals like medical society bulletins and that sort of thing because the homes that are seeking private patients are usually dependent on hospital or doctor referral.

The homes that accept welfare patients have no problem because the welfare department is so desperately short of beds right now so that they keep them filled up to a very high degree.

Senator NEUBERGER. Do you think there are many homes throughout the country that are owned by doctors?

Dr. TRUSSELL. I don't have any direct information about this, Senator Neuberger. There have been allegations but we have no information across the Nation.

Senator NEUBERGER. Do you consider proprietary homes a problem?

Dr. TRUSSELL. Proprietary homes?

Senator NEUBERGER. Nursing homes.

Dr. TRUSSELL. Nursing homes. I don't consider them a major problem in New York City any more because I think that we have gone through a major reappraisal and have made considerable strides

toward improving the situation. As I indicated this morning, I believe there are sincere nursing home operators. In any field there are always some who will attempt to cut corners and we still run into this kind of thing.

I would say across the country that I don't have the same assurance, I don't think there has been the same amount of aggressive attention directed to these kinds of facilities. I do think that this is a challenge to the Federal Government in administering medicare.

Senator NEUBERGER. But you evidently feel that there will be some problems develop with the passage of the new health care bill in regard to nursing homes. Would you mind sort of restating what that is? Is it just a case of overcrowding?

Dr. TRUSSELL. Yes. The problems are essentially in three areas. First of all, in certain parts of the United States, including New York City, there is a shortage of nursing home beds and yet the pressure to transfer people out of hospitals will be greater because people who go into a voluntary hospital or proprietary hospital as a patient will be under pressure to be moved out in order to make room for the next one.

So one of the places they will be moved out to will be nursing homes, whether they be proprietary, municipal, or voluntary.

I think the second problem is that of standards.

The third problem is that of enough nurses to take care of these patients. The nurse shortage is a national shortage but it is particularly acute in certain situations. In some jurisdictions it is not even necessary to have a registered nurse in a nursing home at any time. Here we have a requirement that a nursing home above 60 beds in size must have a registered nurse around the clock.

In homes below 60 beds (and there are relatively few) there must be a registered nurse at least 16 hours of the 24, the day shift and the night shift.

So we have moved a long way toward assuring ourselves of registered nurse coverage for these patients. Nationally, this is far from having been achieved.

Senator NEUBERGER. Thank you.

Senator MOSS. Dr. Trussell, you answered Senator Neuberger that you did not have information as to whether there were many doctors owning proprietary nursing homes. Have you had any problem in determining who does own proprietary nursing homes?

Dr. TRUSSELL. Once in a while, Senator Moss, you have difficulty in getting a clear-cut picture of what is behind a piece of paper. Sometimes past experience had led our legal counsel who handles these matters to suspect some situation and he may require an affidavit. We have even been driven on one or two occasions to a title search. Sometimes you come across interesting observations like a lease in which the landlord was to receive 95 percent of the net profits. That left the administrator with 5 percent of the net profits. In order to make any substantial return he was going to have to have a pretty high profit. This is the kind of lease that our department does not approve of. In fact we have in court at the present time a court test of a lease which relates to this sort of a return on investment, with no responsibility for operation of the institution. This is, however, an isolated instance, it is the only one of its kind we have seen. We disapproved it, as I recall.

Senator Moss. This, of course, leads us back again to the matter that has been raised once or twice about whether a proprietary institution is as appropriate in this area as a public or a nonprofit institution because the proprietor has the motivation, of course, of making a profit, and he may then feel pressure to minimize services in order to assure that the profit will be made.

Dr. TRUSSELL. Well, this problem manifests itself in varying degrees among different institutions. The only one way to monitor it is to require reporting. The department of hospitals requires that the institution submit the names of each of the various kinds of personnel who are on duty on each shift in each nursing home. These are scanned and discrepancies are followed up. Of course, the largest cost in any health care facility is for personnel so that if there are chronic evidences of cutting corners on assignment of personnel the department of hospitals has issued warnings. If the situation is not corrected the department has even had to move to have the home closed.

Usually a warning coupled with a cooperative arrangement which we have with the department of welfare has been very effective. If we advised the department of welfare that we had issued a restricted license, that meant that this nursing home could not admit any new patients. The welfare department would stop admitting patients, and if the situation were grave enough the welfare department would reduce the rate of payment to the nursing home. This would provide an economic incentive for rapid compliance with our code. Again, as I say, I think we have been through the worst years here in New York City and I think that things are improved although there will always be problems.

Senator Moss. Do you have any specific recommendations or criticisms of the Federal programs that apply to nursing homes; construction loans, or anything of that sort?

Dr. TRUSSELL. I think the construction standards are not as unrealistic as has been implied. The Hill-Burton, now the Hill-Harris standards are intended to provide a well-rounded facility for people who are going to be in these institutions in some cases for many years. The facilities which I have heard objected to here today by one witness, it seems to me would be a part of any reasonable facility for the care of long-term chronically ill patients.

The idea that we, for example, should examine people on an open ward, I have seen nursing homes where there were no screens where patients who were examined were examined in bed with absolutely no privacy. This is reducing human dignity too much. I don't think an examination and treatment room is an unreasonable request in a health-care facility.

Now, most people that go into nursing homes are going to be there a very long time and I feel that recreational facilities and getting these people out of bed and getting them to the dining room and having a pleasant, cheerful dining room is a part of their daily living; this is where they can socialize, this is where they can make some use of their physical resources.

This leads me to one other suggestion that was made and that was that patients should be classified as a basis for payment. New York City used to pay for maximal, intermediate, and minimal care, but gave

it up largely because they found that patients were encouraged to stay in bed to maximize the rate.

This is the fastest way to trap an old person into a prone institutional existence that I can think of. I think the status of whether they are in bed, out of bed, or able to walk around the lawn is not a rational basis for reimbursement in nursing homes if the encouragement is there to keep them in bed to get the higher rate of payment.

Senator Moss. What would be the best method of dealing with the problem that you mentioned here of proprietors going out of the nursing home business and simply setting up a home for elderly citizens?

Dr. TRUSSELL. I think the problem has been dealt with by the legislators. They placed it in the hands of the State department of social welfare.

The State department of social welfare has not yet moved into this field. What is needed is a set of standards by which homes can be licensed and under which they can be supervised and regulated.

As I indicated earlier today an old person feeling perfectly well may go into a home at age 75 and expect to spend the rest of his life there. He may have had a physical examination which shows that for that age he is doing extremely well. This does not mean that a year from now he is not going to be a sick individual.

The problem is with the lack of surveillance. There is no assurance now that that person is going to be taken care of. There is no assurance that he will not be victimized.

Senator Moss. Thank you.

Any questions?

Mr. CONSTANTINE. Dr. Trussell, we had some information to the effect that in 1959 one individual allegedly controlled about 50 percent of the nursing home beds in New York City.

Are you familiar with that story?

Dr. TRUSSELL. Well, there have been allegations that one individual had extremely large holdings in this field. However, that individual's name, to my knowledge, never appeared on the license of any of these institutions but he had a reputation within the department of having an extraordinarily large number of relatives who seem to be in the business.

Mr. CONSTANTINE. Thank you.

Senator Moss. Mr. Frantz.

Mr. FRANTZ. Just one point on your construction program which you touched on briefly in your statement. By doing some arithmetic here, I found that the capital costs which are projected for the homes you are building in New York City amount to about $20,000 per bed.

Dr. TRUSSELL. That is right.

Mr. FRANTZ. This is much higher than average. Of course, New York City building costs are higher but they are not twice as high as elsewhere, and the average Hill-Burton home now being built is about $11,000 per bed, I believe. I think the average proprietary is about $6,000 per bed.

Could you indicate why these homes will cost so much more?

Dr. TRUSSELL. I think the $20,000 figure includes site development and site acquisition. It also includes, I would say, a much more substantial type of construction. It has been alleged here today that

municipal facilities do not measure up to proprietary facilities when in fact if you were to examine the architect's contracts written by the department of public works for city facilities, any codes in effect in New York City as of the time this facility is being designed must be taken into account fully.

Now in addition, we are subject to State standards for "public home infirmaries" which are their way of designating a nursing home type of facility. They require a good deal more in the way of recreational areas with those facilities so we find ourselves building large auditoriums and special entrances so that people in wheelchairs can enter.

In other words, the tendency in building a good public facility is to do a lot more of what we require as a minimum of the proprietaries in their homes. Furthermore, we tend to build facilities which are, I would say, substantially more durable, more long-lasting in construction. This is not a minimal investment for minimal time; this is a maximum investment for the longest time for a large number of people.

Also, I would say that in New York State we have a peculiar situation in that there is a State law that requires that governmental agencies that construct facilities do so through the use of four separate contracts; general construction, plumbing, electrical, and heating and ventilating. You cannot build through a general contractor. Any one of these four contractors can hold up the other three. This stretches the job out and it creates inordinate delays in construction and also adds to the cost of construction. Any contractor who is bidding on a city job has to allow for this factor if he is going to be working alongside three other contractors rather than being subordinate to a general contractor. This is something the city of New York has tried to get repealed for a number of years and never succeeded.

Mr. FRANTZ. This is reflected in the cost?

Dr. TRUSSELL. This is reflected in the cost of anything built by the Government; schools, hospitals, nursing homes, anything.

Mr. FRANTZ. One of the factors is that you have more facilities in these homes in relation to the number of beds. Do you have in mind the figure of the number of square feet per bed?

Dr. TRUSSELL. I don't have that figure immediately available, I could get it for you. If you want a rundown on construction costs over the years of these types of facilities. I can certainly get it for you.

Mr. FRANTZ. Thank you.

Senator MOSS. Thank you, Dr. Trussell. We appreciate your testimony very much. You were an excellent witness and have helped us greatly.

Now, Mr. Wallace Johnson. I called you before and asked you to wait and I appreciate your consideration and forbearance. We would like to hear you now.

Mr. Johnson is the chairman of the Board of Medicenters of America, from Memphis.

Are you from New York or are you from Memphis?

Mr. JOHNSON. I am from Memphis.

Senator MOSS. Very good.

Mr. JOHNSON. I have some gentlemen with me.

Senator MOSS. Fine.

You may go right ahead, Mr. Johnson.

STATEMENT OF WALLACE E. JOHNSON, CHAIRMAN OF THE BOARD OF DIRECTORS OF MEDICENTERS OF AMERICA, INC., ACCOMPANIED BY JOHN A. DeCELL, VICE PRESIDENT AND MANAGER, AND HERBERT S. COLTON, ATTORNEY

Mr. JOHNSON. I am Wallace E. Johnson of Memphis, Tenn. I am chairman of the board of directors of Medicenters of America, Inc.; president, a director, and one of the founders of Holiday Inns of America, Inc.

With me on my right is Mr. John A. DeCell who is vice president and manager of Medicenters, and to my left is Mr. Herbert S. Colton who is the attorney for Medicenters.

You have copies of this statement of mine and I am not going to read each word of it but I am going to call on these men to assist me and try to tell you the story that we are trying to do.

Senator Moss. That will be fine. The entire statement will be in the record and then you may present it as you would care to.

(Statement referred to follows:)

STATEMENT OF WALLACE E. JOHNSON

Mr. Chairman and members of the committee, I am Wallace E. Johnson of Memphis, Tenn. I am chairman of the board of directors of Medicenters of America, Inc.; president, a director, and one of the founders of Holiday Inns of America, Inc.; and for the past 25 years or so have built homes and apartments in Memphis, Mississippi, and other cities of the Southeastern United States.

During the past few years Mrs. Johnson and I have built, or are building, 13 facilities for nursing home care including one in Houston, Tex., which is a combined hospital and nursing home. A list of these is attached at the end of my statement. As noted thereon some of these were built in association with others, some we built and operate, and some we built and leased to others for operation.

Until about 12 years ago, I had no more than the usual sympathetic—but remote and inactive interest—in the subject under study by your committee. Then, about 1953, Mrs. Johnson's father (then in his seventies) needed intensive care. We were astonished to find in all of Memphis—a progressive city in most things—we could discover no institution we thought suitable. Consequently he spent the last 5 years of his life in a hospital at a cost exceeding $75,000 although he did not require full hospital care. Thus in the declining years of his life this gentleman lived in a cold and impersonal institution, denied the personal care and attention which he should have had to make him content and comfortable and which an efficient and kind—but busy—hospital staff did not have the time to give him except at the risk of neglecting the acutely ill who were their prime responsibility.

It did not seem right to us that there should be no suitable place in which this man could get the care and attention he needed and deserved and which, fortunately, he could afford.

After his death, Mrs. Johnson and I promised ourselves we would someday build in Memphis the type of facility which we were unable to provide for him. We performed that promise by building the home we now call Rosewood, in Memphis. I have with me some photographs of it which the committee may want to see.

Before developing Rosewood we spent sometime looking at nursing homes, clinics, and medical care facilities throughout the Nation. We found that 50 percent of nursing home beds in many areas were substandard and allowed to function only because of the lack of suitable facilities to replace them. For example, last winter in this State of New York—probably the wealthiest in the Nation—the press reported that the State health department had found unsuitable nearly 50 percent of the nursing home beds in the 13-county Rochester area and that all of the existing long-term care beds in 5 of those 13 counties were so described.

The more deeply we studied this subject of long-term nursing care, particularly of the elderly, the clearer it became to us that here was a vitally necessary service which, in these days of advancing science and highly developed skills, was still in the "horse and buggy stage." We became convinced of the need for a massive effort to develop throughout America well-managed facilities to provide both long and short-term nursing and other inpatient care at moderate rates to patients of all ages. We became convinced, further, this job could and should be done by private industry operating with due concern for the very special nature of the service required. In short, we felt that the time had long since arrived for a modern system of progressive medical care facilities conforming rigidly to high standards in every respect.

To accomplish this, Mr. Kemmons Wilson, chairman of the board of Holiday Inns of America, and I formed Medicenters of America, Inc., early this year. Medicenters is an entirely separate company and has no connection with Holiday Inns. However, the parallel is striking between the rather primitive state of the motel business when we formed Holiday Inns in 1953 and the present typical nursing home. We hope in our new venture to develop in this field a nationwide system of nursing and inpatient care offering uniform high standards of construction and of service, just as Holiday Inns did in the hotel-motel industry.

Based on our experience in constructing and operating the 13 facilities I mentioned above, Medicenters of America has developed—and is intensively working to further improve—standardized construction plans and specifications for the most modern, efficient, and economical facility and equipment and standards for patient care. We will license individuals and groups to construct Medicenters and to operate them under that name, pursuant to our standards. Our criteria are spelled out in detail and rigid adherence is required by the license agreement. They will be enforced through close inspection by our national organization. We propose through Medicenters of America to bring to every city in America the kind of facility which was not available for my father-in-law.

It may be of some interest to the committee that we have received almost 1,000 inquiries from prospective licensees as a result of a somewhat premature newspaper story in March of this year, prior to full completion of our organizational work. Our immediate goal, as a beginning, is to develop 400 of these facilities. We are now processing these inquiries, inspecting proposed sites, issuing preliminary licenses, and we expect that the first of these Medicenters will be under construction shortly.

We believe the Medicenter system is on the right track. The astonishing interest thus far manifested convinces us there is a vast need for the work we have just begun. But much work remains to be done, and there is much to be learned in this field.

Thus far we have come to these firm conclusions:

(1) The need for long-term facilities is so extenisve that it can hardly be met by nonprofit charitable or fraternal organizations. The full force and ingenuity of private industry (of course, subject to State regulation) should be brought to bear on this monumental problem. Long-term care can be provided more economically by private organizations, profit motivated but with a keen sense of public responsibility. Aside from the intangible rewards in terms of satisfaction at helping those who need help, we believe these facilities can and should be run on a business basis.

(2) A facility should be closely related to one or more hospitals and, preferably, should be a combined hospital-nursing home. We disagree with the increasing tendency for nonprofit hospitals in an area to discourage private hospitals, by, in effect, denying them access to Blue Cross benefits. This is done through hospital survey committees of public-spirited and undoubtedly sincere (but in our opinion mistaken) citizens who pass upon hospital needs in the community. Where such committees exist, Blue Cross coverage of hospital bills is not available to a facility not approved by the committee. In our opinion, such arrangement, although for the express purpose of providing better hospital service, has just the opposite effect in that it rejects the efforts of those forces which are beginning to work toward reducing the cost and increasing the availability of care facilities.

(3) The construction and operation of a facility for long-term nursing and medical care is not a real estate development alone—although knowledge of realty values and locations, of construction, and of real estate

finance are helpful and, indeed, essential. Operation of such a facility is not a matter of patient care alone, although adequate and competent nursing and professional attention are fundamental. Above and beyond these requirements, it is necessary to transpose the public image of nursing home from the present rather pathetic concept of a rambling old house to which the ailing aged are consigned as a last resort when their families can no longer care for them to the concept of an attractive, modern facility equipped for physical comfort of patients of all ages who require long-term care, staffed by warmhearted people who understand and sympathize with the needs of the old and infirm, and operated with singleminded purpose to provide comfort and contentment—a sense of dignity and of being needed—as well as adequate professional care. The unsuitable, the coldblooded, that institutional facility must be replaced by "homes" which are all that word implies.

I have with me another set of pictures which will give some idea of the kind of surroundings which we believe a modern facility must offer. These show the interior of Chesapeake Manor Nursing Home at Towson, Md., built and operated by Stewall Corp., of which Mr. Stewart Bainum and Mr. Herbert Colton, of Washington, D.C., and I are stockholders. Of course, a picture cannot show the kind of attention we are insisting our staff give to persons entrusted to our care there and to our other facilities.

Mr. Chairman, this subject is close to my heart. I would be glad to discuss it with you further if your schedule permitted. I hope my quick summary of our experience and intentions has been helpful to the committee.

I shall be glad to answer any questions.

WALLACE E. JOHNSON INTEREST IN FACILITIES FOR NURSING HOME CARE

Rosewood, Memphis, Tenn.
Rosewood Hospital & Nursing Home, Houston, Tex.
Mobile, Ala.
Cherry Hill, N.J.[1]
Richmond, Va.[1]
Chesapeake Manor, Towson, Md.[1]
Regent Nursing & Rehabilitation Center, District Heights, Md.[1 2]
Greenville, N.C.[2]
Greensboro, N.C.
Winston-Salem, N.C.
Gastonia, N.C.
Wilmington, N.C.
Columbia, S.C.
Spartanburg, S.C.

Mr. JOHNSON. For the past 25 years or so, I have built homes and apartments in Memphis in Mississippi, and in several other cities of the Southeastern United States.

Mrs. Johnson and I have been successful in building some hospitals, too. We have one under construction in Indianapolis right now and without experience in Holiday Inns we would have been unable to produce this one and others, at better than 60 percent of the costs of other hospitals in that city. It dates back to the experience we have had in our operations of building Holiday Inns across the Nation.

I want it understand now that Medicenter is not Holiday Inns, Holiday Inns is not Medicenter, because Holiday Inns is a public company.

Our study of nursing homes came about in connection with some sad experience we had about 12 years ago with Mrs. Johnson's father who at the age of 70 years needed a nursing home. We went out on the market in the city of Memphis to see if it was possible to find an acceptable nursing home in that city.

[1] Owned by Stewall Corp., in which Messrs. Stewart Bainum and Herbert S. Colton, of Washington, D.C., are also stockholders.
[2] Leased to others for operation.

We were not able to find something that was acceptable to us. We were able to put him into a hospital which I regret to say cost us better than $75,000 for the balance of his life.

From that experience we decided that with God's help we would build in the city of Memphis a nursing care facility of which everyone would be proud.

We initially built under the name of Rosewood several nursing care facilities that were accepted across the Nation. From our experience with Rosewood, we have developed for Medicenters what we think is the most feasible, well-operated, economically acceptable plan we have run across. I have a picture here of the one we have completed and is in operation now.

My partner Kemmons Wilson who is chairman of the board, of Holiday Inns and myself, have joined together to establish Medicenters of America. We offer to the public franchises similar to the operations of Holiday Inns in the past. Now we start the organization and then find a young man like this young man sitting to my right and turn it over to him to see if he can run it.

John DeCell will now tell a little more about what we are doing.

Mr. DECELL. Senator, in the interest of your time and the allotted time which you requested, I will try to confine my remarks to the salient points of the program.

Based on the experience in constructing and operating the facilities Mr. Johnson has mentioned, Medicenters of America has developed and constantly strives to improve construction plans and specifications for an efficient, economical, building, but more important, standards of care within the facility. I think you have touched on that very adequately in the conversations preceding us.

The Medicenter program is designed to provide at moderate rates inpatient care between intensive hospitalization and a return to a normal, active life regardless of the age of the patient or the length of stay required.

The need for this type of health care facility was pointed out as far back, I believe, as 1952, when the President's Commission on the Health Needs of the Nation reported in part:

> Many patients who do not require the intensive and costly medical care of a general hospital must still be given care in such hospitals because there is nowhere else for them to go. Well-managed facilities can more effectively, and at less cost than hospitals, meet the specialized needs of many chronically ill persons. At the same time, they can remove a considerable and expensive burden from hospitals.

May I emphasize at this point that our program is designed to provide individual skilled nursing care for both the short-term convalescent who would otherwise be in a general hospital and the long-term patient who is being cared for in facilities other than a hospital.

Medicenter guarantees to the public, and to the medical profession, a continuity of care. We will provide this continuity through detailed and rigid adherence to operating procedures outlined in license or lease arrangement with individuals and groups. Every Medicenter will be subject to four or more inspections annually by the national organization.

In addition, every Medicenter will be registered with the American Hospital Association and will be subject to the inspections of that group.

Since our purpose is to supplement acute hospital facilities, every Medicenter will have a working agreement with one or more acute hospitals. I think it appropriate at this time, in light of the conversation that you had this morning concerning the orientation of the medical profession in long-term-care beds, to point out to you that the pilot Medicenter which will be completed early next year in Memphis will be used by the University of Tennessee Medical School for their school of nursing and school of medicine to give them just such an orientation program to which you refer.

We are providing classrooms for their use. In addition, this facility will be used to train every administrator of every Medicenter.

The real impact of the program is the introduction of private enterprise to the health care field on a national scale. I noticed in the paper Sunday, as we were leaving to come here, that the American Hospital Association states that in 1964 the average cost per patient day in hospitals was $41.58. Eighteen years ago, this figure was $9.35.

We believe that we can at least retard the increase of medical costs, if not reduce them, by bringing the full force and ingenuity of private industry to bear on this problem through our program of specialized health care facilities.

You are primarily concerned at this hearing with the problems of long-term care. We believe that this care can be economically provided by a profit motivated organization subject to controls such as are imposed on Medicenters.

Aside from the intangible rewards in terms of satisfaction in helping those who need help, we believe these facilities can and should run on a business basis.

Again in the interest of time, we are concerned, as undoubtedly are you, that the need is great. We believe the answer to a great extent lies in private enterprise dedicated to better health care.

We appreciate your invitation to appear before you; we appreciate the people of New York allowing us to share some of their spotlight since we are visitors.

Mr. Johnson, Mr. Colton, and I will be happy to attempt to answer any questions which you may wish to ask.

Thank you for having us.

Senator Moss. Thank you.

Mr. JOHNSON. Senator, I would like you to take a look at these pictures if you don't mind. These are the pictures of the inside and exterior of the buildings we are operating. We will try to make them as much of a home and a little bit more than an institution. Those are the pictures, Senator, of some actual operations that we have in operation at this particular time.

Senator Moss. Operated now?

Mr. JOHNSON. We do not yet have any operating under the medicenter licensing program. We do have some that were built by Mrs. Johnson and myself. I will refer to the 99-bed nursing home in Houston, Tex., that is under the medicenter program.

We are now building some in the Carolinas that will come into this. But our new floor plan which we show you in this particular folder, is not under construction at this moment.

Senator Moss. These medicenters, then, are built on a franchise basis; is that right?

Mr. JOHNSON. I think probably this is the franchise agreement which I am going to let my attorney explain to you in a few moments. The story about the Wilson-Johnson enterprises being interested in nursing homes was released about 60 days ago in the Wall Street Journal, and from that we went ahead with our medicenter program.

We were planning and working on it but that caused us to accelerate our program and put it into effect. From that story we had more than a thousand inquiries across the Nation.

Now I am going to be a little bit specific. Duluth, Minn., came in and said they wanted to build a 300-bed medicenter. Now we sell a franchise to them for $10,000 and then we give to them a complete basic set of plans and then make up a feasibility report to see if that town under our formula of operation can justify 300 beds.

We just returned from making the feasibility report and we advised them not to build 300 beds but to build 128 beds and that is what they are preparing to build now in that city as a medicenter.

We train their personnel, we give them training films for the employees, from the cooking staff right on through, training them how to do a better job than ever before.

Senator MOSS. Does this supervision continue then?

Mr. JOHNSON. It continues for the life of this franchise.

Senator MOSS. How long does the franchise run?

Mr. JOHNSON. The franchise is for 20 years.

Senator MOSS. I see.

Mr. DECELL. The Medicenter is not only subject to our inspection, but they will be subject to the inspection of the American Hospital Association and hopefully, some day, perhaps the Joint Commission on Accreditation.

Mr. JOHNSON. Now we charge a percentage of the gross income and we use that to promote that medicenter in that town and to supervise the franchise owner to see that he gives to the American public the hallmark of acceptance of perfect service as we think we have been able to do with Holiday Inn.

Senator MOSS. If he does not conduct himself in accordance with your supervision, what is the penalty?

Mr. JOHNSON. Medicenter owns the sign so we take the sign down, and according to the information that is available now the mortgage becomes due. The lending institution that is making the money available incorporates a clause in their mortgage that "if the franchise owner does not operate in keeping with this franchise agreement, the mortgage becomes due."

Mr. DECELL. The license is subject to revocation.

Senator MOSS. You terminate the franchise and the mortgage would fall due at that point if they do not comply with your requirements.

Now as I understand it, the one you are building in Memphis now would be associated with a hospital or have an affiliation with a hospital; is that correct?

Mr. DECELL. We expect to have an affiliation with practically every one of the hospitals. Memphis, as you may know, is quite a medical center in its own right, with medical units being located there. We will work very closely with all of them. As a matter of fact, they have been most helpful with us as has the American Hospital Association and the American Medical Association in putting this whole program together.

Senator Moss. What plan do you have for medical services in the medicenter?

Mr. DeCell. In the particular case of Memphis, there will be no staff physicians, there will be consultant physicians. The patient is subject to his attending physician's orders and directives.

We will use acute hospital facilities for diagnostic purposes. When a patient becomes acutely ill, we will, of course, effect the transfer into the acute hospital. As I said a moment ago, the whole program is designed to supplement, not to duplicate or take the place of general hospitals.

Senator Moss. Are you familiar with the requirements of the code for nursing homes here in New York about which we have been talking earlier?

Mr. DeCell. No. I think we should say our total information should not be considered in context with any previous problems that you have incurred here. We sympathize with them but we are not that familiar with the local situation.

Senator Moss. My next question was to be whether your franchise requirements would be sufficiently detailed and stringent to comply with the code as advanced in the one that was here in New York City?

Mr. Colton. The answer is that a franchise holder must comply with all local, Federal, and State rules and regulations.

Senator Moss. That would be a requirement of the franchise to comply with all those rules?

Mr. Colton. That is one of the affirmative obligations.

Mr. DeCell. In fact, may I say in addition to that, we have found that the requirements begin with State requirements and in most cases to date in the States in which we are working now they exceed the local requirements.

Senator Moss. You spoke of the inspection the American Hospital Association is to make. Is this a blanket contract that medicenter enters into with the American Hospital Association?

Mr. DeCell. No, this is their program which was set up over a year ago to register specialized health care facilities. As someone prior to us brought to your attention, there are two accreditation programs in existence, that one and the National Council for the Accreditation of Nursing Homes.

Senator Moss. Is that on a fee basis?

Mr. DeCell. They have a nominal fee for it. I think I can say it amounts to accreditation, though they do not call it that. I believe I am using the proper terminology in registration or listing.

Mr. Frantz. Just to clarify that, would you recognize either of these accreditations or do you require that of the American Hospital Association.

Mr. DeCell. All medicenters will be accredited by the American Hospital Association.

Senator Moss. Now other than the franchise and the services and supervision, you would not provide any capital for building medicenters; is that correct?

Mr. Johnson. That question has been asked of us and we have been able to assist one or two. If we found that they were fine citizens and if they had a real desire to render service, then I would not say that we would not do it, but I do not want to say that we would just do it in all

cases. The one in Greenville, N.C., that you have a picture of, we did assist in that one.

Senator Moss. Senator Neuberger.

Senator NEUBERGER. Yes.

Do you intend to build any medicenters in New York?

Mr. JOHNSON. We have a number of inquiries for the franchise.

John, do you know how many?

Mr. DECELL. I don't know the exact number; quite a few to answer your question. We would expect to process a request as a normal request and see that our program meets with the approval of all governmental agencies. I feel it will.

Senator NEUBERGER. What do you anticipate would be the monthly range to patients in these medicenters?

Mr. DECELL. National range and not for New York area?

Senator NEUBERGER. Yes.

Mr. DECELL. I would say it would range from $10 to $15 or $16 per day.

Senator NEUBERGER. That is room and board?

Mr. DECELL. That is room and board and skilled nursing care.

Senator NEUBERGER. And skilled nursing care?

Mr. DECELL. That is right.

Senator NEUBERGER. The franchise requires a registered nurse?

Mr. DECELL. That is right.

Senator NEUBERGER. Have you considered the possibility of selling stock in these Medicenters of America to the public?

Mr. JOHNSON. Well, I will try to answer that.

Some of my good friends across the Nation have said, "I am sure that is what you will do," and they could be right. If I am correct there is about $5 million in capital in this company. We have been able to get large insurance companies to agree to make substantial first mortgages to go along with it. So they have a lot, Senator, in this program, too. They have a lot at stake in the health program.

Senator NEUBERGER. In looking through your statement, I see you referred to Blue Cross discouraging the operation of proprietary hospitals. Is the quality of medical care in proprietary hospitals generally as good as that of voluntary hospitals?

Mr. JOHNSON. Let me see if I understand your question again. Are you saying that the quality of service that we give would be the same quality of service at the hospital? Is that your question?

Senator NEUBERGER. I am referring to your reference to Blue Cross. I don't understand this criticsm.

We disagree with the increasing tendency for nonprofit hospitals in an area to discourage private hospitals by, in effect, denying them access to Blue Cross benefits.

Mr. JOHNSON. Let me try to answer that if I can. We feel that we are building in our construction laborsaving devices that will enable private capital to do a job with less number of man-hours.

We have been able to do it in the Holiday Inn and this is what we are referring to.

Senator NEUBERGER. Passage of the recent health care bill, then, must have had your support because——

Mr. JOHNSON. We went into this building before this last bill was introduced. Of course, the newspapers have been full of it. You never know when you Senators are going to bring forth a bill.

Senator NEUBERGER. Of course, it was Harry Truman who started it.

Mr. JOHNSON. That is right.

Senator NEUBERGER. And followed up the activity of legislation. We find that all good things do eventually come to pass, so it is far-sighted of you to be prepared to capitalize on it.

Mr. JOHNSON. Thank you, Senator. Thank you.

Senator NEUBERGER. I agree there is going to be a tremendous shortage of nursing homes. I just don't know in my own mind whether the profit motive is the right motive, because the purchaser of your service is a little different from the average consumer who purchases something from a profit institution. He can never go there again or he can return the product if it was unsatisfactory; but if you are a patient in a profitmaking nursing home, you are stuck.

I don't know how you would get out from under it; actually, when you find out that it disappoints you, you are not getting the care you thought you were going to get, and the cost is unusually high and so on.

Mr. DECELL. May I reply or attempt to?

In the first place, they can leave the facility if they don't like your care. I have heard the statement and do not wish to engage in argument, but I have heard the statement made that private profit or the profit motivation tends to make people reduce the care provided in order to make the profit.

We like to take the affirmative. We do not mean to sound like we are on a soapbox here, but we feel the profit motivation makes us run a little bit longer and faster and harder to provide the care.

Let me say that in several instances in these facilities that have already been developed we are "competing," if you will accept the word, with nonprofit facilities. I think that the inspection would bear me out. We are providing the same level of care and for reasons that I don't care to go into at the moment, at less rates.

Now I am sure that you can find criticism of private enterprise in any field and particularly in this one in light of the history.

I might also tell you that one of the franchise purchasers at least in a phase of negotiation at the present time, is a nonprofit hospital who wants to buy a licence and operate under our program.

Senator NEUBERGER It just seemed to me on the face of it that anybody who paid $10,000 for a franchise is just buying a good name of Medicenter; isn't that right?

Mr. DECELL. No, ma'am; he is buying an operating manual and years of experiences, some of them good, most of them.

Senator NEUBERGER. Yes, but that is what you can pick up in your hand; that is not going to help take care of some old fellow in a nursing home. He invests $10,000. He then has got to run this institution. A return on this investment is necessary if a profit is to be made and it can only come out of one place: the patient's pocket.

Mr. JOHNSON. Let me try to help you, Senator, if I may on that. Before we let him build that building we run a complete feasibility report to know that he can experience a profit on this investment, if he

is running at 50, 60, 70, or whatever the percentage is. Now we feel that the profit motive will enable him to pay a little bit more, get a little bit better labor. I wish you would visit Towson, Md., and experience what you find there; happy people in their homelife and the service is the finest you could find anywhere.

Senator NEUBERGER. Do you think there is going to be some confusion with the name "Medicenter" when the new bill about community health centers goes into effect? Are you going to have community health center versus Medicenter? Someone is going to knock at the door of Medicenter.

Mr. JOHNSON. We will just set him straight.

Senator NEUBERGER. Direct him where he should go.

One more question. Well, maybe you have answered it by saying you are going to make an investigation of whether a franchise should be granted because you have an investment you feel too. I feel you can't lose in a way; you have got the $10,000 and if you don't like what he is doing, you just take the sign down so you have still got the $10,000 and you have got the little paper and the franchise and——

Mr. JOHNSON. Senator, let me say this to you.

Senator NEUBERGER. That is why I wanted to know if you were going to sell stock. [Laughter.]

Mr. JOHNSON. Let me try to say this to you to answer your question.

We didn't just start on this today, we have been making thorough studies on this for a long time. We have made a study; I am on the board of some hospitals and I know what to do from that. I sometimes wish that I owned some of them, and this is still no discredit. I believe that I could get them in a little bit bigger hurry to go to work mopping the floor; maybe I could not but I do it in some of the other enterprises that we have; let me say it that way.

I am not criticizing anyone but I just like to get a good, honest day's work.

Now this manual that we referred to specifically tells you how many hours of maid service, cleanup, and cooks, and every item of it to tell you what you can do. We not only do that but we train a new administrator. We do not want you to go out and hire someone that calls himself or herself an experienced administrator. We want that person to have the experience and the training of Medicenter to do it our way, rather than to do it the other way.

Senator Moss. To what extent do you examine or make a background study of the applicant for your franchise as to character and economic stability?

Mr. JOHNSON. We make a complete study of the references he gives to us. We check the banks, we check the doctors in the town, see if he is a right character and if he is not, he will not get a franchise.

Senator Moss. Do you have a minimum number of beds that you recommend?

Mr. JOHNSON. Yes. We do not want them to build any less than 50.

Senator Moss. Fifty or more?

Mr. JOHNSON. Fifty or more. Now in that case, it will only be $5,000.

Senator Moss. What is the optimum number? Do you have a figure on that? What is the best number to operate?

Mr. JOHNSON. 132 beds we think, is the proper one to build, and you are going to ask why. If you build a hundred beds on today's market, in the average town you will never get a hundred patients in that nursing home because you will sell so many singles. So if you build about 130 or 132 beds, then you might be able to get a hundred patients in that building. This we have learned through experience over a period of time.

Senator Moss. In other words, you would figure on roughly 75 percent occupancy?

Mr. JOHNSON. Yes. Let's say you build half of them for doubles and half of them for singles. Then you rent more singles than you do doubles. Then you are licensed for, say 130. You will probably fill half your rooms at a hundred because the demand has been greater, in our experience, for singles than it has for doubles.

I think we need to add some other things to it. We have the greatest recreation program to get that person to enjoy living; movies in the afternoon, recreation for them to come away from the rooms. We want them to come out of their rooms. Every room that we have has a TV in it but yet we still want them to come to the dining room.

Senator NEUBERGER. Don't you think it would be unethical for a doctor to own a franchise?

Mr. JOHNSON. No, ma'am; I do not.

Senator NEUBERGER. Thank you.

Senator Moss. Mr. Constantine.

Mr. CONSTANTINE. I notice that in your franchise agreement you require the Medicenter to have an arrangement with a hospital for the timely transfer of patients and exchange of medical records, both of which are requirements as you know, in the medicare law.

Did you conclude that those requirements were necessary to provide high-quality care or did you include those requirements in order to meet the standards in medicare?

The reason I am raising that question, is because as you may know, the American Nursing Home Association in its testimony in Washington indicated that these requirements are not necessary to high-quality care.

Mr. DECELL. Please remember that a medicenter is designed for two types of patients, both short term and long term, regardless of age. If we are to get patients who do not need the intensive hospitalization in the facility, we must have a working agreement with the hospital.

So to answer your question specifically this requirement is placed in by a good patient care and I think just good reason.

On the other hand, when a patient has transferred from a hospital we should have adequate medical records and history by this patient's attending physician. This, I think, is just good care. This is not to criticize the stand of any organization pro or con on this, this is merely our statement and our belief.

Mr. CONSTANTINE. Based upon your investigation, you feel those are reasonable requirements designed to achieve good care?

Mr. JOHNSON. It has been our experience that we want that record to follow that patient so that our head nurse will know some of the things that we need to know about that person's life and body and likes and dislikes.

Mr. DeCell. Let me turn the coin over and say this: We intend to provide all of the safeguards possible to guarantee this level of care and we will expose the operation at all times to local hospitals, but there has got to be agreement on both sides as far as reaching the transfer agreement.

We can only say to the hospitals, "This is what we are providing and we want to work with you," and hope that they will work with private enterprise in this field. We think there is a definite contribution.

Mr. Constantine. You don't anticipate any difficulty in your Medicenters working out agreements with voluntary hospitals?

Mr. DeCell. There may be one or two minor exceptions and we would merely cross that bridge when we reach it.

Senator Moss. Do you intend to use FHA financing?

Mr. Johnson. No, sir. We have used FHA financing but we have been successful so far in finding savings and loans and life insurance companies that would furnish the money.

Mr. Miller. Your very attractive brochure, in its summary, refers to the fact that you contemplate providing training for administrators of the affiliated Medicenters and orientation of chief nurses.

My question relates to any plans you may have for continuation of training, including modification to bring in new concepts and ideas as they develop.

Do you have such plans?

Mr. DeCell. Yes.

Mr. Johnson. Yes. We will teach all the time as we do with the Holiday Inns. To keep training is the only way to give better service from year to year.

Mr. Miller. You contemplate then, periodic refresher courses?

Mr. Johnson. Yes; plus the fact that it will be an association where each one of the administrators and owners come together many times for a conference to find out how to do a better job.

Senator Moss. Thank you, gentlemen. We appreciate your appearance and your testimony, and very informative statement and brochure that you submitted. This has been an interesting insight as to what you are doing in this area.

Mr. Johnson. We will leave this package here; if someone wants to come by and get one, if it is all right with you.

Senator Moss. Perfectly all right. Leave it right there.

Our next witness will be Mr. Lawrence E. Larson who is president of the New York State Association of Homes for the Aged.

Mr. Larson, you may proceed.

STATEMENT OF LAWRENCE E. LARSON, PRESIDENT, NEW YORK STATE ASSOCIATION OF HOMES FOR THE AGED, NEW YORK, N.Y.

Mr. Larson. I believe all of you have copies of my statement as well as a brochure of a new institution, a facility that is presently being built in New York City. I would like to read from my presentation, if I may, sir.

Senator Moss. You may.

Mr. Larson. Senator Moss, distinguished members of the committee, and others gathered here today who are interested in long-term care

for the aged, I am pleased to direct my comments, observations, and recommendations.

As president of the New York State Association of Homes for the Aged, as administrator of Isabella Home, and as a member of the central resources committee and former board member of the American Association of Homes for the Aged, I wish to thank you for this opportunity to acquaint you with certain facts concerning private, nonprofit, charitable homes for the aged and of the development, present status, and future of their infirmary facilities.

Since the earliest days of recorded history, the needs of the older person in our society have long been recognized by both public and private officials and groups, as well as those individuals who compose our society. The development of our present-day public and private homes for the aged has come about through the natural evolution of meeting these needs.

It was not, however, until we experienced the social upheavals of the early 20th century, brought about in part by the improvements in transportation and communications as well as the tremendous advancement made in the field of medicine, that officials and interested private citizens realized that for society to play its role in helping the needy aged, new methods, facilities, and means had to be developed to meet this responsibility.

Consequently, our present-day public and private, nonprofit facilities for caring for the aged represent the recognition society is beginning to give to the fact that as long as we are going to help man to live his full fourscore and 10 years and longer, that we have also a corollary obligation to provide these aged individuals with proper and adequate facilities to maintain them as long as they may live.

In the 71st Psalm, David has written:

> Cast me not off in the time of old age; forsake me not when my strength faileth.

This Biblical quote cannot be improved upon, least of all by me, as a fair statement of the challenge the elders in our society present us when they need and ask for our assistance.

Several years ago in a magazine article in the New York Times, Arthur Herzog said:

> Who are the aging? What do we mean by the term? How do older people differ from the rest of us? What are their problems?
>
> There are two myths about the aged which, though contradictory, flourish side by side. The first is that old age is a happy, serene time in which passion has given way to contemplation and experience generated wisdom.

There are, unfortunately, too few benign, elderly sages around for this expectation to be deeply held. The opposite myth supported by Frankenstein-monster photos in the magazines, is that—

> an utter, disastrous, physical and mental decline awaits us all.

I am certain that each of you will agree that the aged person in 1965 presents a picture of more complexities derived from life in an environment fraught with many frustrations and tensions with the sword of Damocles hanging over his head in the form of nuclear explosions, cold and hot wars, charges and countercharges between nations, a refinement, if you will, of the constant, long, struggle of the survival of the fittest, than was represented by grandfather in 1902.

Our science in all its refinements lends every effort to maintain mankind in better health for an ever-increasing number of years. It never arrives at the attainment of one goal without having its sights set on the goal ahead.

Life, as we know it, is never static. It is in a state of constant flux. We may never rest upon our laurels or attainments, but we must always be prepared to help meet the needs of our ever-expanding aged population. We have helped man to live longer and yet we have penalized him for doing so by removing him from the mainstream of society through mandatory retirement. Old people, like all of us, want to be useful and need to be wanted.

Most of you are familiar with the so-called proprietary or commercial nursing homes (and I do not say this except in a spirit of great respect in recognition of the valuable role they play in helping to meet some of the needs of the aged in our society), but you have yet to meet the modern concept of the present day, nonprofit, charitable, home for the aged as it has evolved over the years. It has become a facility which provides an environment that is custodial, therapeutic, protective, and rehabilitative and which is accepted as a normal part of society and which is a far cry from the county poorfarms of our early American heritage.

It is my responsibility to acquaint this committee with the facts and to suggest areas in which legislation may be of help in assisting private homes for the aged to meet and discharge their responsibilities to the aged in our society.

1. There is a need for funds to train administrators to operate properly already existing homes for the aged, as well as other long-term care facilities which are now on drawing boards and in planning stages.

2. There is a need for funds to provide care for that large number of old people who are on 2 to 3 years' waiting lists for admission to a proper facility.

3. There is a need for a program for vocational counseling and job placement for those who are able and wish to work and earn part of their way through life even though retired.

4. There is a need for funds to put back into the mainstream of our communities the talents and experience many of the aged are equipped with. This can be done through volunteer programs, and though VISTA (Volunteers in Service to America) provides an opportunity for some older people to work as volunteers, it is a limited program.

5. There is an urgent need for funds for sociological research. For many years research in gerontology has been biological. We need to know more about aged man in our society and in our institutions.

6. There is a need for capital funds for new equipment, expansion, and construction of homes for the aged with specialized facilities. Although less than 4 percent of the aging in our community ever enter old-age homes, the type of care given by these institutions is so important and so badly needed that we cannot and should not underestimate its importance.

The fact that fewer than 4 percent of our aging population enter old-age homes, is no indication or criteria of the need for such facilities. Indeed, the present-day home with improved infirmary facilities and staffed by professionally trained people is in a far better position

to meet the needs of our older citizens than any other type of agency or institution in our community.

However, there are by no means adequate accommodations in the United States to give this kind of service.

May I ask the committee's indulgence in referring them to Isabella Home and Isabella House in New York City as a prototype of the kind of planning to which we refer.

We use this only because we are more familiar with it, and totally involved in it, and to our knowledge it is the only facility of its exact kind in the country.

Isabella House, a 17-story modern, service-oriented apartment building for the aged grew out of the need to expand and modernize the infirmary facilities of the old Isabella Home and out of an increasing need for more versatile facilities for older people.

It will have a total capacity of over 500. It will provide a package of services to the aged living within its walls in the form of the two main meals of the day (noon and evening), defined medical and nursing care and medications, laundry service and maid service in addition to social service, counseling, activities and recreation, a Golden Age Club, and so forth.

Rents will run from $75 per month to $120 per month and an additional charge of $132 per month for the package of services and $5.50 for utilities. Apartments will be rented furnished at no additional charge to the package.

In other words, a single person can receive complete care short of hospitalization for $212.50 per month. Isabella House will open in November of this year.

I should add that this is being financed on the funds provided by the New York State Division of Housing and Community Renewal. We have a 50-year mortgage of over $6 million to provide us with the capital for building.

The building itself is sponsored by Isabella Home which was founded in 1875 as a private, nonprofit, charitable home for the aged. It has a total resident capacity of 120 with an infirmary capacity of 36.

The average age in Isabella Home is 86 years and this is not unusual for old-age homes. Therefore, the modern home must be staffed by people who are trained to cope with the needs of people who fall in this age range.

The new infirmary of Isabella Home will occupy four floors of the new building and will offer residents of the home complete medical and nursing care of the type associated with general hospitals. It will have X-ray, fluoroscopy, opthalmology, available laboratory facilities, physical and occupational therapy, psychiatrist, dental clinic, podiatry, and so forth.

In many ways the modern home is like a hospital and yet it is not a hospital. It is much more. While giving some of the same type of care that a hospital provides, it does even more. Through infirmary care it provides bedside nursing as needed. When residents become temporarily ill they are formally admitted to the infirmary and when recovered, return to their own rooms.

For those who are permanently confined, the infirmary offers the same type of close personal care that one gets in one's own home.

For the noninfirmary resident, there is a complete assortment of facilities for their personal comfort.

The modern home for the aged is affiliated with a hospital and in some cases a teaching center.

A progressive home has a well-staffed social service department which includes a recreational program. The recreation program ranges from mobile library, language clubs, discussion groups, movies, drama clubs, concerts, painting classes, hospitality shop, dinner parties in well-known restaurants and outing to the New York World's Fair, and so forth.

The modern home goes through a continuous process of involvement and training to be certain that it is meeting the needs of those who are its responsibility. The forward-looking home has a program of applied and theoretical research, although we have found that very little of the money allocated for research in this field finds its way to homes for the aged. A modern home will have institutes, workshops, and seminars to keep abreast of new concepts of care and administration, and of new methods and procedures.

So you see, gentlemen, we are like a hospital and we are not. We are more. We are a home in the truest sense of the word. And we are charged with the moral obligation to give the highest type of care with the greatest amount of warmth and dignity.

President Kennedy said in his February 1963 message on elderly citizens of our Nation:

> Our aged have not been singled out in this special message to segregate them from other ciitzens. Rather, I have sought to emphasize the important values that occurs to us as a Nation if we would but recognize fully the facts concerning our older citizens—their numbers—their situation in the modern world, and our unutilized potential.

In conclusion, may I recommend that your group, or a group appointed by you, visit a representative sample of homes throughout the country and make your own evaluation of the place, the role and needs that a home for the aged play in our society and then be guided to a dynamic program of providing care, facilities, and services to those of our aging population who need them.

And now may I close with a prayer which I find sufficient to keep me from the sin of complacency.

> Lord, Thou knowest better than I know myself that I am growing older and will some day be old. Keep me from the fatal habit of thinking that I must say something on every subject and on every occasion. Release me from craving to try to straighten out everybody's affairs. Make me thoughtful but not moody; helpful, but not bossy. With my vast store of wisdom, it seems a pity not to use it all—but Thou knowest. Lord, that I want a few friends at the end.
>
> Keep my mind free from the recital of endless details—give me wings to get to the point. Seal my lips on my aches and pains. They are increasing, and love of rehearsing them is becoming sweeter as the years go by. I dare not ask for grace enough to enjoy the tales of others' pains, but help me to endure them with patience.
>
> I dare not ask for improved memory, but for a growing humility and a lessening cocksureness when my memory seems to clash with the memories of others. Teach me the glorious lesson that occasionally I may be mistaken.
>
> Keep me reasonably sweet; I do not want to be a saint—some of them are so hard to live with—but a sour, old person is one of the crowning works of the Devil. Give me the ability to see good things in unexpected places and talents in unexpected people. Give me the grace to tell them so. Amen.

Thank you, gentlemen.

Senator Moss. Thank you, Mr. Larson.

I particularly enjoyed that prayer, an excellent one. I should post that up some place where I can read it frequently.

Is the Isabella Home completely self-sustaining on the rents paid by the people who live there?

Mr. LARSON. The Isabella Home is a private, nonprofit home for the aged. It does have a small endowment of its own which is used to make up budgetary deficits which occur. The rates that we charge at our institution, Isabella Home, are rates that are established by the city of New York, Department of Welfare, and these rates fall a little bit short of providing us with 100 percent reimbursement for the services which we render.

Senator Moss. That was to be my next question.

Mr. LARSON. The rates for our new building are established pretty much now on a very arbitrary basis. The rent schedules themselves are established jointly with the New York State Division of Housing and Community Renewal and the Home and are predicated upon what it will cost to pay the interest and amortization on our loan as well as to pay the operating costs for this building per year.

There is no element of profit involved here whatsoever, only what it costs us to run the building. The rest of the package, the charge that we make for meals, medical services, and so forth, are predicated on our present experience in running Isabella Home, the old-age home.

It is our intent to have a centralized kitchen and dining room, centralized supervision of medical services, centralized social services, so that by providing these services in bulk we can cut down the costs considerably over what it would cost to take care of these people in the community.

For what it is worth, Senator, one figure of comparison, at the present time in the city of New York we receive approximately $300 per month to take care of an old-age assistance recipient in our institution. To take care of a person on old-age assistance in this new building which will be opening in September, we estimate it will cost us around $212 per month.

Senator Moss. Is it desirable, in your opinion, to have the infirmary connected and in the same building with the other living facilities which you can provide?

Mr. LARSON. I see no particular problem here, sir. The way we are handling it is this: Our building is so constructed we have two completely separate entrances. On the basement level we have a separate entrance to the infirmary area.

On our first floor level we have another completely separate lobby and elevators for the apartments themselves so that the people who live in the infirmary will at no time have to mingle with people who are the so-called well aged living in the apartments.

I have had some 25 years of experience in running old-age homes and I cannot see any particular problem.

Senator Moss. Do you provide infirmary services to any people who are not residents of the home?

Mr. LARSON. No, sir; we do not. We do have a day center in conjunction with our home which we sponsor jointly with the New York City Department of Welfare. Through this day center we do offer

the consultative services of a nurse who has some advisory capacity to the day center but this is not directly related to the home, and its program of medical and nursing care of the aged.

Senator Moss. Do you find any problem of reluctance on the part of the older people to leave the infirmary and go back to the apartment when they have recovered from whatever the illness was?

Mr. LARSON. Well, I think that I would have to defer an answer to that because at the present time in our present institution, Isabella Home, which is an old building built back in 1888, we have trouble getting them to go from the so-called ambulatory areas into the infirmary again because we are dealing here in ward facilities.

In our new building we will have one-bedroom and two-bedroom facilities which will be equipped with the latest in the way of hospital equipment and will offer a much more pleasant environment for sick people to live.

Senator Moss. I noticed in your statement the call for funds for six different things. Were you thinking in terms there of State-provided funds or federally provided funds?

Mr. LARSON. If I may be very blunt, sir, we don't care where the funds come from but we feel that these are areas that represent areas of great need. In our own institution, for example, we have just completed our first 2-year study. We have a small research department and we are presently approaching HEW for additional funds for research. If I may, it looks fairly favorable at the moment that we will be getting additional funds.

The point is that, in New York State for example, and I am sure that the same probably can be said of other parts of the country, we need more facilities such as we are planning but one of the great problems we have is the lack of adequate and trained personnel to run them; people who can meet with public officials and discuss such things as mortgages and loans. Most of us are social workers by training and profession.

In our professional life we have had little or no exposure to this kind of thing. If we could presently take people who are presently operating as administrators and train them to be able to cope with this world of business and with just the language that is used, that is totally unfamiliar to many of us, we would go a long way toward stimulating the existing private or charitable organizations to venture into this field.

I think that if we could get the Federal funds, for example, to set up instruction in our new building, we would have ideal training facilities. We have both an old-age home and apartment houses for the aged which is going to be operated as a middle-income housing project.

If we had funds to set up training facilities, I am sure that there are other old-age homes in the State of New York that would be very happy to involve themselves providing this type of facility for old people.

Senator Moss. Thank you.

Senator Neuberger?

Senator NEUBERGER. No questions.

Mr. FRANTZ. No questions.

Mr. MILLER. In your statement, the second item listed in the recommendations to which Senator Moss referred, you state there is a need for funds to provide care for that large number of old people who are on 2- to 3-year waiting lists for admission to a proper facility.

I would like a little bit of clarification as to what you are referring to there. Are you referring to funds for construction of facilities because they are inadequate in quantity or are you referring to funds for direct subsidy of residents who are unable to pay?

Mr. LARSON. Well, I am referring to two areas. First of all, most of us who run old age homes that have been approved by the State of New York, that is who have approved infirmary facilities, and are the ordinary old age home, most of us have developed waiting lists that can be as long almost as we want.

In our own instance, we have roughly 400 applications a year and we can accept about 17 or 18 of these. We can take people in only if someone dies. That means many of these people are waiting, looking for a place to live in our institution. They need care. We would accept them if we had the space.

Therefore, we feel that if funds could be made available to allow funds to construct facilities, that would meet the need of many of these people.

Mr. MILLER. Before you go on further, do you have any suggestions as to specific ways in which funds might be made more readily available than they are now?

Mr. LARSON. Well, in the State of New York, we, at Isabella Home, have been very successful in negotiating a loan with the New York State Division of Housing and Community Renewal at a low interest rate. It would seem that if Federal funds could be made available on the same basis that it would be of great interest to the private nonprofit homes or perhaps if direct grants could be made similar to Hill-Burton, Hill-Harris now, that this would be of great interest to homes and agencies who cooperate on a nonprofit basis.

Mr. MILLER. You do not feel that funds are now available?

Mr. LARSON. Not for the type of construction to which I am now referring. I do not feel that the private nonprofit home for the aged is primarily interested in housing as such. I think a fine job is being done by our people in this area. Facilities that are all inclusive that include the type of thing that I have included for Isabella Home is what we need, and most private homes for the aged are just not in position to involve themselves in this because they don't have the resources.

We were very fortunate in that we owned the property in New York City on which our building is constructed and that represented our contribution to the total cost of construction. There are not many homes that have that type of resource.

Then I think the people who are on waiting lists who need more care, that there could be some subsidy so that they could get into this better housing.

It would be of great benefit to them, sir.

Senator Moss. Mr. Frantz.

Mr. FRANTZ. One question.

We had a statement this morning, if I remember the figures correctly, that the welfare rate for patients in proprietary homes is $355 a month and for nonprofit homes $420 a month. Is $420 the rate which is paid?

Mr. LARSON. We have presently approved and certified by the State of New York for a rate of $450 per month plus a $10 a month spending allowance for the patient. This is an all-inclusive figure.

One of the aspects I think that is lost sight of is that the figure that is quoted for the private, nonprofit, charitable home is an all-inclusive figure. For the amount that is paid us we have to provide everything, complete medical facilities. We are allowed to charge no extras as many commercial homes charge.

Our figure is all-inclusive and the only thing it does not include is the hospitalization of that patient.

Mr. MILLER. Senator Moss, pursuing that question further, is the $450 per person, only for those in the infirmary?

Mr. LARSON. In the infirmary that has been approved by the State of New York, Department of Welfare, and by the city of New York, Department of Welfare.

Those patients who are not in the infirmary we are allowed $300 per month old-age assistance. Again, this is an all-inclusive figure. We have to provide their complete medical care short of hospitalization.

Senator Moss. Thank you, Mr. Larson. We do appreciate your testimony.

Mr. LARSON. Thank you very much for the opportunity, Senator.

Senator Moss. Mr. Lawrence A. Kluger, director of the Ramapo Manor Nursing Center, will be our next witness.

We are glad to hear from you, Mr. Kluger.

STATEMENT OF LAWRENCE A. KLUGER, DIRECTOR, RAMAPO MANOR NURSING CENTER, SUFFERN, N.Y.

Mr. KLUGER. Mr. Chairman, honored committee members and staff, this opportunity to appear before you contains a special excitement, for I have followed the progress of the committee hearings for many months. I hope to provide some additional insights into nursing home problems and to suggest possible solutions for them.

I am Lawrence A. Kluger, administrator of Ramapo Manor Nursing Center, a proprietary, owner-operated nursing home, designed and built 9 years ago, accredited with an intensive care rating by the National Council for Accreditation of Nursing Homes and listed by the American Hospital Association.

I am a fellow of the American College of Nursing Home Administrators and have served the New York State Nursing Home Association in such capacities as executive vice president, education chairman and currently am serving as accreditation chairman.

Also, I am a member of the nursing home advisory committee of the north metropolitan region of the Hospital Review & Planning Council of Southern New York.

In the following statement the phrase "nursing home" shall mean an institution which provides continuous medical and nursing care 24 hours a day. I do not want to speak for those homes which are not in the mainstream, although I may speak about them. The problems are as follows:

LACK OF RECOGNITION

Nursing homes lack recognition from doctors, hospital administrators, health insurors, and legislators. The public has been far quicker to recognize nursing homes as evidenced by the fact that over 60 percent of our admissions come directly from their own homes because their needs cannot be met at home or anywhere else.

The allied health field, however, with a stated philosophy of responsibility for total community health care, has been loath to accept the burden of our aging population and work with the profession which cares for it.

We see hospital administrators who refuse to explore affiliation agreements; health insurors who are afraid to save tremendous sums of money by covering nursing home services; legislators, who up to now, have been lax in determining the nursing home's needs in light of the demand for higher standards of care. A recent change in the nurse education law in New York State, for example, has made the professional nurse shortage even more acute.

The physician's lack of recognition often impedes the nursing home program. Many doctors are too willing to discharge hospital patients without concern for the continuity of care they need.

Patients, therefore, arrive at nursing homes (which their families select) lacking medical history, diagnoses and treatment orders. The doctors' lack of concern for the long-term patient and the lack of communication between the acute and the long-term institutions mean time and money wasted in the restoration of the patient. The physician who realizes that a patient cannot go home, but is unaware of nursing homes, causes his patient to remain in an acute hospital bed longer than necessary.

Once treatment for acute disease has been completed, there is no more effective program for aged, infirm patients than that found in a qualified intensive or skilled nursing home specifically geared to their needs. The qualified nursing homes have become quite expert in the management of aged patients.

Hospitals neither can nor wish to do this. Chronic disease can often be a combination of subacute conditions which can only be managed by a specially designed program and specially trained staff. The nursing home has a clearly defined role which cannot be filled by and other medical institution.

The person most affected by the failure of the allied medical professions to recognize the nursing home is the patient himself. The reason for this is hard to explain, although I can surmise that the proprietary nature of nursing homes as opposed to the nonprofit atmosphere of hospitals is a major influence.

Whatever the reason, the situation must be changed and there are several ways to do so:

1. Accept the private, proprietary nature of the nursing home profession, which currently is responsible for 90 percent of the chronic care beds in this country. Like the pharmaceutical industry, nursing homes prove that private enterprise can and does meet a health and welfare need.

2. Adopt the accreditation program of the National Council for Accreditation of Nursing Homes. This will not only elevate the level

of care and eliminate duplication of effort but also provide the best common standard from Maine to California.

3. Make affiliation agreements between hospitals and nursing homes mandatory because this is the most effective method for bringing nursing home patients into the health continuum. The affiliation agreement is of benefit to both the qualified and the substandard nursing home. It assures the qualified nursing home administrator of the service he knows he needs. It assures the substandard nursing home administrator of the services he does not know he needs. Many of these cooperative arrangements exist today successfully, eliminating the heretofore described problems.

4. Stimulate the creation of courses in education for nursing home administrators at colleges and universities. While continuation studies may be helpful for current administrators the field demands that nursing home administrators be as professionally trained as hospital administrators. This will also attract more young people into an expanding profession.

5. Put more teeth into the legislation distinguishing adult homes, boarding homes, and senior citizen hotels from nursing care institutions, by educating physicians and public alike to know that people who need care belong only in nursing homes. Thousands of ill aged, requiring nursing care, now reside in adult homes, boarding homes, and senior citizen hotels receiving improper care. Regulatory agencies are inadequately staffed to police this problem.

THE WELFARE PATIENT

In a proprietary nursing home the only distinction between a private patient and a welfare patient is "who pays the bill?" To think that current reimbursement levels could ever cover the cost of such services as physical occupational and recreational therapy, psychiatric consultation and social service is naive. The average reimbursement rate covers no more than 50 to 75 percent of the actual cost of care.

This condition has forced proprietary nursing homes to make up deficits through private paying patients and is responsible for much of the substandard care.

Proprietary nursing homes cannot continue to carry this burden because as costs rise above welfare payments a self-consuming, liquidating process takes place. Neither operating nor new risk capital is available and this has been the cause of death for more than one industry.

The solution of this problem does not lie in creating a public system for welfare patients, for the proprietary nursing home enables the Government to purchase lower cost service than it could provide itself and in a much better way. In county homes, patients live in an atmosphere of lost dignity, completely dependent upon charity. In a society dedicated to the preservation of human dignity, the proprietary nursing home affords every person the feeling of service with freedom from shame. This concept is neither political nor economic in philosophy. It is simply a basic tenet of good patient care.

A solution must be found in other ways, because cost studies of county homes will reveal a far greater operating deficit than if proprietary nursing homes are paid a proper rate for their welfare patient

care. Also, the large amount of money it would take to create public systems would produce an even larger taxpayer burden.

Since the proprietary nursing home is both economically and psychologically more comfortable, it behooves us to find ways to bring additional dollars into its welfare patient care.

CREATION OF NEW BEDS

There is universal agreement that additional nursing home beds are needed. One problem is to determine where they are needed and how many. This region of the country seems able to support new nursing home construction provided the controls on bed supply are exercised very carefully.

The Hospital Review and Planning Council, which in New York State is providing much of the assistance in determining needs, must not overlook the existing beds and the role they play in meeting welfare and middle-income needs. The judgment that nursing home beds are not suitable for long-range use on the basis of fire resistance alone not only overlooks the quality of care but also breeds permission for construction of more beds than are necessary. This Hill-Burton concept of suitability on the basis of fire resistance only is unrealistic.

Another problem is the method by which new beds are financed. The nursing home industry needs new risk capital but some of the guidelines for obtaining it, such as the Federal Housing Authority, are inviting disaster.

The 10-percent equity, 90-percent carrying charge insurance by FHA is insidiously dangerous in the creation of facilities in which human lives are at stake.

The small cash equity can attract promoters and investors who have little interest in patient care because they have very few dollars risked. No nursing home should be created with less than 50 percent cash equity for the sake of all parties concerned. In that way, no operator is ever placed in the position of sacrificing patient care in order to meet mortgage requirements; enough operating dollars are available to support the broad range of services nursing homes must have; and the FHA will not find itself in possession of a string of defunct nursing homes.

FHA requirements often result in an overly luxurious facility in which many of the trimmings have more to do with selling the space than with patient care. This results in even higher charges in a field in which the basic necessities of nursing care are expensive enough.

PHYSICIANS

Geriatrics, as the physicians at Ramapo Manor perform it, is the practice of medicine on older people. It is neither a mystery nor an unusual specialty. We do not consider aging a disease and the calendar does not always bear upon the condition of a patient.

Some normal capabilities exist in every patient, regardless of diagnosis, and these must be exploited in order to do a proper job. It is relatively simple to provide for the incapabilities of patients. The challenge comes from motivating the patient to do what he can, and 50 to 75 percent of the problem comes from the fact that older people react to their organic losses. If there could be universal acceptance

of these attitudes by doctors, a lot of the older population would not be in nursing homes, or at least, would be a lot happier in them.

The thought that it is "socially unproductive" to apply physical therapy to nursing home residents is totally repugnant. Every human being, regardless of age, deserves the opportunity to regain his health. The decision that restoration is impossible can only be made after thorough evaluation, in professionally oriented surroundings, over periods of time much longer than are customary for young patients.

If only partial results are obtainable and institutional care is required for life, a complete program of maintenance therapy must be instituted in order to assure well-being.

To consider removal of maintenance therapy programs in nursing homes is to arbitrarily foreshorten a human being's life, the control of which has not yet been granted to mortal man.

AMERICAN HOSPITAL ASSOCIATION

The current schism within the Joint Health Council, which seems to have erupted over the medicare issue, but which had earlier roots in the instinctive reaction of the "nonprofits" against the frightened, insecure "proprietaries," has delayed healthy progress in the nursing home profession.

Two expensive, aggressive compaigns are being waged today to establish accreditation programs for nursing homes; one by the National Council for Accreditation of Nursing Homes and the other by the American Hospital Association. This is divisive and will cause considerable delay in the implementation of medicare. Who caused this schism is of no concern.

This conflict must be resolved and all energies directed toward the need of our aged patients who are growing in number.

The solution lies in putting the responsibility for establishing criteria and accrediting nursing homes in the hands of that group most qualified to judge—the National Council for Accreditation of Nursing Homes. This action would not be precedent setting and would be in keeping with the policy that professionals are best able to judge their peers.

The National Council's standards, the most extensive and thorough perusal of nursing home programs, were created by people who know nursing homes best and should become the established yardstick. Any worthwhile attempts by other groups to establish evaluation criteria for nursing homes must result in similar standards and a waste, therefore, of time and money.

Isn't this issue really a matter of leaders versus followers? Isn't it time for the allied health field to seek out the people who created the National Council's program and accord to them the status of professional ally?

BLUE CROSS

There is an analogy that can be made between the nursing home profession and the Blue Cross plans. It has been said in some areas that nursing homes are centers of enlightenment while in others they border on the medieval. The same statement also describes Blue Cross plans.

It is inconceivable that Blue Cross has not univerally purchased nursing home service in light of the lower patient care cost. This is one of the major reasons for the frequency and size of premium increases. This refusal to meet subscriber needs not only compounds the problems mentioned heretofore but creates them as well.

The fact that aged patients can get hospital but not nursing home coverage causes overutilization of acute beds and leads to overconstruction of hospital beds.

Blue Cross was the product of people with the vision to see the public need for third party payment of hospital care. Where is that vision today? Is the answer that not all nursing homes are suitable? If so, in the State of New York, it is a direct insult to the regulatory inspection and advisory program of the New York State Department of Social Welfare.

This does not mean that every nursing home deserves coverage, but every Blue Cross plan should make use of the large number of qualified nursing homes. There are enough of these to alleviate part of the current dollar crisis within Blue Cross.

By using nursing homes Blue Cross could save one-third to one-half of the daily cost of hospitals. For the same cost as hospital care Blue Cross could provide two to three times the length of nursing home care, alleviate the acute bed shortage, hold down premium costs, and make the aged person's dollar go a longer way. A byproduct of this extended coverage would be additional incentive for substandard nursing homes to upgrade themselves.

The last 10 years have seen major changes in the nursing home profession. Along with the increase in lifespan, the conquest of disease, and the development of the justifiable entity of the nursing home has come the evolution of leadership—men and women who pioneered in a field which is only recently receiving national attention.

These individuals have traveled a long road, alone. The time has come when they cannot progress much further unless they are joined by all their professional brothers in the struggle toward the common goal of comfort and peace in the last years of life.

Senator Moss. Thank you, Mr. Kluger, for a very fine statement. You state rather strongly that there has been a sort of a boycott of the nursing home services by the medical profession, by the insurors, and by others.

Is there any reason for that, do you think?

Mr. KLUGER. I didn't mean to imply, Senator, that this is a universal boycott. We have pockets of enlightenment across the country, certainly with which I am familiar. But even in our area we have individuals who would not view aged patients in what I think is a good way to look at them. We often get patients every week where there is a total lack of information and we have to go scurrying to really find it, and there is no reason for it.

Senator Moss. Don't you think the problem is in part the fact that only recently have we really upgraded the services of nursing homes through codes and otherwise, and that perhaps we have not caught up with that in the general consciousness yet?

Mr. KLUGER. Perhaps I am motivated by the fact that many colleagues in our field have been operating along the lines that are only recently being developed. For example, in our own relationship with

the local hospital we have been in a sense not literally, figuratively affiliated with them since our inception because we recognized very early that these individuals will need total health care that no nursing home could provide alone.

Many other nursing homes across the country are doing this and have done it. We cannot seem to learn why there is all this delay and failure for recognition which continues.

Senator Moss. I note your recommendation that we put teeth in the legislation to distinguish the nursing home from these adult homes or boarding homes. How, specifically, would you do that?

Mr. KLUGER. I think the best approach to this problem which is a prevalent one, is public and professional education. The kind of abuse you will find in a hotel is a diabetic individual with four or five concurrent medical problems who at one point in her life was able to care for herself. Now she could not have gotten all these medications without some physician ordering them. Somewhere in the background for all these aging persons is a doctor, or at least in a vast majority of them. So we educate him. He is not to permit his patient to enter that kind of environment.

The same applies to the public. As I mentioned in the beginning, the public has accepted the nursing homes far ahead of the professional fields because they must place these patients somewhere. We cannot keep pace with the demands of care. If the public were to be notified that the senior hotel will not take care of a person who has four or five concurrent medical problems, that is one way.

The same approach you have had—by "you" I mean regulatory agencies have had—with nursing homes over their development, is to educate the individuals who run them. So we educate the manager of a hotel that he just does not take in this kind of person, and then that is another way of helping.

Senator Moss. The medicare bill that has just been signed by the President recognizes nursing home care as one of the needs of elderly citizens.

Do you think this is a long step along the way you have been recommending?

Mr. KLUGER. Absolutely. I think it is a fine thing because it is the first universal thing that is going to be done.

The question of whether there were better kinds of programs is a rhetorical question at this point, but I will say in passing that there were other areas of the health field where dollars could have been made available. It was just the reluctance of some of these groups that I have described here just not—I think they failed to rally around the basic core of this thing—the individual who is sick and old.

For example, I didn't put this in the paper but on the subject of welfare dollars, there is a concept that I think should be explored and that is, quickly stated, supplementation. I think there are a lot of voluntary dollars out there, individuals who don't want to become members of the rolls of charity and yet who cannot pay $15 or $18 a day who maybe could pay $7, $8 or $10.

If they had an opportunity to share in the provision of care for their loved one—that is, share with the welfare assistance agency plus their own few dollars—you would be taking advantage of moneys out there without digging into tax dollars.

Senator Moss. Very good suggestions.

Are there any staff questions?

Mr. CONSTANTINE. Yes.

You speak of the nursing homes which you describe as not in the mainstream. That would be a fairly large stream, would it not, because a large percentage of homes are not——

Mr. KLUGER. Not in the mainstream. Yes; I have to agree. I cannot cite figures, Mr. Constantine, but I do know there is a large number of individuals whom our programs in the association have failed to reach. They are individuals who probably don't know such words as "affiliation" and "accreditation" and "education" and a lot of other modern concepts.

We have done research on why. We know that half of those are so essential to the function of their homes that they cannot leave them.

Mr. CONSTANTINE. Mr. Kluger, if you don't mind, do you have any information which you could give us as to the approximate rate of return on your investment? Then as an official of the State nursing home association, what would you estimate is the rate of return on proprietary nursing home operations in New York State?

Mr. KLUGER. Well, I would be able to give you some figures that I gleaned after researching the possibilities of a second unit of my own in Nassau County. In other words, our unit is in Rockland County, our current home, and 3 years ago we thought about the possibilities of developing another in Nassau County.

I am speaking now strictly as an investor in that instance. In other words, I would not have run that second unit. We estimated an 8-percent return on our investment, which we felt was inadequate for the amount of responsibility that would go along with it.

My own personal feelings are that private nursing homes should be owned or operated in order for the owner to have at least a reasonable return for risking his life and limb and his gray hairs in this profession and in order to have the thing on a sound business basis.

After all, they are businesses, they should be accorded that view.

Senator MOSS. Thank you very much, Mr. Kluger. We appreciate your testimony. You have been very helpful and enlightening to us.

Mr. KLUGER. Thank you.

Senator MOSS. We have another witness but I am going to have about a 5- or 10-minute stretch for the seventh inning and then we will have Mrs. Carey as the next witness.

(Whereupon, a brief recess was taken.)

Senator MOSS. We will now proceed.

Our next witness is Mrs. Jean Wallace Carey, who is the staff associate for aging, department of public affairs, Community Service Society of New York City.

We are very pleased to have you, Mrs. Carey, and look forward to your testimony. You may go right ahead.

STATEMENT OF MRS. JEAN WALLACE CAREY, STAFF ASSOCIATE FOR AGING, DEPARTMENT OF PUBLIC AFFAIRS, COMMUNITY SERVICE SOCIETY, NEW YORK CITY

Mrs. CAREY. Thank you for the opportunity to participate in hearings which attest the concern of the Special Committee on Aging for the thousands of older Americans who now need or in the future may need some kind of long-term care.

My own experience in the field of aging in New York City goes back to 1950. It includes 10 years of on-going consultation given to more than 50 sectarian and nonsectarian homes for the aged and nursing homes. Since 1960, I have been involved in the social action program of the Community Service Society, the oldest and largest voluntary family welfare agency in the country with a direct and communitywide concern for the total well-being of families and individuals in New York.

Clearly, this concern includes those individuals who are chronically ill and infirm; who need many-sided services in a living arrangement whose appropriateness should be determined by patient need and not by the availability or absence of basic and supporting services.

My testimony is deliberately directed to the need for community-based services that will achieve the goal of maintaining older men and women in their own homes or in family-like settings as long as possible. Quite apart from the social desirability of this goal—and few question this—the slowdown in growth of long-term institutional facilities meeting acceptable standards in New York City imposes the necessity to stress noninstitutional care.

To be specific:

In January 1960, there were 181 nursing-home-type facilities with a bed capacity of 16,698 for the care of adults in New York City. By the end of 1964, such institutions numbered 147 and the bed capacity was 16,355—down 343 or 2 percent.

Facilities under voluntary nonprofit auspices which numbered 55 in 1964, showed a modest increase in bed capacity of 291 or some 6 percent—up from 5,124 to 5,415.

The capacity of six public home infirmaries was 2,255 in 1964 and was up a little from the 1960 capacity of 2,200, or 2.5 percent.

Proprietary nursing homes were down in number from 118 to 86 as we have heard earlier today, and the bed capacity was down from 9,347 to 8,685 for a reduction of 689 or about 7 percent.

These are disturbing facts in the light of a 1962 study ("Background, Issues, and Policies in Health Services for the Aged in New York City," a report prepared for the Interdepartmental Health Council and the Health Research Council, New York City, and issued in March 1962) which carried projections based on prevalence rates of a need by 1970 for 15,000 new and replacement beds for long-term care for New York City's older age population.

The Hospital Review and Planning Council concurs in this projection and conservatively estimates that the requirement for building long-term facilities for people in New York City is in the order of 13,000 to 15,000 beds—7,500 to 10,000 new beds and 5,400 beds now in unsuitable buildings. Capital cost outlay for construction, figured at an average cost of $13,000 per bed, is $169 to $195 million.

My architect friends tell me that in New York City a $13,000 figure per bed is probably on the low side and probably should be figured at $15,000 to $20,000 per bed. This, of course, makes the capital cost outlay higher.

What are the prospects of meeting this projected need? Our review in late 1964 indicated that expansion and replacement under all auspices may be in the range of 7,900 to 8,600 beds by 1970.

The estimates are optimistic, it is believed, but could go up or down depending on many factors. Taken at their face value, it seems highly likely that the projected requirement based on 1960 prevalence rates will not be reached; that the "shortage" may range from 4,400 to 7,100 beds for long-term care of New York City's adults who are chronically ill or infirm and need protected but not hospital care.

Prevalence rates are by no means static. They change as the potentialities and methods of medical care and institutional care change. Tightness in the nursing home situation can be met by decreasing the need for institutionalization through increasing the quantity, quality, and coordination of community-based programs—housing accomodated to the needs of older persons, clinic and home care programs, home nursing, homemaker services, foster care programs, escort and transportation service, meal service, and friendly visiting.

On the face of it, the provision of community-based services seems a simple and obvious answer. But the delivery of such services is complicated, indeed, as a study recently completed by the committee on health in the society's department of public affairs indicates. (The project was a collaborative enterprise of the society, Goldwater Memorial Hospital Geriatric Rehabilitation Service, the Department of Physical Medicine and Rehabilitation of New York University-Bellevue Medical Center, and the Departments of Hospitals, Health, and Welfare of the City of New York. It was financed in part by a grant from the Office of Vocational Rehabilation.)

The major aim of this demonstration project was to develop and assess the effects of a program of family-centered public health nursing provided to patients 60 years of age and older, discharged from the rehabilitation service of a municipal hospital.

A secondary aim was to learn how well the community was prepared to meet patient needs that might arise following discharge from the rehabilitation center. Certain findings are pertinent to the purpose of this hearing, even though the study population was seriously disabled and otherwise atypical of older persons in general.

For patients discharged to the community and served under the public health nursing program for 18 months, there is evidence suggesting that in respect to:

> Physical functioning the program did not have a measurable impact. The health of all participants generally deteriorated. This was particularly true for individuals who lived in institutions and, it should be noted, one-third of those institutionalized were independent in physical functioning (except for tub bathing) and had no evidence of disease or personality defect that would affect ability to plan and manage their affairs outside of an institution.

Interestingly, self-ratings by individuals living in the community indicated that the program was effective in reducing regression:

> Health care and management on a variety of indexes (medical care, food intake, and adherence to special diets) the program was consistently effective for those served as against those not served. This held true for the institutionalized group as well as for the noninstitutionalized served under the program.
>
> In mental health, adjustment, and morale the program was effective in respect to patient's understanding of reality, self-

understanding, and self-acceptance. Beyond these indicators, the evidence was inconclusive. There was a general downward trend in mental health which was particularly marked for the institutional group.

Living arrangements and material circumstances the program had modest, if any, impact.

Social environment the program had little effect. However, there appeared to be less regression in interpersonal relationships for the served group in the community and somewhat more recreational activity for the served group, particularly those in institutions.

Movement (a composite judgment of change, involving health and adaptive efficiency, understanding and attitudes, and environmental circumstances) the program was effective when the "served" and "not served" groups living in the community were compared. There is no evidence to support this conclusion for the institutionalized group.

So much for study findings per se. The public health nursing program was heavily dependent on the availability and accessibility of other social and health services. The study, therefore, throws considerable light on the changes in related services that are needed to accomplish more striking results with this elderly, handicapped patient group and, in fact, for all older individuals whose physical or mental condition requires help and intervention beyond the usual resources that the individual or his family can command and understand.

The study indicates the necessity of continued and comprehensive care by well-coordinated social and health services if vulnerable sections of the older age group are to live independently.

What emerged from project experience is this:

Many individuals are unable, for social or medical reasons, to reach out and utilize available resources. It is important, therefore, for health and welfare services to seek them out and make easily available the resources that advanced age and physical or mental impairment may require.

There is a breakdown in elementary communication between existing services and between existing services and individuals. In many instances problems were created solely because information was not conveyed to another service or because the limitations in patients' understanding of instructions were not appreciated.

Restrictive intake policies often place the individual in a quandary since he could be excluded from one needed service because he was known or being cared for by another resource.

Absence of periodic review of the patient's total situation by the service taking major responsibility means that new needs are not evaluated which may require a change in service.

Individuals and their families are unaware more often than not of what to expect with declining health or what can be expected from communal services.

Slowness in the delivery and impediments to obtaining needed services combine to confuse and discourage older persons and lead to neglect of medical problems and unnecessary complications.

If the need for institutionalization for long-term care is to be reduced by increasing community-based programs, complications clearly exist. These are amenable to resolution. This testimony is to urge that attention be directed not only to improving the quality of institutional care for the long-term patient who needs 24-hour protection and care but also to improving the quantity, quality, and coordination of community-based services for those who can benefit from this type of care.

That the results from community-based services can be individually satisfying and socially satisfactory is illustrated by the following situation:

Mr. Lewis—we identify him by a name not his own—a 77-year-old man with no relatives, received hospital rehabilitation after surgery for a fractured hip. He was discharged ambulating with two canes indoors and two crutches outdoors.

His health was fairly good, except that at hospital admission he was considered undernourished. Mr. Lewis had made arrangements with the manager of the hotel where he had worked as a bookkeeper to return to his room after hospital discharge.

He received $78 a month from social security and he said he had "several hundred dollars in savings." He was told by the medical social worker at the hospital that he could apply for old-age assistance when these savings were depleted. He was also advised to return for clinic followup.

Mr. Lewis was in the group that received service in the study project. When he was first seen he was upset about money matters. His room rent was more than he had expected. He had received a $1,500 bill for surgery. The few hundred dollars in savings turned out to be a few uncashed social security checks.

Mr. Lewis had other problems. It was expensive to get to the clinic—two fares going and two fares returning—and was physically difficult to manage on buses or subways. The waiting time at the clinic was long. Mr. Lewis was also learning that he couldn't get to the restaurant where he had eaten before because his gait was too slow to cross the street in the time span of the traffic lights. Food was more expensive than he had remembered and so he planned to save money by eating only two meals a day. And he said, "There is just nobody around I can talk to."

The consequences of his disability were bewildering and well-nigh overwhelming. He needed help to identify his problems and then to implement plans for the future.

An early step was to have Mr. Lewis discuss his actual financial situation with the hospital where surgery had been performed. The hospital bill was covered by MAA.

Through a voluntary family agency, he was placed in a foster home where he was delighted to find there were teenagers in the family.

Mr. Lewis, who had resisted applying for "welfare," was helped to consider it. In his own words, this was "really a supplement to social security and not as degrading as receiving welfare support." From regular and nourishing meals, he gained weight. Transportation for regular clinic care was arranged.

At project intake, Mr. Lewis felt inadequate to handle his personal problems. At service closing he was no longer apprehensive or unsure of himself. He had made a good transition from independence to living with a disability. He was enjoying a relatively full and satisfying life.

The thrust of our testimony is to urge the importance of social assessment prior to institutionalization and, where medically and socially appropriate, the marshaling of community services that will defer, even if it does not prevent institutionalization.

Mr. Lewis was lucky. Long-term care in a living arrangement appropriate to the patient's need should not and need not depend on chance.

Senator Moss. Thank you, Mrs. Carey, for your testimony, I appreciate it. I think perhaps in our discussion of institutional care we do tend to overlook the really great possibilities in portions of utilizing other community services because the best way possible for aiding our elderly citizens is to help them continue to live in the community.

As I think some of our earlier witnesses testified, older people tend to become dependent on the institution so completely in a short period of time. If we can keep their independence alive, it is so much better. I appreciate your bringing us back to this, and this is an important part of our record.

Out in my State of Utah there is a program by a rather imaginative name. They call it Meals on Wheels because they have a method of bringing hot meals to older people who are not able to get the kind of nutrition that they need where they happen to be living alone.

This is one little, narrow facet of course, but it indicates the things that we can do with a little ingenuity and effort to help our older citizens to have a satisfying and full life without going to an institution.

Mrs. CAREY. It has always been a surprise to me that Meals on Wheels, so typically American in its name and its connotation, has not been more widely picked up in communities throughout the country. You know, it started in England.

We have seen some variations of that coming along, in some of the newer housing projects, for example, where a cafeteria or food service is being planned in the day center in the building. They are figuring on a certain proportion of carryout meals so that the individual who can have a hot meal at noon does not have to prepare the supper meal. I think that this is a variation of Meals on Wheels that deserves further exploration. It is hard to cook for one or for two when your energy is drained.

Senator Moss. We were discussing the infirmaries connected with a nursing home or long-term care, and I asked the question earlier whether the infirmary might not be available on a more or less outpatient basis.

Do you think there is an area here that we ought to direct some more attention to?

Mrs. CAREY. I think that this is a possibility, and now I am speaking particularly to the nonprofit field, be it under public or voluntary auspices.

As you see increasing affiliations being worked out with hospitals, more medical services are available. Under New York State laws, as

you perhaps know, proprietary nursing homes may not provide medical service except under an emergency.

It does seem to me this is a possibility and particularly for those individuals who have been accepted for future admission or for nonresident programs, home-care programs, call it what you will. These are to extend the services of the institution to those who either cannot now be served or perhaps do not at the point of application and acceptance need either home for the aged or infirmary care. I think you have to look to stretching services in this kind of fashion.

I also think you have to see that somebody acts as a responsible agent or agency for older individuals. You can get awfully lost in the maze of services, and if this were an obligation that was assumed by the nursing home, this would provide the continuing link to community services other than those that the institution itself might provide.

I think this is terribly important.

Senator Moss. Mr. Larson testified about the backlog or waiting list that existed in his particular home and others. Do you think we could make considerable reduction in that if we emphasized more the community services that you have been talking about? Do you have any estimate of how much could be done?

Mrs. CAREY. I hate to get into the question of waiting lists because the definition of what is a waiting list and what is not a waiting list is a very complicated one. Certainly there are "waiting lists" for admission for infirmary care. I think that there is no question about this. The length of the waiting list for domiciliary or custodial care, I think, may be something else again.

Some of the institutions, and here I think of Peabody Home and what used to be the Home for Aged and Infirm Hebrews—it has a new title, Jewish Home and Hospital for the Aged—have rendered service to a group on their waiting list. Peabody Home, I was familiar with and I know that people stayed on that waiting list or nonresident aid program until there was a real demonstrable need for the 24-hour care because they had assurance of admission at the point of need.

For many people the application is in anticipation of need rather than confrontation with the actuality of need at a given moment.

Senator Moss. With the advent of medicare, do you think we are going to have adequate facilities to meet the great number of increased applicants?

Mrs. CAREY. I think clearly the provisions of medicare are going to pose problems for the hospitals. I do not see medicare as providing much of an answer to the need for long-term institutional care in nursing homes. The limitation on days of care, the requirement of a period of hospital care means that this is a very little bit of a solution; it would cover, it would seem to me, convalescent needs and this could be a desirable solution.

I would hope that the provisions both in plan A and plan B for care, however these may be defined in rules and regulations, would take some of the pressure off the hospitals and convalescent facilities and I would think, would still meet the needs of many older individuals through home health services protected by the fact of physician authorization. This certainly would reduce the drain on resources, both in plan A and plan B.

Other people discussed no benefit costs of hospital care. I don't need to talk about $48 per diem.

Senator Moss. Thank you, Mrs. Carey.

Are there any staff questions?

Mr. CONSTANTINE. Yes.

Mrs. Carey, just a point. The Senator called attention to the Meals on Wheels program and I think there is quite a bit of discussion in this general area.

Do you think it might be possible for an organization such as Holiday Inns to set up a franchised operation for Meals on Wheels? I mean that seriously. With their skills and so on, might they productively devote their attention to that?

Mrs. CAREY. There is a representative here from the National Council on Aging and I think her comments could be directed to this. I do think that that is a place for the experienced purveyor of food to get into the making of meals and the delivery of these rather than depending, I think, as many problems have, on volunteer or less expert services.

This could be a place where nutritious meals at low cost could be made available. I think this has been a point that the national council has made, that this is the place that private enterprise can serve.

Mr. CONSTANTINE. Just one more question. In Dr. Haughton's testimony earlier this morning, he called attention to the lack of attention in hospitals in terms of discharging patients to appropriate facilities.

Dr. Haughton did not describe what might be appropriate mechanisms for proper placement. Do you think that this is an area where the Community Service Society or similar groups could assist?

Mrs. CAREY. Yes; I think, this is something our own nursing subcommittee on aging on which I work could direct attention to. I do think that here medicare legislation is going to have some useful safeguards in respect to the arrangements that must be made between the nursing home facility, under any auspices, and the hospital from whence nursing home patients will come after some length of stay.

I do think, too, that you need a sturdy social assessment of the situation going hand in hand with the medical assessment of needs.

I think somehow we can simplify that assessment procedure. Forgetting the kind of thing I think you were suggesting in your question. Mr. Constantine, we would be glad to take a look at this on our own.

Mr. MILLER. Mr. Constantine was a little freewheeling but in all seriousness, with meals on wheels, is not a major kind of problem in delivering meals on wheels the wheels end, the actual delivery? Pursuing Mr. Constantine's question might not the dairy groups that are engaged in regular house-to-house deliveries become involved in this and be a great source of help?

Mrs. CAREY. I live in Manhattan. I don't know how much the dairies deliver house-to-house but I do think it is possible to think of some neighborhood-based operation or some such arrangement as you are talking about.

What I think we are seeing in the housing projects where this is envisaged is possible delivery where there is a measure of concentration of older persons? As a matter of fact, I think for many of these home-based services you have to have some concentration of older persons else your travel time by the older person or by the professional

or the subprofessional giving the service is appallingly expensive and your system breaks down thereby.

I think this neighborhood basis of deliveries, as you suggest by dairies, is something you have to think of in the neighborhood character.

Senator Moss. Thank you, Mrs. Carey.

Mrs. CAREY. Thank you very much.

Senator Moss. We enjoyed having your testimony and it has been excellent.

We are going to recess now until 10 o'clock tomorrow morning.

I have here a statement prepared by Mr. Irving Levin that will be placed in the record. It won't be possible to hear it personally but it will be made part of the record.

(The statement follows:)

PREPARED STATEMENT OF IRVING LEVIN, INSTITUTIONAL REAL ESTATE SPECIALIST, NEW YORK, N.Y.

A troublesome aspect of the problem of the aged is absence of facts on local community levels about the health needs of the aged-ill. We have many opinions, a plethora of interesting statistics, and many broad generalizations—but no really significant, concrete, reliable or up-to-date facts on which to predicate sound regulatory action on town, municipal, or county levels. I want to make a few observations and suggestions on the need for basic facts about the health needs of the aged and how to get them.

It is obvious that medicare expresses the legislative will of the U.S. Senate and the House of Representatives. But, that is only the bare beginning. The regulatory implementation by States and municipalities will determine to what extent congressional intent will be carried out. Billions of dollars will be involved in many programs for the aged-ill—formulated by nonprofit, governmental, and proprietary interests, and they will be making huge financial investments in capital improvements and operating programs. What practical facts about the medical and health needs of the aged will guide them? There are, of course, many other problems to be faced by these three principal participants in our health-economy (nonprofit, government, and proprietary) but let us confine ourselves for the moment to the simple question: What set of facts will they need to plan, program, and implement?

I submit the observation that we now have practically no reliable facts about the health needs of the aged in any community in the United States, on the basis of which local government, eleemosynary or business interests can proceed intelligently with the building of health-care facilities or the programing of health services. For any given community (a town, city, county, or metropolitan municipal area) we now do not know how many of the aged have chronic or acute illnesses and what specific posthospital short- or long-term care facilities and programs they require.

We know that 19 million Americans, 65 years of age and older, will become eligible for hospital and nursing care under social security but for Elkhart, Ind.; or Miami, Fla.; or Poughkeepsie, N.Y.; or Chicago, Los Angeles, New York City, etc.—for each of thousands of communities throughout the country there is no reliable guide to action by individuals and organizations interested in providing the necessary institutional facilities and services.

I say this from 15 years of experience as a nursing home consultant and broker who has made hundreds of nursing home appraisals and who now finds himself called upon frequently, to make feasibilibility studies for nursing home sponsors, banks, mortgage brokers who are concerned less with opinions and generalizations than with facts about the demonstrable need for the proposed nursing home projects which they are promoting. In making these feasibility or need-justification analyses I have interviewed many nursing home owners, nursing home licensing officials, physicians, hospital and nursing home administrators, social workers, heads of public welfare and health departments, the hospital review and planning agency in New York State and government bureaus concerned with the problems of the aged in Pennsylvania, New Jersey, Vermont, Kansas, etc. I have gone through much of the relevant literature and statistical data and I am sorry to report they offer no factual bases for local community action.

Let me be specific. I was recently asked to make a feasibility study for a nursing home owner who planned to build a brand-new, nursing home separate from his present facility. While there was available the standard-generalized, Census Bureau statistics on persons 65 and older, the usual local chamber of commerce data about the community, there was nothing specifically helpful or remotely relevant on the local needs of the aged at the local hospital, the welfare and health department offices, or any other local source. Everybody interviewed was of the opinion there was a real need for nursing home beds. No one, however, could offer any worthwhile facts to support opinions.

The ideal set of facts to determine a community's nursing home needs would be based in part on having for each person coming under medicare the following information: Age, residence, and state of health. If a health condition exists: what is it, what is being done for it, what does the person's health condition require? If in a hospital: the date admitted, source of referral, name of physician, cause of admission, daily hospital rate for room and board, public welfare or nonwelfare status, medical diagnosis and prognosis. Is there a need for posthospital care and, if so, what type of posthospital care and treatment? Is hospital discharge being held up for lack of nursing home or convalescent home or other facilities? If in an existing adult-care institution, specify the type (nursing home, county home, or infirmary, nonprofit home for aged, etc.) and submit information somewhat similar to that for hospital patients. A simple schedule of this general order would enable communities to develop basic health-need facts and to plan accordingly.

In short, we need a national inventory of health-needs based on some such relatively simple schedule applied to each person age 65 and over. It should be part of the U.S. decennial census program in 1970. However, passage of medicare and its imminent implementation by Federal, State, and local regulatory agencies have created an urgent need for facts now, not 5 years from now. Vast sums of money will be poured into the Nation's health-economy before 1970. Without facts about the health-needs of the aged, the economic and political consequences of regulatory implementation may be disastrous. If a mid-decennial comprehensive, national inventory of health-need should be impractical then we must have an inventory based on the application of the aforementioned schedule to all adults in hospitals and adult-care institutions as well as to the elderly who are outpatients of clinics, medical groups, and physicians.

Rivalry is mounting among governmental, nonprofit, and proprietary interests in the race to provide health facilities and services for the aged. It is highly important that this rivalry be encouraged on a fair and equal basis. These three segments of our national health economy can by their unique contributions of experience and resources provide a firm foundation for a soundly administered medicare program. A sensible way to encourage the three partners in this national health effort is to first make freely available to them the basic facts of local health needs of the aged. I am convinced that this can best be done by a national health inventory for medicare. Let Government, nonprofit, limited-profit, private entrepreneural and any other form of organizational effort participate in the implementation of the national dream of the Great Society but first give them the facts on which to proceed. Later on, let us examine and evaluate what they have done by measuring the quality of health-care thus rendered.

Let's formulate standards of health care to be observed uniformly by Government, nonprofit, and proprietary interests—but, first, let's have the facts about health needs to blueprint the way. Can you imagine a modern skyscraper, bridge, or tunnel being built without plans and specifications? The tremendous health engineering challenge of medicare cannot and should not be met without comparable planning.

Senator Moss. I might announce if there are others who have pertinent information that they think should be presented to this subcommittee and it is not possible to hear them personally, they may submit in a statement in writing and if it is appropriate to what we are discussing, it will be made a part of the record and will be available to the committee when we study this problem in the Congress.

We are now in recess until 10 o'clock tomorrow morning.

(Whereupon, at 4:45 p.m., the subcommittee recessed, to reconvene at 10 a.m., Tuesday, August 3, 1965.)

CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

TUESDAY, AUGUST 3, 1965

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
New York, N.Y.

The subcommittee met at 10:10 a.m., pursuant to recess, in the auditoruim, New York University Medical School, 550 First Avenue, New York, N.Y., Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss and Neuberger.

Committee staff members present: Frank C. Frantz, professional staff member; Jay B. Constantine, research director; and John Guy Miller, minority staff director.

Senator Moss. The hearing will come to order.

We have delayed just a little bit in expecting our first witness but I have not seen him in the hearing room yet. Therefore, we will start with the second witness and hope that Congressman Lindsey will arrive in time to appear before the subcommittee.

This is the second day of hearings of the Subcommittee on Long-Term Care which is a subcommittee of the Senate Special Committee on Aging.

We had some very fine testimony yesterday. I believe that we added greatly to the record that we are trying to compile. These hearings are being held in various parts of the United States to determine what progress is being made in this field of nursing home care and long-term care and to help us to assess whether there is any need for further Federal action at this time.

We will hear this morning first from Dr. I. J. Brightman, who is the assistant commissioner for chronic disease services for the State of New York. If you will come up and sit at the table here, Dr. Brightman, we will be very pleased to have your testimony.

STATEMENT OF DR. I. J. BRIGHTMAN, ASSISTANT COMMISSIONER FOR CHRONIC DISEASE SERVICES, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, N.Y.

Dr. BRIGHTMAN. Senator Moss, Senator Neuberger, and staff and representatives: I am Dr. I. J. Brightman, M.D., assistant commissioner in charge of the Division of Chronic Disease Services of the New York Department of Health. The health department responsibilities for long-term care have been placed with this division.

On behalf of Dr. Ingraham I want to state that we are very pleased to make this presentation before you, Senator.

I am a resident of Albany, N.Y. I am a board-qualified specialist in both internal medicine and preventive medicine, the latter in the subspeciality of public health. I am an associate professor in community health in the Albany Medical College and have been with the State department of health since 1941.

Up to the present time, primary State responsibility for the supervision of long-term medical care facilities was placed with the State department of social welfare in accord with section 21 of the New York State social welfare law. The specific provisions regulating the supervision of private nursing homes, convalescent homes, and homes for adults were spelled out in section 35(a) of that law.

I note by the program that the representative of the department of social welfare follows me and will give an accounting, I presume, of that department's operations.

Nevertheless, the health department has been deeply concerned at all times with the health of its older citizens and particularly with the medical care problems of those whose needs must be met by long-term facilities.

This is exemplified by the following areas of interest:

1. LOCAL HEALTH DEPARTMENT PROGRAMS

Outside of New York City, where the city department of hospitals has responsibility for proprietary nursing homes, nine counties and four cities in the State have placed some degree of responsibility in this field upon their local health departments. All of these health units now administer licensing programs but the scope of coverage varies considerably, extending from limited checks on the environmental health aspects, including water supply and sewage disposal, to a reasonably comprehensive program including quality of services provided.

Four of the larger counties employ a full-time nurse for the latter purpose. Despite the desirability of local responsibilities for the nursing home program, and several instances of excellent cooperation between the personnel of the State department of social welfare and the local health department staff, there have obviously been difficulties in operation, including duplicaion in some areas with inadequate coverage in others. Also, there have been the problems involved with nursing home administrators having to deal with two separate types of agencies at two different levels.

2. HILL-HARRIS PROGRAM

In conjunction with the Hill-Harris program, formerly known as the Hill-Burton program, which is administered by the State department of health through its division of hospital review and planning, 17 public or voluntary nursing home type facilities have been constructed over the past 8 years at a cost of $15,562,346. Of this total, Federal funds have contributed $4,154,218. In addition, four long-term medical care wings of general hospitals were constructed at a cost of $3,997,058 of which Federal funds contributed $868,660.

There are currently about 850 facilities in the State providing nursing home type of services in proprietary nursing homes, incorporated convalescent and nursing homes, infirmaries of public homes and homes for the aged, and in nursing home units of hospitals. Although the total number of these facilities has decreased in recent years, their combined capacity has risen from 32,000 to 42,341 beds since 1955. Unfortunately, approximately half of these accommodations are in non-fire-resistant structures and, therefore, unsuitable for long-range planning. It is estimated that we still require about 16,000 beds as replacements for existing unsuitable beds and about 4,000 beds in addition.

Recognizing that additional financial assistance beyond that provided by the Hill-Harris program was needed to further stimulate local construction, new State legislation was passed this year (ch. 394 of the laws of 1965) permitting State aid reimbursement to counties and the city of New York of one-third of the amount of money expended for the construction or expansion of a public nursing home. The amount of $1,100,000 was appropriated for this purpose for the fiscal year. These funds will be a welcome supplement to the $1,886,906 available to New York State under the Hill-Harris program for nursing homes.

3. SPECIAL PROJECTS UNDER COMMUNITY HEALTH PROGRAM

In 1961, the Community Health Services Act was passed by the Congress with funds being provided primarily for the chronically ill and aging. Utilizing funds available to it under the formula grants, the State department of health was able to strengthen its bureau of adult health and geriatrics, one of the six operating units of the division of chronic disease services, by the addition of consultants in social work, public health nursing, physical therapy, and medical care administration. These specialists were assigned to work with local health departments and, through them, with selected facilities with the goal of extending and improving programs in nursing homes and home care services.

In addition, grants were made for rehabilitation and social work projects in Erie County, for improving services in long-term care facilities in Niagara County, and for a nursing home personnel training program operated by the Sanitorium Gabriels for the benefit of staffs of other nursing homes in the northern Adirondack region of the State.

Sixteen other grants were made to localities for such activities as health information and referral services, home care programs, and homemaker programs, all of which are related to the nursing home service to the extent that they make admission to long-term care facilities unnecessary in some instances, insure the best possible placement when placement is essential, and aid in the discharge of patients back to the community wherever possible. One project provides for the development of educational films for a closed-circuit television program directed at nurse's aids in nursing homes.

4. DETERMINATION OF NEED FOR CONSTRUCTION AND EXPANSION

A significant step toward involving the State department of health in the nursing home program was brought about by chapter 730 of the laws of 1964. Known as the Metcalf-McCloskey Act, this legislation was of great importance in that it set up machinery for requiring prior approval before any new hospitals or nursing homes could be constructed or additions made to existing facilities. Primary responsibility was placed with the State board of social welfare, but active participation was assigned to the State department of health and the State and regional hospital review and planning councils.

According to this legislation, the State department of social welfare cannot approve any new construction, modification or addition until it has received the advice of the commissioner of health with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws, and standards of medical care proposed to be used in the operation of the facility.

Completion of the transition of responsibility for nursing home supervision in New York State was effected by the passage of chapter 795 of the laws of 1965, which establishes a new article 28 in the public health law under the generic title "Hospitals," to be effective February 1, 1966. This legislation was based upon a report of a special Governor's Committee on the Cost of Hospital Care in New York State, headed by Mr. Marion Folsom, of Rochester, N.Y., formerly Secretary of the U.S. Department of Health, Education, and Welfare.

The word "hospital" in this legislation is defined as covering general hospitals, nursing homes, and any other facilities where patients are treated by or under the supervision of a physician, other than mental facilities.

The declaration of policy of the legislation is of considerable interest and reads as follows:

> Hospital and related services of the highest quality efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, pursuant to section 3 of article 17 of the constitution, the department of health shall have the central comprehensive responsibility for the development and administration of the State policy with respect to hospital and related services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity, or physical condition shall be subject to the provisions of this article.

Responsibility for determining need for new or expanded facilities, approval of construction and operating plans, and continued supervision of existing facilities will be placed with the State department of health, with the active assistance of the State and regional hospital review and planning councils.

The State council is charged with adopting and amending rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of the article, including: (*a*) The establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical care provided, hospital utilization and costs; (*b*) certification by the department of schedule of rates, payments, reimbursements, grants, and other charges for hospital services; and (*c*) standards and procedures relating to op-

erating certificates which will be required by hospitals and nursing homes for continued operation.

All the functions and powers of the department of social welfare relating to construction and operation of hospitals and nursing homes are to be transferred to the department of health.

As this bill did not become law until June 22, 1965, the State department of health is still in the early stages of making the plans for an effective transition. The commissioner of health has appointed five task forces in the fields of long-term medical facilities, hospital construction (utilizing the broad definition of hospitals), general hospital inspection, medical audit and utilization, and cost analysis and health economics.

Top responsibility is to be assigned to a deputy commissioner for hospital affairs who shall be immediately responsible to the commissioner. Directly responsible to this deputy commissioner will be three new bureaus of medical audit, health economics, and hospital inspection. The present division of hospital review and planning which operates the Hill-Harris program will continue to do so and will be responsible for approving all phases of construction of hospitals, nursing homes, or other facilities regardless of whether these facilities are eligible for Hill-Harris, State assistance, or neither.

A new bureau of long-term medical facilities will be placed in the division of chronic disease services so that the nursing home program can be closely coordinated with the establishment of other community health activities, particularly in home care, services by nurses, social workers, physical therapists and homemakers, portable meal service, and other programs designed to keep long-term patients at home or to reduce nursing home stays to the minimum.

The bureau of long-term medical facilities will be staffed by a medical director, a medical administrator and consultants in nursing, nutrition, occupational and physical therapy, recreational service, social work, environmental health, dentistry and medical economics, plus necessary statistical and clerical services. Medical consultants from other health regions will be employed on a fee basis to aid the bureau in auditing the quality of medical care.

The bureau will be responsible for general supervision of the long-term medical facility program, the development of an appropriate code of rules and regulations, the establishment of the necessary procedures for surveys and consultations, the providing of assistance to regional health directors and local health officers involved in the program, and the development of training institutes for health department staff as well as for the staffs of nursing homes.

The director will work with the division of hospital review and planning in determination of needs for new beds, approval of proposed programs of new facilities, and promotion of affiliations between hospitals and nursing homes. Likewise, he will collaborate with the unit of health economics in regard to the collection of service data and the determination of costs. Special studies and demonstrations will be carried out to determine how high-quality care can be assured without costs being skyrocketed.

New York State is divided for health purposes into five regions plus New York City. It is planned that the regional health director shall be responsible for coordinating the program at the regional level,

approving and signing operating certificates and recommending any disciplinary actions indicated.

The larger city and county health departments will be encouraged and assisted in developing their own programs to meet all of the requirements of the legislation and of the codes to be established. In most instances, the programs of these local health departments will have to be strengthened through the training and employment of necessary personnel if they are to administer programs adhering to the State code. Certainly, larger health departments should have at least one full-time person responsible for the program. Sufficient personnel should be available to provide for at least one detailed examination per year spot visits at frequent intervals depending upon need. The basic visiting team will consist of a qualified nurse and a qualified environmental health specialist.

Consultations in nutrition, physical therapy, occupational therapy, social work, and dental service may be obtained through the resources of the local departments themselves in a few instances, more commonly through the regional health offices of the State department of health and in selected instances from the bureau of long-term medical facilities in the central office of the State department of health.

Areas of the State with no approved local program will be covered by staff from the regional health offices. The valid operating certificates for facilities complying with the State code will be issued by the State commissioner of health or his designee and cosigned by the local health officer when his department has accepted responsibility for the program at the city or county level.

We well recognize the problem involved in assuring to our older citizens the best of care in long-term medical facilities as well as elsewhere, at the most reasonable cost possible. We have now considerable interest in this problem on the part of the Governor and the State legislature and we know that we can count on active assistance from such agencies as the State Medical Society, the State Hospital Association, the State Dental Association and the State Nursing Home Association, either individually or through its joint council to improve the care of the aged, on which the State department of health serves as consulting members along with the department of social welfare and the Governor's Office of Aging.

We can count on many other professional groups and schools of public health, medicine, dentistry, nursing, social work, physical and occupational therapy and others to help the necessary education and training programs, which we see as a major part of our program. We see no easy task ahead but we accept the challenge.

Thank you, sir.

Senator Moss. Thank you, Dr. Brightman, for your very comprehensive statement indicating the organization and planning that is going on here in the State of New York in this field of long-term health care for the elderly.

Dr. Trussell indicated in his testimony yesterday that Hill-Harris funds will provide a very minor portion of New York City's hospital capital costs.

Does the department of health recommend any specific legislative changes to relieve this burden on the city?

Dr. BRIGHTMAN. The big problem throughout the entire State and especially in New York City concerns funds. The Hill-Burton funds have stimulated much construction but as we indicated, we are still almost 20,000 beds short in the State, considerably in New York City. It was for this reason, Senator, that the legislation in the State was passed this year to supplement the Hill-Harris funds to the tune of a little over $1 million. Because of the State constitution, State funds can only be given to public agencies and not to voluntary.

This will relieve the load of Hill-Harris in taking care of the voluntary agencies as it provides over a million dollars to help the public agencies throughout the State. New York City can be expected to receive a due share of this, by all means.

Senator Moss. The only recommendation you would have is that more money should be provided, is that right?

Dr. BRIGHTMAN. Buildings yes, and beyond the buildings we need the training of staff. This is a considerable item in itself.

Senator Moss. Establishment of a statewide uniform nursing home code was strongly recommended by several witnesses yesterday.

Does your department believe a statewide code is desirable?

Dr. BRIGHTMAN. Very definitely, Senator. Any city or county always has the privilege to establish a code of its own providing it at least meets the standards of the State code.

There are some examples up to the present time where certain communities have had reasonably high standards but it is the State's responsibility, from our viewpoint, for assuring that minimal standards are applicable throughout the State.

There is no reason why any community in the State should have less than the minimal standards.

Senator Moss. Are plans underway for establishing this code?

Dr. BRIGHTMAN. Yes. Actually, we are inheriting from the State Department of Social Welfare a considerable amount of work toward a State code. The code, now in its sixth revision, is not adopted as yet. We have their material and this will be helpful in the development of a final code. We have a document which would be creditable right now but we still think it requires an additional amount of work.

Senator Moss. The code of the city of New York seemed to be rather well worked out and comprehensive. Would it be adaptable to be taken over and made a statewide code?

Dr. BRIGHTMAN. Nothing would please us more than to take the New York City code over as it is. Actually, in its present form, the proposed State code is a little more lenient or less rigid than the city code.

At the beginning, at least, we could accept as recommendations all of the requirements of the city code that we could reasonably require immediately. I would hope that eventually as our educational program proceeds, the city code would be the model for the State and eventually a requirement for the State. These things have to be taken in steps with education always pushing the program forward.

Senator Moss. Just so we don't take too long on the steps.

Senator Neuberger.

Senator NEUBERGER. I just have one question. I don't understand the proliferation of Hill-Harris funds. How do we staff these hospitals? We are building constantly faster than they are training nurses.

Dr. BRIGHTMAN. This is a very serious problem and one which we do not have all the answers. We must use skilled personnel only where their skills are required. We do believe that there is a considerable amount of inefficient use of professional personnel across the board.

I think that much progress has been made in this area through nursing aids, physical therapy aids, occupational therapy aids, but as already presented before this committee, every hospital is short of nurses.

Our situation is only slightly less severe in the upstate New York area. We are receiving numerous applications for new proprietary nursing homes regardless of the difficulties in getting adequate numbers of registered nurses in these areas.

We are really holding up some of these of uncertainty of operating standards.

Senator NEUBERGER. I found myself doing something I never thought I would do; that is urging the director of the Hill-Burton program not to approve a grant for a hospital that was requested in my own State. It seems almost like heresy but on investigation I found the doctors were getting so lazy that they didn't want to drive 25 miles up to the coast to the hospital. Yet they were asking for a hospital to be built in a small community where there are only five nurses in three counties.

How they were going to build this hospital with no adequate nursing staff is beyond my understanding. But they could get the Government money to construct a hospital and then it was going to sit there. To continue this is ridiculous until we start putting some emphasis on nursing education.

Dr. BRIGHTMAN. We believe, Senator Neuberger, that the Metcalf-McCloskey Act passed in New York State last year, is a very important approach to this problem because now no new beds can be built in new facilities or in existing facilities without approval and that approval consists of many things being evaluated; ability to staff, ability to finance, the character of the people behind the facility, and the actual need for these beds in this community.

We have had several instances in New York State where we have not approved projects.

We prohibit them from building if it appears that the nursing home cannot be operated satisfactorily.

Senator NEUBERGER. What are you doing in the State to increase the supply of nurses?

Dr. BRIGHTMAN. This is being handled through the educational program of providing more fellowships.

Senator NEUBERGER. Is the State subsidizing some nursing education?

Dr. BRIGHTMAN. Only through fellowships and scholarships.

Senator NEUBERGER. How do you get that?

Dr. BRIGHTMAN. Through the State education department. I cannot tell you the number, we can get that for you. There are nursing and medical fellowships available through the State education department.

Senator NEUBERGER. Thank you.

Senator Moss. One of the criticisms we hear is that the Federal program on long-term care overemphasizes the institutional aspect of care. Has this been your observation, too?

Dr. BRIGHTMAN. Are you referring, Senator, to the legislation for the multicomplex regional centers?

Senator Moss. Well, that and what we have done toward making money available for construction of nursing homes and so on, the emphasis being on institutional and very little emphasis on other types of long-term care.

Dr. BRIGHTMAN. We could see no objection to the emphasis on institutional services provided that as an institution we are talking about a community facility which has forks extending into the community. We talk about our home care programs as being a very vital part of our services for the chronically ill and aged.

These can best be administered through hospitals. They don't have to be operated by hospitals directly, but if not, they have to be associated with the hospitals. We look upon nursing homes more as community facilities.

Unless they are affiliated with hospitals it is doubtful whether the nursing homes can achieve optional care. We look upon hospitals as the medical focus of any community regardless of its size and we would like to see those institutions show leadership in the communities.

Unfortunatey, this is not always the case, and some of our ivory tower institutions hardly extend beyond their walls.

Senator Moss. Does the staff have questions?

Mr. CONSTANTINE. Yes.

Dr. Brightman, we understand that about 2 years ago the legislature gave the department of health authority to make medical audits in any institution in the State. How many institutions have you audited?

Dr. BRIGHTON. This has been an experimental, or what might better be called a demonstration program and has been very limited. We did not come out and say we were going to immediately operate a total medical audit program during the first few years. This started in the Rochester region which covers some 11 counties in the areas focused around the city of Rochester and has been emphasizing the infant and maternal child health services. It is not trying to copy the established ways of doing medical audits, of which there are several as you know. Rather, we are looking for ways in which health department personnel working with hospital councils and other facilities can do medical audits on an economical basis.

The number of hospitals involved would probably not reach beyond 25 or 30 in the Rochester region. We are now expanding this program to cover similar services in other regions of the State as well as to expand into the medical and surgical aspects during the coming year.

We have had a grant of $100,000 from the State for this purpose this year. This is the largest amount of money we have had to work with and we are now in the third year of the program. It has been limited up to this point.

Mr. CONSTANTINE. One other question. The department has had an opportunity to study the new medicare law, certainly. What specific administration functions do you think that the State department

of health in New York is equipped to perform or could equip itself to perform?

Dr. BRIGHTMAN. Our feeling is that the State department of health, as the medical arm of State government, and the government arm of medicine in the State should play a very active role in all of these programs, and, of course, this is going to be one of the biggest health programs we have had in this country.

Certainly New York State is very fortunate in that the State legislation on hospitals and nursing homes that I described in my statement was passed this year, and in that we will have an improved and expanded program for classifying hospitals and nursing homes, setting standards and working to achieve these standards.

With the health department in this operation, we would certainly see the health department assisting the Federal Government in determining the qualifications of government and nursing homes for rendering service to the recipients of care under this program.

We would certainly like to see the health departments go beyond this in the operation of the program and be the contact with all of the medical facilities. We have had a successful experience with our State programs of medical care, such as rehabilitation, crippled children programs, and so forth.

Otherwise, I see a great conflict and confusion of physicians and hospitals being approached by two different levels of government with different philosophies, different fee schedules, and different standards being developed. I think this would be unnecessarily complex.

Mr. CONSTANTINE. Your department could do utilization review and cost auditing, for example?

Dr. BRIGHTMAN. We are going to be doing these under our program. It would be a shame to duplicate them.

Senator Moss. Thank you, Dr. Brightman. We do appreciate your testimony, very enlightening and very helpful to the committee.

Dr. BRIGHTMAN. Our pleasure, indeed, sir.

Senator Moss. We have received word that Congressman Lindsay will not be able to appear in person this morning. However, he has sent a statement for the record.

The Congressman made five recommendations here that are of interest.

Briefly stated, first, he recommends that the voluntary hospitals here in New York City each attempt to provide by 1972 an additional 100 beds for nursing home care to be operating in conjunction with the hospital and thus relieve the shortage of nursing home beds.

Second, he recommended the Medicare Act be modified to permit patients to enter directly into a nursing home rather than first being assigned to a hospital and then to a nursing home.

Third, that the 100-day maximum on nursing home care during a single illness be extended.

Fourth, that compensation for nursing home care for medicare and welfare patients be placed on a sliding scale according to value of services received.

Fifth, that HEW intensify its research into personnel needs for long-term care facilities and into training personnel needed for the facilities where medicare patients will be placed.

These are very thoughtful recommendations and they, together with the full statement of the Congressman, are a part of the record.

(The statement follows:)

TESTIMONY BY CONGRESSMAN JOHN LINDSAY

Chairman Moss, members of the subcommittee, I am grateful for the opportunity to express my views today, for the problems of the aged are to a large extent the problems of New York and other American cities.

I have been concerned with these problems as the Representative of New York's 17th Congressional District. In 1960, in introducing a bill providing for hospital care for the aged, I then said:

"Mounting costs of hospital and nursing care, coupled with a steady increase in our elderly population, have made health protection for the aged a major national problem. More and more, we hear of an entire family's savings wiped away by the high cost of hospital or nursing home care. Almost one-half of the over 65 population in the United States must live on less than $2,500 a year. About 40 percent has less than $5,000 in total assets, including homes. Yet four out of five has a chronic ailment.

"With this high tendency to illness, our over 65 citizens need three times as much hospital care as younger people and are the primary users of nursing homes and chronic disease hospitals. I suggest that a broad-scale health insurance program for all of our aged, financed through the social security system, is the best kind of help we can give."

I am both pleased and proud that most of the provisions of my bill were incorporated in the Medicare Act passed by Congress this year. The act was not only a good law, in terms of its impact upon the lives of millions of Americans, it was an unquestionably great contribution to this country's social legislation.

It will be invaluable to the estimated 800,000 New Yorkers who are 65 years old or older. For if they subscribe to the medicare supplemental plan it will entitle them to hospital and medical benefits covering most illnesses for a payment of only $3 per person per month. More modified benefits will be free.

In my judgment, the advent of medicare will bring great and sweeping changes to the methods by which we have cared for the aged and infirm.

It is true that its hospitalization provisions are the most important and prominent, but the nursing home care provision may be its most practical. The program provides up to 100 days of nursing home care for each episode of illness. The first 20 days is paid for under the program. Each additional day—up to 80 days—is chargeable at $5 a day.

The obvious conclusion is that many of our aged, particularly those who are impoverished, will be able to receive nursing home care that previously was closed to them. Consequently, our existing and long-term-care facilities may soon be under even more severe pressures for admissions.

The Medicare Act empowers the Secretary of Health, Education, and Welfare to set standards for nursing homes serving patients whose bills are paid for by the Government. For example, simple custodial homes will be excluded from reimbursement; the law will recognize only those homes that qualify as "extended care facilities"—in other words, those providing skilled nursing care and related services or rehabilitation services.

One stipulation is that at least one registered nurse must be on duty at all times and every patient must be under a physician's supervision. I think it reasonable to expect that many of our convalescent and nursing homes, particularly the small ones, will not be able to meet these standards and thus will not be selected by patients eligible for medicare benefits. Increased applications for space in qualifying homes surely will result.

In New York City, we have approximately 16,000 beds for long-term patients in nursing homes and related facilities. According to the 1965 report of the Hospital Review and Planning Council of Southern New York, some 8,800 of these beds are in proprietary facilities, somewhat under 5,000 are in voluntary homes, and about 2,250 are under the supervision of the city government.

New York City will need about 15,000 additional nursing home beds by 1972. Yet under current construction schedules, we will add only about half that total to our current capacity over the next 7 years.

The situation here probably is not atypical. It is more than probable that most cities face the triple problem of increased demand for long-term care, a dwindling number of acceptable facilities, and an inability to meet the demand for nursing and convalescent home space.

I should like to offer five recommendations to this subcommittee. All are concerned with nursing homes, with which the subcommittee is primarily concerned, and all should prove of interest to the Congress.

First. I suggest that energetic encouragement be given to the association of nursing homes with voluntary hospitals. There are 79 voluntary hospitals in New York City, more than twice the number of the proprietary hospitals. If by 1972 each was able to provide an additional 100 beds for nursing home care, beyond present construction plans it would eliminate the expected deficit in long-term-care capacity cited earlier.

The advantages to this procedure are many. With a nursing home located on the same grounds as a hospital, the medical staff, the operating room, the dispensary, the kitchen, the radiology department, and all the other services of a functioning hospital would be only minutes and yards away from the facilities for the aged.

Second. The Medicare Act should be modified to permit aged patients receiving benefits under the program to enter directly into a nursing home. The law as enacted provides that each patient qualifying for nursing home benefits must spend at least 3 days in a hospital. One of the major problems, in hospitals, here and elsewhere, is that many chronically ill persons are taking up space that should be available to the acutely ill. The 3-day period, which may often prove to be only for observation, accentuates the problem. Adoption of this proposal, of course, would be predicated on a finding that nursing homes certified to admit medicare patients be staffed and equipped for immediate and professional diagnosis.

Third. At the earliest possible time—and I recognize the acceptance of this recommendation may be obliged to wait some experience with the financing of the medicare program—the 100-day maximum on nursing home care during a single illness should be extended. If the Federal health insurance fund will permit the additional costs involved, I suggest that 6 months would be a more reasonable and beneficial time limitation.

Fourth. The compensation paid nursing homes for medicare and welfare patients should be placed on a sliding scale according to the value—in quarters, in staff, in food, etc.—offered by the individual home. The current maximum of $355 per month may in some instances be too low and in other cases may be too high. I think more flexibility should be given the administering agency.

Fifth. The Department of Health, Education, and Welfare should enlarge and intensify its research into the expected personnel needs of long-term-care facilities across the country. In some areas there are acute shortages of qualified persons to staff nursing homes and similar facilities. With passage of the medicare bill, the Federal Government has assumed increased responsibilities for the welfare of the aged. Perhaps one of them may prove to be an assistance program for the training of personnel needed in the facilities where medicare patients will be placed.

In summary, then, the medicare program passed by Congress will be of unmistakable and momentous value to America's aged. Yet I believe it can be refined, that it can be improved upon.

This subcommittee, I hope, will return to Washington with sufficient information and perhaps some sound advice, on which it can propose legislation reflecting the needs it has heard here and elsewhere around the country.

I wish you well, and I thank you again for your invitation to submit my views.

Senator Moss. Our next witness is Dr. Carlyle Nuckols, Jr., deputy commissioner, Division of Medical Services, Department of Social Welfare, Albany, N.Y.

Dr. Nuckols, we are happy to have you here. You may proceed, sir, as you would care to do.

STATEMENT OF C. CARLYLE NUCKOLS, JR., M.D., DEPUTY COMMISSIONER, DIVISION OF MEDICAL SERVICES, DEPARTMENT OF SOCIAL WELFARE, ALBANY, N.Y.

Dr. NUCKOLS. Senator Moss, Senator Neuberger, Mr. Constantine, Mr. Frantz, and Mr. Miller, my name is C. Carlyle Nuckols, M.D. I am the deputy commissioner for the Division of Medical Services in the New York Department of Social Welfare.

I have had 27 years' experience in the practice of internal medicine and am board-certified as an internist.

After 1 year of experience as a part-time medical consultant to a 17-county area in New York State, I took on my present position as a full-time administrator in March of 1964.

Relatively speaking, I am rather a newcomer.

I sent a copy of some material to Mr. Constantine, and I am sure that this material has been delivered to each of you so I shall spare you the pain of listening to me read it. However, I do have an oral statement to supplement this. It will not take me very long.

Senator Moss. This will be fine, Dr. Nuckols.

Your statement submitted will be part of the record, and in addition, we would like to have your comments.

(The statement referred to follows:)

NURSING HOME CARE IN NEW YORK STATE

The care provided to people convalescing from an acute medical condition or to those having a chronic long-term illness is an important part of the overall medical care program in New York State. It involves both the private self-pay patient and the patient who is in receipt of public assistance. With the anticipated enactment of H.R. 6675, the problem is sure to be magnified.

Definition: Nursing home.—The concept of what is meant by a nursing home varies from State to State, and even from locality to locality. In New York State, when we refer to a nursing home we mean an institution in which nursing service is available when needed, on a 24-hour-a-day basis. A nursing home may be run on a nonprofit or private proprietary basis for profit. Nursing home type care can also be provided in institutions otherwise classified—a public home infirmary, or the infirmary section of a home for the aged. The basic factor is that nursing care must always be available.

The care provided in a nursing home type of institution is designed for a particular type of patient. He may be convalescing from an acute medical or surgical condition, and be cared for in the nursing home as a transitional place between hospitalization and restoration to the community. He may have a chronic disability requiring long-term nursing care. His medical condition should not be so severe or complicated that he needs hospital care, or so mild or uncomplicated that he may be able to exist in a home setting—either private or of the group living variety. Appropriate placement in a nursing home should be the subject of careful evaluation. This has been the subject of a recent study involving six infirmaries in New York City and two upstate infirmaries. A copy of this report is attached. It reveals that a substantial number of patients in the infirmaries should have been able to be maintained in the community, had adequate planning for disposition been made from the time of admission to the infirmary.

A composite report on 833 chronic care institutions, based on reports submitted in 1963 ("Medical Economics Notes No. 6, 1965," table 12, attached) reveals that from 32 to 42 percent of the patients in nursing care facilities were fully ambulatory. Clearly there is need for a careful study to be carried out in order to assess the utilization of institutions providing nursing care. If a substantial number of patients could be discharged from the nursing homes, this would free a considerable number of beds for more appropriate use. This would tie in with what must be a need for the establishment and construction of high quality public homes, homes for the aged, and private proprietary homes for adults.

Attention is directed to two attached reports: "Special Research and Statistical Reports No. 32, July 1965," and "Medical Economics Notes No. 6, 1965."[1] Both of these reports contain detailed statistics related to the utilization and operation of nursing homes, as well as other factors relating to the cost of medical care. Table 9, pages 22 and 23, of "Medical Economics Notes No. 6, 1965," reveals that the largest part of the occupant population in nursing facilities is over age 65. Table 4 on page 17 of this same report indicates that the occupancy rate is high—85.5 percent statewide, 91.4 percent in New York City, and 81.6 percent upstate.

Of incidental interest, it should be pointed out that although the number of blind persons in New York State is small in relation to those with other disabilities, a substantial number are confined to nursing homes. It is the policy of the board of social welfare in New York State not to approve segregated nursing homes for blind persons, but rather to integrate them into standard nursing home facilities. In these institutions a concerted effort is directed toward activity to prevent blindness through adequate medical care.

Attached is a copy of "Medical Economics Reports No. 2, November 1964."[1] Although this report is a not confined to nursing home activities, it provides valuable detailed information on the expenditures involved in nursing home operations, broken down into statewide, New York City, upstate, and individual welfare district categories. Other cost items such as physicians' services, drugs, and so forth may be of interest.

The impact of H.R. 6675 must certainly involve increased demands for hospital and nursing home beds. New construction will be necessary for both types of care. In this type of program the nursing home is in the middle. It should be able to accept patients transferred from the hospital, and it should be deeply involved in activity directed toward discharging its patients into the community as soon as the need for nursing care has been satisfied. This should be accomplished by means of intelligent planning for disposition and rehabilitative activity.

If patients are allowed to stagnate within the nursing home beyond the demands of need, simply because the allotted days for nursing home care have not been exhausted, the whole procedure for orderly progression through transfer and discharge will be interrupted, and the entire program for the provision of medical institutional care will be hopelessly bogged down. This may result in a variety of complications. Patients may be detained in hospitals unnecessarily, awaiting available beds in the crowded nursing homes. A second, and more insidious, result may occur, in that patients may be placed in domiciliary institutions where they receive "bootlegged" nursing care from staff incompetent to provide it. This can result in disaster to the patient and agony to his family.

In New York State the responsibility for supervision of nursing homes will pass from the department of social welfare to the department of health as of February 1, 1966. It is assumed that the concern for adequate and appropriate use of nursing homes will be a continuing factor in supervision by the health department. Proper and efficient utilization of the nursing homes will result in better patient care, and may be an important factor in limiting the necessity for costly construction programs.

Sincerely yours,

C. CARLYLE NUCKOLS, JR., M.D.
Deputy Commissioner for Medical Services.

Dr. NUCKOLS. As will be indicated from my introductory statement, I am concerned, both personally and as an official of a public agency, in the proper function of the nursing homes in this State.

During my 27 years of private practice in internal medicine prior to accepting my full-time appointment with the department, I had occasion to care for patients in nursing homes.

Like so many other physicians, my concern was for my individual patients, and as long as the patient's family was unable to provide care at home, the cost of institutional care could be borne financially, and the nursing home was willing to accept the patient and provide care, I

[1] The reports referred to are contained in the files of the subcommittee.

was not too much concerned with the operation of the nursing home as an institution which should have a more specific function.

When I left private practice and assumed the responsibility for supervision of the bureau of adult institutions as an activity within the division of medical services, I became aware of the specificity assigned to the nursing home as a part of the pattern of health care facilities in the State.

I remembered the overall characteristics of the patient populations in the nursing homes I had visited, and I strongly suspected that nursing homes were being inappropriately used—more on the basis of convenience, rather than need for specific and specialized care.

Table 2 of "Medical Economics Notes No. 6, 1965," of which you have a copy, indicates that there are approximately 40,000 beds in nursing homes, public home infirmaries, and the infirmary section of homes for the aged combined.

If 25 percent of these patients could be transferred from the medical facilities on the basis of insufficient need for nursing care, and this figure of 25 percent is not unrealistic, it would theoretically be possible to free 10,000 nursing care beds in the State.

This would have an immediate effect on the overcrowded acute hospitals in the State. A study on long-term hospitalization published by Frank VanDyke and his associates at Columbia University School of Public Health, points out the problems that the hospitals in New York City have related to unnecessary and prolonged hospital utilization.

A real need exists to evaluate the use made of nursing homes. But even if an evaluation is made, corrective measures are difficult to initiate. For the most part, the staffs of attending physicians have little, if any, organization, and an understandable attitude of laissez-faire is assumed by the individual attending doctor. There is little motivation on his part to rock the boat.

There is the further problem of where to place his patient, if he judges that nursing home care is not necessary. There is a shortage of good homes for well adults in the State.

Tables 16 to 19 of "Medical Economics Notes No. 6, 1965," provide a breakdown of the number of public charges in the various types of institutions throughout the State, and these are quite considerable. Because of the relative control that the local public welfare commissioners have concerning placement of recipients, it is possible for the commissioners, through consultation with his medical consultant, and related liaison with the physicians attending welfare recipients, to enter into a program of positive planning aimed at proper placement of recipients needing chronic care— whether medical or purely custodial.

The problem as related to the private patient in the nursing home is not so simple. Here, the physician may not be arbitrarily asked to consider discharge of his patient to another, less specialized institution. This will mandate a program of education involving the practicing physicians, aimed at stressing the importance of freeing nursing home beds for their proper use.

I cannot speak for the other States that will be involved in the implementation of H.R. 6675, but I hope I would not be presumptious to strongly urge that this Committee on Long-Term Care consider in its

recommendations for planning the necessity of seeking advice and counsel from the Americal Medical Association, through its council on medical services, the committee on aging, of which Dr. Fred V. Hein, is the secretary. Maybe this has already been done. Private practitioners will be charged with the responsibility of carrying out any recommendations concerned with the proper utilization of nursing homes, and the success of any nationwide plan will be influenced by their cooperation and participation.

In conclusion, may I repeat what I said earlier—the availability of institutions for the care of the well aged is limited, and this whole problem of transfer of patients from nursing homes to domiciliary facilities depends on the existence of these necessary institutions. Older persons who must have care outside of their own homes may be housed in nursing homes or homes for the well aged. The demands will be increased as time goes on.

It should be pointed out that construction costs differ, depending on the type of institution to be built. In New York State, the average cost of nursing home construction will vary from $15,000 to $25,000 per bed. A safe, adequate home for adults may be constructed at a cost of $5,000 to $10,000 per bed, or even less.

In addition, the cost of operation of a home for adults is considerably less than a nursing home. This would be reflected in decreased rates for occupancy.

The whole problem of nursing home care requires thorough study, both as to demonstrated need and adequate utilization. It is at present a matter of grave concern to New York State, and I am sure will be a matter of national importance.

Senator Moss. Thank you, Dr. Nuckols, for your statement and for the material you submitted for our records. This will help us in evaluating the problem that exists here and exists in various parts of the country.

In our hearing yesterday, it was indicated that homes for adults come under the State welfare department for licensing, is that right?

Dr. NUCKOLS. This is correct, sir. There are two types of homes for adults. One is called the small family-size style which accommodates two to four occupants. In New York State the supervision of the small home-care institution is the responsibility of the local welfare commissioners, but in the homes that accommodate five or more, this is a direct responsibility of the department of social welfare.

Senator Moss. It was indicated in some of our discussion yesterday tha many of these adult homes are substandard. Is that true?

Dr. NUCKOLS. I am sure it is true, sir.

Senator Moss. What, if anything, is being done by the welfare department to insist on upgrading these homes, as a condition for continuing to receive a license to operate?

Dr. NUCKOLS. Since the first of the year, we have been trying to collect the homes for which we will have responsibility because prior to this, the local welfare commissioners had responsibility for the supervision and the list is far from complete.

In New York City, for instance, we had turned over to us at the end of the year a list of some 26 institutions from the department of hospitals and about 6 more were turned over by the department of welfare. Yet, we are almost sure that there are in excess of 200 of this type of home in the city.

Now it is a matter of detective work to try to find out just where these homes are before we can even go into them to make sure that they are operating in compliance. There are various ways in which this information can be obtained but nobody is coming forward immediately and offering his home for supervision.

There have been some instances in which people have called and said they were operating a home and they would like to have somebody visit and see whether or not they are operating in compliance, but it is a matter of trying to find out just what the magnitude of the job is first, before we can even go in.

Senator Moss. You can start supervision, though.

Dr. NUCKOLS. That is right. I might say that every one of these homes which have been referred to us, I should say to the department of social welfare through either the New York City Department of Welfare or the Department of Hospitals, has already been visited.

Now we have had problems there because some of these institutions that were reported as unregistered nursing homes turned out to be hotels that could not be classified as a home for adults, they had a permit from the department of hotels in this city allowing them to operate as a hotel.

There were other instances in which the homes were closed by the time we got around to them. There were others in which the door was banged in the face of the social welfare representative who went to look at the home. This would require, then, a court order to get inside the home.

Senator Moss. You are experiencing considerable difficulty in getting supervision over these homes?

Dr. NUCKOLS. Yes, sir.

Senator Moss. There was some indication that you didn't receive the June 1964 report in your department on these homes. Is that so?

Dr. NUCKOLS. I can find no record of its having been received in the office, Senator. I just read about this this morning. It is possible it may have gotten lost in the mail, but we have no record of it, and we certainly intend to get a copy of it.

Senator Moss. You don't know why it was not forwarded to you?

Dr. NUCKOLS. I do not.

Senator Moss. It just did not show up?

Dr. NUCKOLS. No.

Senator Moss. With the report that you have, I would assume you are going to take some immediate steps on some of those problems that were pointed out in the report.

Dr. NUCKOLS. That is absolutely correct, sir.

Senator Moss. Your jurisdiction is limited on one side by bona fide hotels, you would not have any jurisdiction there; and on the other side, licensed nursing homes would not come under your department, but in between would be adult homes, or senior citizen homes.

Dr. NUCKOLS. County public homes where there is no specific infirmary attached to it and homes for the aged. This is where you have a domiciliary-type institution with an infirmary attached to it. This is a gray area involved in the transfer of responsibility through the department of social welfare to the department of health.

The local ground rules have yet to be worked out, but there is a conference that is being set up for September in which these problems,

I am sure, can be very amicably ironed out so that there will be no duplication of responsibility and no problems concerning the specified responsibility of one department or the other in the supervision of these mixed-type homes.

Senator Moss. Is it the county welfare department that supervises this kind of home outside the city of New York?

Dr. NUCKOLS. The State department of social welfare outside of the city through its area offices. I don't mean to belabor this, but the State is divided up into areas with headquarters in Buffalo and Rochester and Syracuse and Albany and two of them in New York City, one for suburban New York and the other for the city proper.

Each area has a director and a staff of adult institution supervisors who have the responsibility then of supervising the homes for adults and allied institutions within that particular area.

In New York City, its responsibility will still be with the department of social welfare through its area 6 office as far as the proprietary homes are concerned, taking care of more than five or more occupants.

Senator Moss. Senator Neuberger.

Senator NEUBERGER. What was the professional reason for changing over from a social welfare department to the public health department?

Dr. NUCKOLS. Somebody wanted it.

No, that is a facetious remark.

Senator NEUBERGER. Political move or professional?

Dr. NUCKOLS. No, New York State has been one of the two States in the Union in which the department of health has not had the responsibility for the supervision of health care facilities, hospitals, nursing homes, and so forth. There has been some expressed concern on the part of the Governor and his staff as to whether or not this supervision on the part of the department of social welfare was properly placed, and as a result of this and complicated by the rapidly rising cost of hospital care, Governor Rockefeller appointed the Folsom committee to investigate this whole problem of health care facilities and the associated costs with them.

The Folsom committee recommendation was that the responsibility for the supervision of the health care facilities be transferred from the department of social welfare to the department of health. The Governor submitted a bill to the legislature, it was passed, and as of February 1, the control of hospitals and nursing homes will pass over to the health department.

Senator NEUBERGER. Has the Kerr-Mills bill been administered by the social welfare department?

Dr. NUCKOLS. That is right. I would assume it will remain there, certainly the title 19 part of the medicare proposal, because I would assume that the agency which has had the responsibility for the administration of the OAA, old-age assistance, part of it will retain the administration on supervision for the so-called Kerr-Mills for all and as expanded.

Senator NEUBERGER. I can see some reason for that because now it is under the social security program.

As I remembered the Senate version of the bill it provided for an advisory committee of doctors to determine who should remain in hos-

pitals and nursing homes. Well, if the doctor is professionally fulfilling his position, then he would automatically say this patient no longer needs to be kept there. Don't you think this is a needless fear?

Dr. NUCKOLS. In the best of all possible worlds, Senator, it would be a needless fear, but I have had the experience working in hospitals for a number of years, and I have seen utilization committees organized, try to function, and sometimes fail. I do not believe that this is any reason to quit trying. Certainly there will be urging on the part of the family of patients to "let mother stay in the nursing home just a few more days until we can get things ready for her," and so forth. This is what happens in hospitals now.

Senator NEUBERGER. But in your statement which I don't have before me, but which you submitted today, you said it would be wise to seek counsel from the American Medical Association.

If the American Medical Association is going to advise and see that this program does not bog down, then their members should see that this does not happen.

Dr. NUCKOLS. This is right.

Senator NEUBERGER. This is where the responsibility goes to the American Medical Association to make this thing work. During the long fight over all these 20 years for this kind of a bill, the American Medical Association has constantly put up roadblocks and said all the reasons it would not work. They seemed to think if we passed such a bill that suddenly doctors would become second-class citizens and would no longer be protected. But it seems to me that it is up to the doctors to make this bill work. They should not assign a patient to a hospital that would not have been assigned a month ago, or 2 months ago.

If they are ethical, practicing professionals, this bill is going to work all right. That is why I don't see why this thing should occur, but it is up to the doctors.

Dr. NUCKOLS. You are right.

Senator NEUBERGER. Do you think there has been any misappropriation of patients' funds by nursing home operators?

Dr. NUCKOLS. I don't believe I understand your specifics. You mean just actually stealing money from them?

Senator NEUBERGER. Well, if you can't pay the bill, you sign in your will to leave us so much. Does this happen very often?

Dr. NUCKOLS. It is not supposed to happen. This is a field where I must admit I am a little inexperienced, and I should not say anything for the record, I suppose, unless I can prove it, but it is my impression that if it involves a proprietary-type nursing home which is run for profit that this is not allowed, but that if a person wants to go into a home for the aged and sign over a certain specified sum of money for life tenure, then this is allowable.

Now, if I am in error, I will do my best to get the proper information to the committee. I am talking off the top of my head.

Senator NEUBERGER. What happens to the patient's funds when he enters the home? Does he make a deposit of some funds?

Dr. NUCKOLS. He may. You mean somebody that does not have a family at home where he can leave funds and who may portion it out to him little by little?

Senator NEUBERGER. Yes.

Dr. NUCKOLS. I would think that the thing to do would be to have a properly witnessed deposit slip made into a safekeeping place in the nursing home and some responsible person know that the fund is there.

Senator NEUBERGER. Now just one more question about the bootleg nursing care you mentioned in your submitted statement.

Are there any examples of such abuses in domiciliary institutions?

Dr. NUCKOLS. Yes.

Senator NEUBERGER. There are. In the State of New York?

Dr. NUCKOLS. Yes.

Senator NEUBERGER. How widespread is the situation?

Dr. NUCKOLS. Well, I can't quote statistics or percentage figures, but I know that it happens often enough so that we are concerned. What we mean by this is that patients who require nursing care really are being taken care of in a home for adults where there is no properly trained nursing personnel, and we have problems sometimes with physicians, particularly in the sparsely settled country parts of the State in which there are no nursing homes within a reasonable distance of visitation on the part of the patient's family.

So sometimes even the doctors will say, "Well, this is a good home, they give her good care, they give him good care, why should we move this patient from this well-run home for adults 60 miles over into another county where there is a nursing home?"

You can understand the question, but the point is this: that if some emergency should happen, the home is unprotected so far as the provision of adequate nursing care because in my book, the definition of a nursing home type facility is one in which nursing service is available 24 hours a day on call.

Furthermore, we have recently passed a law in the last session of our legislature which specifically states that nursing care will be prohibited in homes for adults. So this is a law now which has supported one of our board rules.

Mr. CONSTANTINE. Dr. Nuckols, you indicated that the problem with the rendering of medical services by unqualified personnel exists in homes for adults.

Are you familiar with the study which was made in Westchester County about 2 years ago? I believe some nine nursing homes were involved, where unqualified personnel were giving injections and rendering other medical services?

Dr. NUCKOLS. I don't believe I am, sir; in specifics.

Mr. CONSTANTINE. Then, the other question I have was whether your Department has received any information concerning under-the-counter payments or demanding that relatives make payments to nursing home operators above welfare allowances?

Dr. NUCKOLS. To my knowledge, nothing of this type has come to my attention. Now this does not say that it could not have happened, but I have no reason to suspect it.

Mr. CONSTANTINE. As far as you know?

Dr. NUCKOLS. As far as I know.

Senator Moss. Mr. Miller.

Mr. MILLER. Dr. Nuckols, just a moment ago you stated, if I understood you correctly, that a recent law prohibits nursing care in homes for adults, is that correct?

Dr. NUCKOLS. Yes, sir.

Mr. MILLER. As a matter of clarification, does this mean nursing care by the normal personnel in the home or does this prohibit qualified nursing care coming in from the outside?

Dr. NUCKOLS. It means that long-term nursing care with no identifiable conclusions is prohibited. If somebody gets sick with a cold or some short-term illness, it does not mean that the individual could not be taken care of in the home for adults on a short-term basis with the help, if necessary, of an outside nurse coming in just as a person who may get sick in his own home and does not have to have to go to a nursing home or to a hospital. At least almost all of these homes for adults have a small sick bay which is used just for emergency purposes for short-term illnesses and when the individual is recovered, then he just stays there.

Mr. MILLER. Would this law preclude the use of home health care services such as provided by visiting nurses groups and so forth?

Dr. NUCKOLS. For instance, if somebody had diabetes and required a daily injection of insulin, this is all, and she could not give it to herself. A nurse could come in once a day to give insulin. There is nothing wrong with this any more than what would happen in her own home.

Senator Moss. Thank you, Dr. Nuckols. We appreciate your testimony and the response to our questions. You have contributed to our record.

(The following letter supplementing Dr. Nuckols testimony was subsequently received.)

STATE OF NEW YORK,
DEPARTMENT OF SOCIAL WELFARE,
Albany, August 20, 1965.

Mr. JAY CONSTANTINE,
Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR MR. CONSTANTINE: I am writing to correct an error which occurred in my testimony before the Senate Special Committee on Aging on August 3, 1965.

On page 222 of the transcript, at the bottom of the page, you will note that Senator Moss indicated that I had not received the ad hoc committee's report on homes for adults. You will further note that my statement was that I could not find any record of having received this report.

I now find that my statement was incorrect. Just yesterday a copy of this report was finally tracked down in the department files. It had been forwarded from New York City over a year ago and I had sent the report to another staff office for review and recommendation where it remained for the past year.

My only explanation for this lack of followup is that I was new in the department and had not set up a tickler file to remind me of urgent problems requiring continued action.

I have already expressed my personal apology to Dr. Yerby and Dr. Houghton for this inadvertent error on my part. I wish to have the record of your committee hearing corrected in this instance.

Sincerely yours,

C. CARLYLE NUCKOLS, Jr., M.D.,
Deputy Commissioner for Medical Services.

Senator Moss. Our next witness is Msgr. Patrick J. Frawley of the Catholic Charities of the Archdiocese of New York.

We are very glad to have you, Monsignor Frawley.

STATEMENT OF RT. REV. PATRICK J. FRAWLEY, CATHOLIC CHARITIES OF THE ARCHDIOCESE OF NEW YORK

Monsignor FRAWLEY. Senator Moss, Senator Neuberger, members of the staff, ladies and gentlemen, I am pleased to come this morning not to add anything new, but certainly to confirm what has been said several times already.

I have no formal statement but certainly I would like to emphasize the fact that there is no more critical need in the health field today than the need to encourage skillfully administered, well-staffed, and adequately financed nursing homes under voluntary nonprofit leadership.

Now that the issue of financing operations of nursing homes has been somewhat eased by additional funds under the new medicare legislation, the construction of nursing homes needs to be encouraged and this can be best stimulated by a grant program to voluntary nonprofit institutions such as now happens under the Hill-Burton or Hill-Harris programs provided the matching is more realistic. Rather than a one-third of the cost shared through the Federal Government, one-half or two-thirds would obviously be more effective.

As you know, $70 million is authorized under the Hill-Hains Act for each year until 1969. Perhaps we need, according to the experts, $250 million for each of 5 years to bridge this gap in medical care.

Legislation to channel Federal funds into voluntary institutions and organizations to build nursing homes to assure the sound operation of these homes should be given the highest priority in the health field if the right patient is to be in the right bed at the right time, if planning of facilities is to be meaningful, if health costs are to be contained, and if the health dollar is to be well spent.

I appreciate very much the opportunity to be here. I certainly commend Senator Moss and Senator Neuberger and the members of the staff for thir diligent pursuit of this problem because, in New York City, I know of no public health need which is more crucial than the construction of nursing home beds under voluntary nonprofit auspices.

Thank you very much.

Senator Moss. Thank you, Monsignor Frawley.

In your opinion, the demand is going to increase and the use of nursing home facilities is going to increase so that we need now to devote our attention to the construction of more institutions, more nursing home beds?

Monsignor FRAWLEY. Yes, under voluntary nonprofit leadership That is a very key consideration and that is why I am here.

I think that we ought to concentrate upon this type of institution (voluntary nonprofit) and this type of hospital (voluntary nonprofit) and this type of organization (voluntary nonprofit) if we wish to guarantee and best protect the interests of the patient and the public.

Senator Moss. Thank you very much.

Senator NEUBERGER. Would you enlarge on that a little bit? Why do you think that a voluntary institution is better than a proprietary institution?

Monsignor FRAWLEY. I think the motivation is different. I think the motivation of a voluntary nonprofit organization is geared necessarily to the highest possible quality of care for each patient.

Senator Moss. Dedication to care of the patient?

Monsignor FRAWLEY. Yes. That is a key consideration.

Senator NEUBERGER. Does your diocese have a nursing home?

Monsignor FRAWLEY. Yes. At the present time, we take care of the sick aged in our homes for the aged and there are a thousand beds dedicated to the sick aged.

Now I am not up to date on the statistics but I am sure that the growth of proprietary nursing homes is moving much more rapidly than the growth and development of voluntary institutions. Therefore, you must close the gap. Furthermore, you mentioned the need to staff these facilities, Senator. You said it is a very important thing that we get the nurses into this field. To staff these facilities I think the time has come to concentrate upon Federal funds in hospital schools of nursing.

Senator NEUBERGER. Then, with your experience, have you sort of an off-the-cuff estimate of how much per bed it costs to build a nursing home?

Monsignor FRAWLEY. Senator, there are tremendous ranges but I would say in New York City it would cost us anywhere from $15,000 to $19,000 a bed. I would be inclined to think it would be more like $19,000 a bed.

Senator NEUBERGER. Then under the Federal grant you suggest maybe 50 percent of that?

Monsignor FRAWLEY. I think that would be a much more effective way to stimulate construction, yes. I think, if you went to two-thirds, you would effect a real incentive to move very rapidly and quickly. Also I would like to see those homes affiliated with hospitals.

I am sure you have been over this already but I thought I would press it again.

Mr. FRANTZ. One of the problems in the use of Hill-Burton for these facilities, one of the reasons there has been so little done in the past, as I understand it, is the difficulty sponsors have in supplying the matching funds, matching funds depend on philanthropy and public fundraising.

Now even with the percent grant you recommend, if there were a very large program in an area the demand for private funds would be very great. A major expansion of these facilities in the nonprofit field would depend heavily on philanthropy. Is there that much philanthropic money around?

Monsignor FRAWLEY. I do believe that in our financing of nursing homes to date we have relied upon one-third. We have borrowed money up to one-third and have gotten the rest from donors.

However, I do believe that it would be more realistic to talk about 75-percent matching and have the owner either contribute that minor share or raise it. Am I answering your question?

Mr. FRANTZ. You think that it would be possible to raise necessary funds?

Monsignor FRAWLEY. I think if you offer 50 percent share or 75 percent share you certainly are taking the major burden from the owner or from the voluntary nonprofit institution, and I think you are certainly encouraging him to do everything possible to raise the difference.

At the present time, the major burden is that we have to put up $2 to every $1. Well, if we have to match dollar for dollar we would be much better off. Better still if the Government will match $2 to every volunteer $1. Certainly you would get more sponsors than under the present distribution.

I can see your point. I think that we are running out of philanthropic funds but I would not go so far as to say I believe the Federal Government should take the full burden of financing. I don't think the Federal Government should put a hundred percent into these fields. In doing so, I think, you move away from the voluntary nonprofit concept, from dedication and motivation and the like.

Mr. MILLER. As a practical matter if you have a 60- or 70-percent grant from the Federal Government, could the institution get the loans to take care of the balance?

Monsignor FRAWLEY. In our situation we are able to negotiate loans and I think in New York City it would not be a great problem for the majority of the hospitals to negotiate loans of that size to meet the lesser share whatever it may be.

Mr. CONSTANTINE. Monsignor Frawley, I have two questions. It has been suggested to us that the provision of long-term care is particularly appropriate for a voluntary organization because there is far more routine to such care than there is in acute care which requires an almost religious dedication which many proprietary institutions might not have.

Would you agree with that?

Monsignor FRAWLEY. No, I certainly would not. I don't think that it is possible to keep these institutions from stagnating unless they are tied into an active medical center and unless they are closely affiliated with a dynamic, active general or a medical center. I think these institutions would be less than they might otherwise be.

Mr. CONSTANTINE. Any institution, voluntary or proprietary?

Monsignor FRAWLEY. In either case I think there is a tendency to stagnate unless you have the stimulation of young doctors who are eager to move into the institution, to see what is happening, who are concerned about medical care and are interested in these patients.

Mr. CONSTANTINE. One other point that you have raised in nursing home care is that you shouldn't construct these institutions if you can't operate them.

Monsignor FRAWLEY. Yes.

Mr. CONSTANTINE. I am sure you know that in the new title 19 of the medicare law public welfare departments will be required to pay reasonable costs for hospital care.

Do you think that similar provision for nursing home care would be desirable?

Monsignor FRAWLEY. I certainly would. I think that we should receive full and adequate payment. One of the problems, of course, is that I think someone estimated 50 percent of the patients now in nursing homes have needs that go beyond what is provided in the law at the present time.

Those studies are very preliminary and I would not want to predict. Unless we get adequate funds to operate these institutions, however, you are not going to have people involved in constructing them. I think that the medicare program does a great deal. I think we should

guarantee that some agency will pick up financially after the medicare benefits cease so that nursing homes will be properly and soundly financed after they are built.

Senator Moss. Thank you, Monsignor Frawley. We appreciate very much your coming to testify before us today.

The next witness will be Dr. Alonzo S. Yerby.

Will you come forward, please?

Dr. Yerby is director of medical care services for the city of New York. Glad to have you, sir, and you may proceed.

STATEMENT OF DR. ALONZO S. YERBY, EXECUTIVE DIRECTOR OF MEDICAL CARE SERVICES, CITY OF NEW YORK, N.Y.

Dr. YERBY. Thank you very much.

Senator Moss, Senator Neuberger, and members of the staff, I must apoligize for not having submitted previously a prepared statement but a bout with a virus interfered. While I do have a limited number of copies, I will, if you permit me to, read this statement and then attempt to answer questions as you proceed.

Senator Moss. That will be fine, proceed in that manner. If you have an extra copy you might give one to the reporter and she can follow then as you read it, it makes it simpler.

Dr. YERBY. I am Alonzo S. Yerby, a physician and medical care administrator. I hold a tripartite position in the New York City Departments of Health, Hospitals, and Welfare. This position, unique in the United States, is an admixture of direct administration, coordination and planning of medical care services for the indigent and medically indigent and other high risk population groups of this city.

The office of medical care administration was created in the department of health 5 years ago on the recommendation of the interdepartmental health council. The interdepartmental health council is composed of the commissioners of health, welfare, mental health and hospitals, appointed by the mayor of the city of New York to serve as a coordinating planning body for health services provided by the city of New York to its population.

On the recommendation of this council, the office of medical care, which I head, was established. The development of this office, staffed by persons with experience and training in medical care administration, has made it possible to build quality and rational patterns of organizations into the services provided by municipal agencies for the needy and medically needy.

You have heard from Dr. Trussell and Dr. Haughton and others, how nursing home care has been improved through enforcement of a far-reaching code, and the development of imaginative ways of restructuring the pattern of physician's services in these facilities.

In my opinion, the following are essential for a good nursing home program:

1. Adequate financing to encourage the development of nonprofit or governmental nursing home as part of or closely affiliated with general hospitals.

2. Appropriate and effective evaluation of chronically ill patients prior to admission to a nursing home to determine whether or not they need this or other types of service such as home care.

3. The development and proper administration of a meaningful regulatory code covering such areas as staffing, administration, and care as well as fire safety and sanitation.

4. An organized staff of competent physicians providing care under appropriate professional safeguards.

5. A mechanism for periodic patient reevaluation to prevent the retention of persons no longer in need of nursing home care.

6. Adequate level of payment for nursing home care.

Dr. Trussell has pointed out the gross inadequacy of Federal funds available to New York State and New York City for nursing home construction. Hospitals who may be interested in the operation of an associated nursing home are unable to take on this additional financial burden.

In many instances, people are admitted to nursing homes who could be cared for in a more appropriate setting like home care or foster home care.

This is often due to a lack of awareness of the existence of suitable alternatives. There is a pressing need for better discharge planning in hospitals and the development of information and referral services in the community.

The development and administration of an effective nursing home code has been done all too infrequently in the United States. Most codes are devoted almost entirely to the regulation of the physical plant without regard to such vital questions as staff requirements or standards of care.

In this State, the proprietary nursing home is the only medical institution which is not required to have an organized medical staff. When nursing homes first came into being they were generally small with 10 or 12 beds, usually occupied by the patients of 1 physician.

Under the pressure of need for long-term care, plus the availability of welfare payments, nursing homes have grown into large multibedded institutions, frequently larger than hospitals. However, these institutions are not required to have the pattern of medical staff organization, which has developed in hospitals. The medical staffs of hospitals conduct regular bedside rounds, review clinical records, discuss patient care in case conferences—activities which serve to safeguard the quality of medical care.

Contrast this to the proprietary nursing home where as many as 35 doctors are visiting patients, each physician a law unto himself, with no other physician reviewing or ever aware of the accuracy of the diagnosis or the appropriateness of the treatment.

Moreover, the random visits of the doctors, frequently at odd hours sandwiched into a busy practice, makes it difficult for the nursing staff to be present at the bedside when the physician sees the patient—and gives the careless physician another opportunity or excuse to provide hurried, inadequate care.

Patients all too often are forgotten in nursing homes, visitors are few, hopelessness and apathy prevails. While recreational and divisional activities are necessary, it is equally important to provide regular reevaluation of patients to identify those who may need the more specialized care of a hospital or who are ready for discharge to their own home or a foster home.

Adequate payment for nursing home care must be provided irrespective of the source of funds or the profit or nonprofit status of the home. Otherwise, the facilities, personnel, and services which are required will not be provided in adequate quantity or quality. Public agencies such as welfare departments often faced with mandatory ceilings on case expenditures or inadequate budgets, or both, frequently make payments which are too low to permit and encourage the provision of adequate care and service.

Often, these same welfare agencies are responsible for supervision of nursing homes and have little incentive to require needed improvements since these would add to the per diem charges.

In New York City, the department of welfare determines eligibility for, the appropriateness of nursing home placement and makes payment for care at a rate based on reported costs. The department of hospitals licenses, inspects, and regulates nursing homes. The department of health provides sanitary inspection of nursing homes and the professional direction, coordination, and planning of patient care for welfare residents of such homes.

This shared and balanced responsibility permits these agencies to play their appropriate roles without duplication of effort or conflict of interest.

In closing, I would like to point out the newly enacted medicare, which is now law, is likely to have profound effects on nursing homes. I have publicly supported this legislation from its inception. I was a member of the small and often lonely group of Physicians for Medical Care Through Social Security who spent long hours before congressional committees and in television and radio studios trying to interject a rational professional view into the emotion-laden dialog which prevailed.

I mention this to take no credit but establish my claim to being a friendly critic. Medicare, as passed by the Congress and signed into law by the President, will buy nursing home care of poor quality unless the States with Federal aid and guidance exert a massive effort to improve the services now available.

In an effort to avoid arousing the cry of Federal intervention, safeguards are almost entirely lacking in the medicare law. The responsibility rests with the States and, to a very large degree, with the medical profession.

It is my fervent hope that the generally dismal record of State regulation and physician leadership in the field of nursing home care will not be repeated and compounded under the new program. Minimal Federal standards for nursing homes would provide some assurance that many of our aged citizens would not spend their last days neglected and forgotten in drab substandard institutions.

Senator Moss. Thank you, Dr. Yerby, for your very fine statement. Your recommendation that we ought to have minimum Federal standards is one that has been presented before and this committee has considered, and I am glad to have your professional opinion on it as a practicing physician and the position that you hold here in the city of New York as director of medical care services.

I would like to hark back a little to the report that was made by the council on these homes for adults.

Do you know why that report did not get to the welfare department?

Dr. YERBY. That report was made after request of the interdepartmental health council as I established in my testimony, and was sent to the council. It was the responsibility of the council to send it to the State department of social welfare. I might point out there is no legal requirement that this be done.

Dr. Haughton, my assistant, did in fact mail a copy of the report to the State department of social welfare.

I do know that contact was made with the State department of social welfare in discussing the city department of welfare's own clients.[1]

Senator Moss. The council itself, didn't take any steps to remedy some of these situations?

Dr. YERBY. Oh, yes; very specific steps were taken, Senator. After the report was given to the council, the 22 homes in question were again visited by nurse inspectors of the department of hospitals to determine whether or not any people remained in those homes who should be in nursing homes.

At the time of these reinspections, it was the opinion of the inspectors that there were no longer people in those homes who required nursing home type care. In addition to that, in any instance in which the original survey charged violation, for instance in such areas as sanitation or fire hazards, requests were made to the department of health and to the fire department for inspections, and inspections were made.

Moreover, toward the end of the summer, I think around August and September, all of the owners of these homes were called in by the department of hospitals, chief of the division of institutional inspection, and the nursing home regulations were reviewed with the owners of these homes. It was made quite clear to them that they could not and should not be operating nursing homes and that if they were keeping patients who were needing nursing home care that this would not be permitted. So that action was taken by the city in regard to the report and the action I described here was a followup.

Senator Moss. Thank you, Dr. Yerby.

Senator Neuberger?

Senator NEUBERGER. Yes.

I make reference to item 2 of your recommendation about the effective evaluation of chronically ill patients at admission. As you know, Dr. Yerby, the health care bill has a provision that this person must be 3 days in the hospital before he is assigned to a nursing home. Do you think that is necessary?

Dr. YERBY. Well, if you are asking what I think, if I agree with it, I don't. On the other hand, the reasoning as I understand it, went something like this: (1) that if you make such a requirement, this would tend to reduce or minimize the overutilization of nursing homes. Prior hospitalization, in a sense, serves as a barrier to direct nursing home admission and it as such, becomes a control, a negative one, but a control, nevertheless.

The other reason and the one that I am in sympathy with, is that the 3 days minimal time spent on the hospital would be an opportunity for an accurate evaluation of the patient medically and hopefully,

[1] See letter on p. 585.

socially, so that when the patient is moved to a nursing home, if this is what is needed, there would be a solid basis of information about his medical and social needs on which the treatment of the nursing home is to be based.

I think this is all to the good. Whether this particular mechanism is used, I think that an evaluation of the patient before admission to the nursing home is very important.

Senator NEUBERGER. It is a question of whether it is 3 days or 2 days or 1 day, isn't it? I mean there would be no harm in keeping a patient in the hospital 3 days if it was found to be necessary, but is that the minimal time before he could be referred to a nursing home?

Dr. YERBY. I hold no brief for the 3 days as such. I support the idea that prior hospital care may allow for an adequate evaluation of the patient. In my own opinion, this can be done without having the patient admitted to the hospital.

It is not necessary under all circumstances to have a patient admitted to a hospital to provide adequate evaluation prior to admission to a nursing home. Here in New York, we in the department of welfare place over 4,000 patients in nursing homes a year and about a third of those patients are placed from their own homes, they are not placed from hospitals.

We do require that these patients be seen and evaluated and have a medical and social record and afterward, see that their care is properly supervised and provided for. I am not convinced that one has to have prior hospitalization to see that the patient is worked up medically. I think that the 3 days of hospitalization requirement is a reasonable thing for many parts of the country where other mechanisms for patient evaluation are not readily available.

Senator NEUBERGER. I can also understand why the doctors would like this provision, because they are the ones on whom the assignment or referral rests. This would justify their position that this patient does not need to stay in the hospital.

Of course, lots of people go to nursing homes who are under 65 and who don't spend 3 days in the hospital before they go. So I presume this is legislation that will have to be done by trial and error. We will have to wait and see if it is necessary.

Dr. YERBY. Yes. As I indicated, over 4,000 cases we place, all are not from hospitals, one-third are from their own homes. This presents no special problem to us.

Senator Moss. Any further questions?

Mr. Frantz has a question.

Mr. FRANTZ. Doctor, we have been told a number of times that most patients or a majority, anyway, of patients, admitted to nursing homes are sent there by their families, and there may or may not be a physician involved in this decision; apparently there usually is.

The suggestion has been made that patients be admitted to nursing homes only on order of a physician, as is the case in hospitals, giving an opportunity to get an admission examination, a basis for continuing physician responsibility for the patient.

Would you comment on that?

Dr. YERBY. I would be in sympathy with such recommendation. I realize the burden it places on the practicing physician and makes him sort of a gatekeeper in a sense, to the nursing home, but I am

more concerned with the patient than the burden on the practicing physician, as much as I feel physicians are burdened.

I think the idea of having an evaluation of a patient prior to his admission is so sound, that any mechanism that will bring it about is worthy of a try. Even if you have an evaluation provision after admission, the patient is then in the nursing home and it is difficult to effect a transfer. We often find, that there are alternative solutions to the patient's problems other than nursing home care; home care, for instance, which is often a very adequate and acceptable alternative to nursing home care or even foster home care with a doctor and a nurse going in occasionally. These are substitutes for nursing home care.

If you can arrange for alternative forms of care prior to the admission of the patient, to the nursing home, this is preferable. We have had experiences in which we tried to get people out of the nursing homes when we have reevaluated them and run into many difficulties, including objections from the patients. He has made his peace with the nursing home, he does not want to change; he is afraid of change and he would just as soon not be moved, even though medically he does not need to be in the nursing home.

So all of these things happen if you are are not careful to evaluate and screen the patient to determine who should not go into the nursing home in the first place. There should be a reevaluation of those who do need nursing care so that if their clinical status improves, it may be possible to move them into the community.

Mr. MILLER. In response to Mr. Frantz' question, you made refence to foster home placement. Mr. Frantz' question was essentially directed to placement in institutions by families. This raises a question as to the extent to which in your experience foster homes have been used for older persons where they have a family of their own.

Is this very common?

Dr. YERBY. Let me see if I can clarify that, Mr. Miller.

I was responding to Mr. Frantz' question on evaluation prior to admission. I should have added that here in New York, two-thirds of nursing home residents are under care of the department of welfare and admission is arranged by that department. The other one-third are private patients who have been admitted by family or friends.

Now coming back to Mr. Miller's point in regard to foster homes, the program in New York is operated by the department of welfare. These homes are owned by private individuals who have an extra room or two and are able to take in a person who may need minimal care.

We place people in foster homes who do not need to be in a nursing home. Such a person might need to be reminded to take his medication or perhaps have help in getting into the bathtub or something of that kind.

Now if a doctor is available to get into that home and see the patient and if the visiting nurse is available when needed this form of care becomes a perfectly good substitute for others.

Now we find that working with a welfare population these are people who have no home, or if they had a home, the home disappears with the hospitalization. Occasionally, too, we may make placement in a foster home where the individual has a family. However there may be good reasons why the family may not be able to manage such a person in the home. The family may consist of an elderly couple who cannot cope with the person who has relatively significant needs. In this instance we would use a foster home. We make a decision based on the needs of the patient as best we can. If the family is unable to aid such a person and there is a foster home available, we feel this is a better use of the taxpayers' money since it costs much less to provide care in a foster home than a nursing home.

Mr. MILLER. But use of the foster home is relatively rare, or is it very common?

Dr. YERBY. I would not say it is rare. I can't give you a specific statistic. We have, I think, about 900 individuals in foster homes at the present time. What percentage of that 900 actually is of the total of such persons in the community? I do not know.

Mr. MILLER. Is more financial assistance made available through your department to the operator of the foster home than might be to the person's own family?

Dr. YERBY. Well, the foster home proprietor in a sense is in business and he is paid, $150 a month. Now if an individual is on assistance and living at home, the grant would depend on need. His own needs will be met by his grant and whether or not his family receives a grant.

Senator Moss. Thank you, Dr. Yerby. We appreciate very much having you come and testify before us and for the information that you have given us.

Mr. Alton E. Barlow of the New York Nursing Home Association, will be our next witness.

Glad to have you, Mr. Barlow. We look forward to your testimony.

STATEMENT OF ALTON E. BARLOW, EXECUTIVE VICE PRESIDENT, NEW YORK NURSING HOME ASSOCIATION, CANTON, N.Y.

Mr. BARLOW. Senator Moss, Senator Neuberger, members of the subcommittee, my name is Alton E. Barlow. I am vice chairman of the National Council for the Accreditation of Nursing Homes, executive vice president of the New York State Nursing Home Association, director of the American College of Nursing Home Administrators, and past president of both the American Nursing Home Association and the New York State Nursing Home Association.

It was during my term of office in the American Nursing Home Association that an accreditation program for nursing homes and related facilities became a reality, and that the first steps toward professionalism in nursing home administration through establishment of the American College of Nursing Home Administrators and the first program leading to a master's degree in nursing home administration at the George Washington University were undertaken.

During the 35 years I have been active in the health care field I have administered an acute short-term hospital and a long-term nursing home for care of the chronically ill. I have seen the major attention

of the professional groups and the general public focused on the dramatic, acute short-term illnesses with the consequent neglect to the patient suffering from a chronic disease and, within the past 6 years, have seen the pendulum swing toward increasing interest in care of the chronically ill and aged.

There are demands from all sides for increased professional staff, higher educational standards for administrators, more stringent enforcement of higher licensing requirements and for the first time attention given to supportative services through the use of consultants or full-time personnel.

In spite of these pressures and the fact that care of the chronically ill is difficult at best, there will always be the need for nursing homes and I believe there will always be nursing homes.

How these facilities are operated and by whom depends a great deal on the attitude of the present day administrators' the demands of the licensing agencies and, hand in glove with higher standards, a realistic reimbursement program. I am sure the recommendations made by this subcommittee, based on findings across the country, will bear much weight in revisions of the model nursing home licensure code presently under study by the Council of State Governments as well as in final regulations drafted for implementation of H.R. 6675.

Other speakers have covered the problems in New York City and New York State and I am sure you have found them not too different from the rest of the Nation. Rather than reiterate the problems I would like to direct my time toward what has been done to improve nursing home services and administration, what additional measures are under consideration and the manner in which Government can assist us in reaching our goals. I believe our goals are identical: care of the long-term patient in an institution that affords him the kind of services most appropriate to his current needs at a realistic cost.

Administrators of nursing homes were among the first to recognize the need for higher standards of care and organized in 1939 the Association of Certified Nursing Homes; in 1948, the American Association of Nursing Homes came into being in Ohio.

These two organizations joined in 1954 and now represent over 5,000 licensed nursing homes or about one-half the recognized skilled nursing homes in the country. From the very first, representatives of these organizations were in the forefront at conferences, on both county, State, and Federal level, concerned with improvement in all aspects of nursing home service.

In many States nursing home associations joined with licensing and reimbursing agencies in sponsoring legislation toward higher standards and, in the majority of States, first efforts toward extension courses in various aspects of nursing home care were pioneered by individual nursing home administrators and local associations.

In the early 1950's, the New York State association cosponsored with the department of social welfare educational seminars at Cornell University.

As in other areas, these early efforts in New York fell by the wayside; and it was not until other States, through either the nursing home association or the licensing agency, evidenced interest in continuing education that New York again became active in this field.

Another speaker has commented on the educational programs being conducted in New York City. With the exception of the educational TV programs these educational programs are open to and have been attended by administrators from facilities throughout the State.

We shifted responsibility for nursing from social welfare to the State department of health and we have no way of knowing what additional requirements will be added to the code. Rather than reiterate the problems, I would like to direct my attention toward what has been done to improve nursing home services and administration, what additional measures are under consideration, and the manner in which the Government can assist us in reaching our goals.

In 1961, George Washington University offered the first program leading to a master's degree in nursing home administration. There are presently 7 students enrolled in the program which has graduated 24 persons. George Washington also conducts a correspondence course in 3 phases of nursing home administration with a registration of 300 persons at this time.

Oklahoma State University, University of Minnesota, Iowa State University, and Columbia University offer residence programs on a sustained basis. Northeastern University has offered a continuing program, which is frequently modified to meet new needs over the past 7 years. Many State nursing home associations, working alone or with their licensing agency or another medical facility, offer monthly seminars on some particular aspect of patient care and/or administration that serves the needs of the membership. In most instances, the associations have opened these seminars to nonmember facilities.

As the awareness for more professional skills is realized other universities will offer additional education opportunities and these beginning courses will be expanded. Then, and only then, will nursing home administration become truly a profession. Until that time we must utilize the knowledge and experience of the people who have been working in this field for many years. These successful administrators have been persons with an understanding of human behavior, with training in other professional fields, such as ministry, nursing, medicine, social work, and business.

I feel that improvement of institutional care depends to a great extent on the quality of personnel. The shortage of qualified health personnel to care for long-term patients is no more a stranger to nursing homes than it is to the acute general hospital or most other health facilities.

I know of no one who has received a letter of warning if for no fault of the administration or staff a shift may not have been completely covered one 8-hour shift during the day. Most such policing is a nit-picking level rather than an attitude of assistance toward improvement of care.

The belief is held among the health professions that the care of the aged is uninteresting and unlikely to improve. However, there exists in our culture a phenomenon of rejection of the aged and disabled; the belief is held among the health professions that care of the long-term patient is uninteresting, unlikely to produce improvement in the patient, is distasteful and discouraging. Often it is physically

taxing and the modern concept of rehabilitation has not produced dramatic results in many long-term patients.

The nurse scholarship program sponsored by the Metropolitan New York Nursing Home Association is but one of many maintained by nursing home associations throughout the country. Indeed, in some areas the program has been extended to physical therapy, recreational activities directors, and the like.

These "stopgap" efforts—and that is truly what they are—will not long suffice. Training and recuitment programs to alleviate current shortages and to avoid even more serious deficits must be built upon. Education for some classes of health personnel must be reoriented.

Students must have the opportunity to observe and serve patients in a setting other than a short-term hospital, then and only then, will they gain full appreciation of the psychological and social factors that affect and are affected by long-term illness.

National and local associations representative of professional personnel, such as the National League of Nursing, must reexamine their educational programs, at all levels, with a view toward modification in line with existing and projected needs.

Foundations, State and Federal Governments, have been an important source of funds for improving quality of instruction in schools training personnel for the various health professions. These forms of support must be continued and augmented to permit the fullest possible development of field demonstrations.

An important contribution in the early 1950's was the Public Health Service participation in a nationwide program for training nurses aides—but that was 15 years ago. Although I have no totals of the various expenditures by many agencies toward health education, I am sure the sum is staggering. Is now not the time to pool our resources, stop the needless duplication, and start talking to one another about the need and how best to solve the problem?

In recognition of the efforts of administrators to improve their educational competence, and thus better serve their staff and patients, and in recognition of the many professional people in the nursing home field the American College of Nursing Home Administrators was organized in 1962. Membership is on three levels—fellow, associate, and member—with each level requiring specific educational qualifications as well as continuing improvement and awareness of professional advancement.

Membership presently is around 250 with another 200 applications being processed. The first meeting of the college was held at Northeastern University in October 1964 and another is planned for this October. Our eventual hope is coordination of all the educational opportunities in nursing home care and administration from all levels and recognition of educational attainment through certification of administrators.

We believe this type approach more valuable than licensure programs for administrators developed by individual States on the slow State-by-State method. Naturally, in developing programs we have been working closely with the various educational facilities offering nursing home courses.

In another area the American Nursing Home Association and its affiliates made the initial efforts toward recognition of quality of care through the establishment of an accreditation program. Much has been written, and even more said, about what group made what effort, where, when, and how.

As then president of the ANHA, I worked closely with the committee developing the accreditation program and negotiating with other groups, but I do not feel the time of this subcommittee should be given to past history.

Sufficient to say, through the joint efforts of the American Medical Association and the American Nursing Home Association, a multilateral, professionally based, realistic accreditation program for nursing homes became a reality.

The National Council for the Accreditation of Nursing Homes is funded by the two sponsoring organizations but is a separate nonprofit corporation with a nine-person board of directors who follow the dictates of their own conscience rather than that of any organization.

As of July 26, 1965, the national council had accredited 707 facilities totaling 47,513 beds in 45 States (intensive, 227, 20,941 beds; skilled, 309, 18,241 beds; intermediate, 171, 8,331 beds). New York State has 82 facilities accredited with a total of 10,132 beds (intensive, 38, 7,964 beds; skilled, 44, 1,903 beds).

Inasmuch as the New York State licensing code requires licensed personnel 24 hours per day, there are no intermediate care facilities in this State.

The New York State Nursing Home Association represents 245 of the 545 licensed nursing homes, or about one-half of the licensed beds. This figure does not include the nonprofit institutions nor the adult care homes which render merely board and shelter.

Applying for accreditation survey, paying a survey fee, and inviting another agency to evaluate the services rendered in an institution is certainly evidence of the desire of nursing home administrators toward improvement. Such an evaluation of professional qualifications, medical and nursing service plus medical and nursing records, dietary standards, safety features, sanitation, diversional activity, and spiritual services gives evidence to the public, licensing agency, reimbursing agency, and other third party groups that a specific institution is capable of rendering a measured level of service. Such a program should assist in proper placement of the patient in a facility that will best meet his current needs.

I feel that such an evaluation of standards, higher than licensing requirements of most of the State, should receive the proper recognition. Indeed, we are just beginning to receive this.

During the past 2 years, I am sure you have heard much about "hospital affiliation or transfer agreements," indeed, I would be astonished if you said that neither had been mentioned during other hearings. But what is an affiliation? Nationwide, it is something which has been tried with little success. Of 10 pilot projects underwritten by the U.S. Public Health Service in the past 8 years, only 1 is still functioning.

Among the arguments in favor of such an arrangement have been: prompt hospitalization of the patient when needed, better utilization of facilities through early referrals from the general hospital to the

nursing home, better medical supervision, improved public understanding of the long-term facility as part of the total health resources of the community. There is even feeling that the agreement should be a formal, legally binding, one signed by the governing body of the participating facilities.

I neither say the arrangement is right nor wrong. This is a decision for the individual nursing home administrator and hospital governing board. However, I suggest that it is unrealistic for any general hospital to have an arrangement with several nursing homes. Not only would it spread the so-called medical supervision and hospital consulting services rather thinly about the community, but would deny other nursing homes and patients of such services or even free choice of nursing home or hospital.

I suggest that most placements in nursing homes are made by families and they still prefer freedom of choice, usually based on financial cost, and accessibility for visiting. Admissions from the nursing home to the hospital are, or should be, made by the physician—and I know of no State licensing law that does not require the patient to have a personal physician—so where is the advantage of prompt hospitalization offered through affiliation or contract? Neither can I envisage any nursing home being financially able to set aside a number of beds for the exclusive use of one hospital. Such beds are likely to be empty at one time and in overdemand, another.

It would appear more advantageous to both the nursing home and the hospital to have a loose arrangement—not necessarily in writing—where the specialized services of the hospital's staff are available to the nursing home on a fee for service basis, if and when they are not being utilized by the hospital. Then nursing homes could indicate priority of admission for the hospital's patients, as beds become available.

Within the last few years, we have seen much emphasis on rehabilitation in long-term care facilities. I have heard rehabilitation defined as restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable. To me, this would mean three things: First and most important, an adequate diagnosis and proper evaluation of the patient's potential, and second, a team approach. I have already discussed at some length the insufficient supply of trained personnel. This applies to the field of physical therapy as much as to that of nursing.

In various States the licensing agency in cooperation with the nursing home association, and in most cases, with the use of Federal funds, has initiated programs to teach nursing home staff members some of the basic rehabilitation techniques. Efforts to train rehabilitation aids or technicians, on a united effort, have not been as successful. Here again is an era in which the Federal Government could take aggressive action—someone must, if we are to assist those patients whose only realistic hope may be a higher level of self-care.

The low, unrealistic reimbursement rates paid by most public agencies for long-term care has been discussed rather completely by others. I would urge adoption of the uniform chart of accounts for cost accounting, an impartial cost commission to determine reimbursement rates, and particularly in those States with a variety of county reimbursement formulas, a rate based on services offered and cost as deter-

mined by the reporting system. Second, a team approach; third, a proper placement of the patient where maximum gains have been achieved. The diagnosis is added. The team is a physician, the physical therapist, the rehabilitative nurse and the aid who continues the periodic treatment and redefinition of goals to be obtained, but what then becomes of these patients who may have specialized services of the nursing home?

In many areas of the United States such patients are transferred to the nursing home over a lesser level of service called a rest home with supervision or possibly the patient goes to a personal care home.

It is my understanding that such is not possible in New York City since no licensed adult care homes are allowed. The four-person foster care home is an excellent idea but sometimes this type of facility offers too limited a service. We often see a patient who is returned to his home and in 3 to 6 months is readmitted to the nursing home because the existing home care program has not been properly utilized in giving maintenance therapy.

I have already discussed at some length the insufficient supply of trained personnel. This applies to the field of physical therapy as much as to that of nursing. And various States, in cooperation and in most cases with the use of Federal funds, have initiated programs to teach nursing home staff members some of the basic rehabilitation techniques.

We must have $20,000 per bed for new long-term beds in New York City. Such costs result in costs out of the reach of the public and certainly reimbursement rates must be significantly higher for such type facilities. We might examine these in light of present costs, especially in the city of New York. Twelve dollars to the private home, $15 for voluntary institutions, and $20 for city-owned facilities.

Before we rush into the building of any new beds in anticipation of medicare or some other demand, let us evaluate the existing facilities in light of proper utilization. Let us reexamine the patient population. Are they in the right place receiving the right care to the right degree?

The Connecticut Chronic & Convalescent Hospital Association, working with the State health department and the State welfare department, introduced into the State legislature a bill requiring adoption of the uniform chart of accounts, a uniform closing date for all facilities, obligatory reporting to the hospital cost commission, a right of appeal from a decision of the hospital cost commission, and consideration of cost-of-living increases in the reimbursement rate determination.

This bill, after being signed by Governor Dempsey, together with another association-sponsored bill of 4 years ago, outlining classification of facilities, should allow the State of Connecticut to pay a realistic rate for the care offered the 60-percent medical assistance to the aged patients presently in Connecticut nursing homes.

However, I am sure you will hear more of this program in Boston, next week, as undoubtedly you will hear about use of long-term care facilities for patients in all age groups, a subject with which one of my Connecticut colleagues is much concerned.

In closing, may I state that it is my feeling that the owners of nursing homes—public, private, voluntary or church-sponsored—are in an

unenviable position. Most of them are conscientious people, and some are truly dedicated. For many, the job entails hard physical work and emotional strain. For most, the monetary rewards are small. The satisfaction of achievement may be limited to the fact that, in spite of the best that can be done for them, many patients cannot be changed in body or mind.

Nursing home administrators are subject to many pressures. On the one hand, they can see the need for physical improvement in their plants, better qualified staff, and additional services to their residents.

On the other hand, they are faced with the fact that most people who need nursing home care have limited funds with which to pay for it. Even the much heralded insurance benefits and the medicare program are limited. Administrators may endorse improvement in quality of care, only to be faced with the reality that such improvements must be accompanied by a rise in rates which may preclude care to those most in need of it.

Thank you for the opportunity to appear before the committee.

We have come a long way since social security legislation was enacted in 1935 and subsequent abolishment of the county poorhouse. We still have a long way to go and we can best serve the patients under our care but all concerned agencies are traveling that road together.

Thank you very much.

Senator Moss. Thank you, Mr. Barlow, for a very fine and complete statement. You obviously have done a lot of work in preparing it and we appreciate your bringing it to us.

I understood from your statement that you felt the affiliation arrangement between the hospital and the nursing home was not necessarily advantageous.

Would you explain that a little to me?

Mr. BARLOW. Well, we are finding a great deal of resistance from the hospitals themselves. Even the hospital association has admitted that most hospitals are not in agreement with the affiliation agreements. They would be more inclined to favor, as I said, a loose arrangement or a gentlemen's agreement between the local community nursing home and the hospital.

Senator Moss. Well, perhaps the affiliation should not be bordering on integration, but don't you think there should be an arrangement whereby the hospital could be called upon to render service to the patients in the nursing home and that there should be arrangements for their transfer back and forth as their condition dictated?

Mr. BARLOW. I agree but, as I said, most hospitals and nursing homes as well would rather that it would be a gentlemen's agreement.

Senator Moss. When we were holding hearings last year the American Hospital Association strongly recommended affiliation.

Mr. BARLOW. They are changing their mind.

Senator Moss. You think they are changing?

Mr. BARLOW. They have so stated. The hospitals themselves do not want legal contracts of affiliation; they are perfectly willing to have agreements.

Senator Moss We have heard recently that the board of trustees of the AMA, the American Medical Association, has voted to reopen the question of nursing home accreditation by the Joint Commission on Accreditation of Hospitals. Do you have any comments on that?

Mr. BARLOW. That is true. A meeting of the representatives of the sponsoring organizations of the national council was held recently in Chicago. It is our belief that with the urgent demands anticipated by new Government medical care programs and by extension of benefits of other organizations as well as the new situation that a favorable climate exists for a reexamination of the responsibility for the accreditation of nursing homes.

Discussions will be held with members of the joint commission. We still believe that any accreditation program must have an active participation and a major voice from those being accredited. Neither sponsoring agency intends to settle for less.

Senator MOSS. In your testimony, Mr. Barlow, you indicated that a great many of the patients referred to nursing homes were placed there by the families and you seem to think that this was desirable; whereas, Dr. Yerby in his testimony indicated that he rather favored the requirement that a physician be responsible for the referral so that the records and basic data could be worked out.

Mr. BARLOW. I am sorry, Senator, I did not mean to infer that. A lot of families do contact the nursing home. I believe that they should be placed there by a physician, but we must face reality. In my own institution, if a family calls me I ask them who the physician is and I call the physician. I do not admit anyone without the orders of the physician.

Senator MOSS. Thank you for clearing that up for me.

Senator Neuberger.

Senator NEUBERGER. Yes.

I think there is a problem about the accreditation. You referred to a licensing agency. Do you mean a city or a State commission? What is your definition of a licensing agency?

Mr. BARLOW. I mean by a licensing agency that body that controls the issuing of a license to nursing homes in the State or municipality, whichever controls the facility.

Senator NEUBERGER. There is no place that does not require such license, no State, is there?

Mr. BARLOW. No. All States require it.

Senator NEUBERGER. It seems to me you could have a problem of conflict of interests in accreditation of nursing homes. I would not know what to do about it. You can't ask a bootblack or a plumber to come in and accredit a nursing home; you have to ask a doctor or supervisor of nursing.

Mr. BARLOW. We don't ask a bootblack to accredit nursing homes.

Senator NEUBERGER. I know, that is the trouble. Sometimes the very people who are asked to come in and accredit are people who may have a conflict of interest, proprietary interest in the nursing home.

Mr. BARLOW. No, we have no surveyors in any way connected with nursing homes. They are retired physicians, hospital charge nurses or retired Public Health nurses, people of this type. We have no nursing home personnel as surveyors.

Senator NEUBERGER. But if the licensing person is the one that determines who is in the agency——

Mr. BARLOW. We select our own surveyors, the national council selects their own surveyors.

Senator NEUBERGER. That puts an entirely different light on it.

Mr. BARLOW. I might say you have to have a license before you can even be surveyed.

Senator NEUBERGER. But who is on the licensing board in the State? This is what I referred to.

Mr. BARLOW. Well, as of the present time, in New York State it is the department of social welfare. As of next February, it will be the department of health.

Senator NEUBERGER. In your organization, do you have many doctor owners of nursing homes?

Mr. BARLOW. Yes, I am sure there are.

Senator NEUBERGER. Well, how many?

Mr. BARLOW. I have no way of knowing, Senator.

Senator NEUBERGER. You are the executive vice president, and you have no knowledge of how many of your owners are doctors?

Mr. BARLOW. The facility is a member of the association not the administrator.

Senator NEUBERGER. What about fair return? I, myself, am wondering how a good nursing home can really make very much money in the cost of really good care. What is a fair return in a member facility in your organization?

Mr. BARLOW. Well, of course, it would average. My return on my investment has averaged over the last 30 years from 5 to the very peak years of 10 percent, it is going back down again.

Senator NEUBERGER. Do you personally have a nursing home?

Mr. BARLOW. I have; yes, I supervise it.

Senator NEUBERGER. Where?

Mr. BARLOW. In Canton, N.Y.

Senator NEUBERGER. Thank you.

Senator MOSS. Mr. Constantine?

Mr. CONSTANTINE. Yes.

Mr. Barlow, just a quick question. How many nursing homes have been accredited by the national council that were never surveyed but were accredited on the basis of prior registration by the ANHA?

Mr. BARLOW. I think 180.

Mr. CONSTANTINE. That is about one-third of the total?

Mr. BARLOW. 740.

Mr. CONSTANTINE. On a bed basis it might be a higher percentage, 25 percent?

Mr. BARLOW. I could not truthfully say.

Mr. CONSTANTINE. The other question I have is this: Senator Young, of Ohio, is a member of this committee. His amendment to the public assistance titles of the Social Security Act would have the effect of establishing minimum Federal standards of fire safety and protection against other hazards to health and safety of people on public assistance in institutions. That amendment was passed by the Senate.

Does your organization favor establishment of minimum Federal standards?

Mr. BARLOW. Indeed. We brought out a fire manual, I think in 1963. We cooperated with the fire association or organization and brought out this manual for nursing homes as early as 1963.

Mr. CONSTANTINE. But Federal standards——

Mr. BARLOW. We are for Federal standards, yes.

Senator NEUBERGER. I have another question.

What about provision for mental patients?

Mr. BARLOW. In the State of New York, we are not allowed to take mental patients.

Senator NEUBERGER. They must go to a special place.

Now, with the health care bill, there is going to be a change because social security beneficiaries will be entitled to care for a limited time during their lifetime for mental illness. Then are we going to have special nursing homes?

Mr. BARLOW. This is true.

Senator NEUBERGER. But that will just be true in New York, because of your State law, is that it?

Mr. BARLOW. That is right. In the State of California they are bringing their patients from the mental institutions back into the local community nursing homes and have been very successful.

Senator MOSS. Mr. Barlow, Dr. Haughton testified yesterday that turnover of personnel in the nursing home, especially nursing personnel, has been greatly reduced when the medical standards were elevated.

Do you think this would be true generally, not only in the homes in New York that he was discussing but elsewhere?

Mr. BARLOW. Yes, sir; I do.

Senator MOSS. So one of the ways to help solve the very difficult problems of staffing and turnover is to elevate professional standards?

Mr. BARLOW. That has been our goal for many years in the association.

Senator MOSS. Thank you.

Mr. MILLER. Yesterday, comment was made several times about the fact that nonprofit nursing homes receive payment, I believe, in New York city as high as $450 a month; whereas, proprietary homes receive reimbursement I believe to $355 a month.

You made reference to this, in your just completed statement in which you pointed out on a day basis it is approximately the same, a $12 payment for proprietary home, $15 per day in voluntary homes, and $20 per day in public institutions.

Subsequent to yesterday's hearings an operator of a nonprofit home commented to me that this $450 figure was not always applicable, that the payment given the voluntary nonprofit home was related to the services that were made available by these homes.

On page 5 of your statement, you said:

> I would urge adoption of the uniform chart of accounts for cost accounting, an impartial cost commission to determine reimbursement rates, and particularly in those States with a variety of county reimbursement formulas, a rate based on services offered and cost as determined by the reporting system.

Under a flat rate, the proprietary home may be paid the same for very mediocre or possibly inferior services as it is paid for high-quality service. Would you like to see an arrangement under which the proprietary homes would receive treatment like voluntary nonprofit homes whereby the payment would be related to the services and costs?

Mr. BARLOW. Yes. The task of taking care of our aged throughout this Nation is great now and it is going to be greater and greater as time goes by. I can't see the point of arguing about voluntary, proprietary, and this sort of thing. We are wasting our time.

I believe that we should concentrate on eliminating the bad apples in the barrel, and we all have them, voluntary and proprietary alike.

I think that we should concentrate on doing an excellent job for our fellowman. I don't care who does it, I think we all should have an opportunity. I mean those people that are trying to take care of people should all have the opportunity of doing a good service and should all be treated alike.

Senator Moss. Thank you, Mr. Barlow. We do appreciate your statement and it will be helpful to the committee.

The hearing will be in recess now until 2 p.m.

(Whereupon, at 12:35 p.m. the subcommittee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m., Senator Frank E. Moss, chairman of the subcommittee, presiding.)

Senator Moss. The hearing will come to order. We will resume receiving testimony.

Dr. Roginsky and Dr. Pickard, I believe, are going to appear at the same time and sit together on the stand. Dr. Roginsky is the medical director of the Metropolitan Hudson Medical Group of New York City and Dr. Pickard is medical administrator of the Central Medical Group of Brooklyn.

We are pleased to have you gentlemen come and appear before us. You may proceed, whoever would like to go first. Perhaps you could draw straws.

STATEMENTS OF DR. DAVID N. ROGINSKY,[1] MEDICAL DIRECTOR, METROPOLITAN HUDSON MEDICAL GROUP OF NEW YORK CITY; AND DR. KARL PICKARD, MEDICAL ADMINISTRATOR, CENTRAL MEDICAL GROUP OF BROOKLYN, N.Y.

Dr. PICKARD. Apparently the senior member has indicated me as the beginner.

Senator Moss. Very good. We will take you first, then.

Dr. PICKARD. As an introduction, I would like to say that you have received the printed material which we have presented and rather than just read that, I would like to hit the highlights.

As introduction, my name is Karl Pickard. I am a graduate of Harvard University class of 1931. I have been in the practice of medicine for some 30 years. I was a founder-member of the Central Medical Group of Brooklyn, which, as you know, is affiliated with the Health Insurance Plan of Greater New York.

Senator Moss. Very good, Dr. Pickard. Your full printed statement will appear in the record and we will ask you to highlight it and emphasize the parts you want.

(Statement referred to follows:)

PREPARED STATEMENT OF DR. KARL PICKARD, MEDICAL ADMINISTRATOR, CENTRAL MEDICAL GROUP OF BROOKLYN

Mr. Chairman, members of the committee, my name is Dr. Karl Pickard. I have been in the active practice of medicine for the past 30 years. I am a founder-member of the Central Medical Group of Brooklyn. As chief internist

[1] See p. 544.

and medical administrator, I am responsible for the supervision of medical services provided by the group.

Our medical staff consists of 17 family physicians, 6 pediatricians, and 20 other specialists representing practically all of the branches of medicine. Since 1947 our group has been affiliated with the Health Insurance Plan of Greater New York (HIP), providing care to its enrollees on a prepayment (nonfee for service) basis. We presently serve some 36,000 men, women, and children.

Since 1962 we have been caring for some 3,000 welfare recipients over age 65 under an arrangement between HIP and New York City's welfare department. Of these, approximately 1,000 men and women are residents of 4 nursing homes in Brooklyn.

I am here to discuss with you our experiences in providing medical care for these nursing home patients.

At the outset, I believe it would be worthwhile to define, or redefine, what I mean by a nursing home. For far too many, a nursing home has come to represent a place where old people go to vegetate until they die. For many families a nursing home is a convenient place to dispose of aging ailing parents or grandparents while preserving an illusion of filial responsibility. In the case of the welfare patient this is compounded by a family unable to meet nursing home costs and the community being called upon to fulfill its obligation through budgetary allocations and making provision for facilities (which in some cases are little removed from the poorhouse concept of the 19th century). On occasion the community goes one step further and adopts administrative codes aimed at setting minimum standards of geriatric care.

When our group accepted the responsibility for the medical care of these 1,000 welfare recipients in 4 nursing homes, it was with the clear objective of helping to make these homes into places where these aged people could, with proper medical attention, live as comfortably and happily as possible with atmosphere, activities, and treatment oriented, where possible, toward rehabilitation and return to the community. Therefore, when I speak of a nursing home, I have in mind something much more than a final postal address for old people who don't get letters.

I think this attitude was shared by the city's welfare department which demonstrated commendable initiative by entering into an arrangement with HIP to provide group practice medical care for these nursing homes and by the hospital department, which has recently developed a new code for proprietary nursing homes and which supervises their operations.

The cooperation and advice we've received from the department of welfare, particularly from Commissioner Dumpson, Dr. Yerby, Dr. Haughton, and their staffs, and from Dr. Trussell, Dr. Horowitz, and their staffs at the hospital department, demonstrates that there are people with initiative in government who are concerned and are developing practical programs for improving care for the aged.

What I hope will be derived from our experience is an insight into those needs of the system where creative legislation can provide the necessary tools for those who want to improve conditions in nursing homes.

As you probably know, our type of medical group coordinates activities between the family physician and the specialists. We maintain a central record system for each patient. We maintain a physical facility, a group center, in which many of the ancillary services, often only available at a hospital, can be provided. These services include laboratory and X-ray procedures, physiotherapy, cardiography, etc. Also available is the guidance of psychiatrists, social workers, nutritionists, and psychologists. Our patients also receive the services, on referral by their group specialists, of consultants in the highly specialized fields of neurosurgery, cardiovascular and thoracic surgery, plastic surgery, etc.

For nonwelfare patients our group provides medical care at the office, at the home of the patient and in the hospital. Regulations, however, do not permit the department of welfare to contract with HIP for inhospital medical care. As a result, welfare patients must be treated by the hospital staff. We have, however, managed to establish a liaison with two of the hospitals to which our welfare patients are referred and are able to maintain continuity of medical care.

I intend here to review highlights of (1) our initial experience when we undertook the care of patients in the four nursing homes, (2) the establishment of an organized and supervised medical care program for the patients in these homes, and (3) our hopes for future development of this program.

In 1964 the medical care for these patients was assigned to our group. Our first impression, to put it mildly, was very disturbing. We found:

The city's code for nursing homes was not adhered to;

There was no consistent pattern of medical service available to patients;

Although each patient was seen by a physician one each month, as required by statute, many different doctors provided the care on a fee for service basis;

There was no central record of a physical examination or any followup system and there was no complete history and physical examination on the patient's chart at the nursing home;

There was no uniformity or consistency of instructions to the nursing home staffs;

There was no coordination as to proper handling of these elderly people;

There was no direct supervision of the staff by the doctors treating these patients or of the doctors themselves;

There was no apparent attempt on the part of the doctors to rehabilitate these patients according to any established uniform program, in fact there was no rehabilitation at all:

There was no liaison with any hospital, when a patient left the hospital there had been no continuity of care—the patient was "lost" for the period in which he was hospitalized.

When we began the care of these patients, our first concern was the selection of physicians who could best do the work. I was particularly fortunate in having as my associate medical administrator one of my partner internists, Dr. Joseph Kelter, who set as his goal, from the beginning, working out a program of rehabilitation.

In choosing physicians for this responsibility, we felt it was not sufficient that all of our group family doctors were qualified as board eligible or board members in internal medicine. We wanted those who had a special interest in the care of elderly people. We wanted those who had that special touch which in medical circles is called T.L.C.—tender loving care.

We were fortunate in our selection of physicians; only one had to leave because he was temperamentally unsuited for the work. We were fortunate too in that all of our physicians had been practicing with others as part of a medical team and could therefore accept supervision and orientation to this special type of medical practice. Let me say here that I feel unsupervised medicine is, or should be, a thing of the past. Medical practice is supervised in good hospitals, in many group practices, in university institutions, and in industry. Medical practice today requires coordination. No one physician can go it alone. In our type of group practice supervision exists because there is common group responsibility for the care of all patients and each physician works as a member of one team.

Our first function on taking over medical care in these nursing homes was to perform a most careful physical examination of every patient. For many of them, this was the first time such a basic medical service had been performed. The reports of these examinations were dictated and entered into the nursing home chart in typewritten form to provide a permanent legible record. The code for nursing homes requires a complete laboratory workup and chest X-ray which we did. But we were not satisfied with meeting minimum requirements. A cardiogram and other indicated tests were also done on each patient.

Our nursing home administrators and directresses of nursing welcomed this new intensive medical care and were of considerable help in undertaking new procedures, new orders, new record forms, and data-collecting methods. They met with us and our physicians frequently and as the program progressed, on a routine monthly basis. These meetings were not only for indoctrination, but afforded the opportunity for constructive criticism of the way the work was being carried out.

Our family physicians requested specialist consultation whenever indicated. In many instances the medical group's administrative staff went to the hospital from which these patients had originally come in order to obtain the complete medical history and workup. Each patient was considered as one who had just entered the home. At the same time we had to give routine care to these patients and also care for the acute illnesses which arose.

It took us over 6 months to accomplish all this. It was well worth the effort. Innumerable conditions were uncovered which, although chronic, could be treated and stabilized if not cured. Actually, it would have been worth the

effort if the one case of severe anemia we found (which after investigation proved to be a malignancy which went to successful surgery) was the only case helped in this period.

Although we have managed to complete our medical workup on all patients, establish a liaison with the two hospitals, develop a patient-doctor relationship which is more than just adequate; although we have categorized the care of diseases so that a metabolic specialist takes care of our diabetics and is now working on a possible identification of hyperthyroidism in the elderly patient (not an easy task); although we may pride ourselves in having made important diagnoses which had been missed before; although we have made some headway in cleaning up some of the chronic body sores (decubitus ulcers) to which elderly patients are prone; although we have done screening for glaucoma on all of the patients as a prevention of insidious blindness; although our doctors have been on the alert for walking and hearing difficulties and changes in mental attitudes; and although we have rendered about 15,000 physician services to these people in the past year—gentlemen, we have only begun to scratch the surface.

We would like to see nursing homes develop "intensive care units" so that many instances of costly hospitalization would be unnecessary and so that we could minimize enervating transfers between nursing home and hospital. There are many conditions which doctors normally treat at patients' homes. These include mild pneumonia, bronchitis with fever, mild congestive heart conditions, leg ulcers, etc. These could readily be treated in the nursing homes if infirmary beds were made available in a particular section where more nursing care could be available than is required by the average nursing home patient. Such a program definitely needs the cooperation of the administrators, head nurses, and owners of nursing homes.

Medicare will be calling for an increase in the number of nursing home beds. Perhaps a thought (a legislative thought) should be given to the use of these "posthospital extended care services." The hospital load could be lessened if nursing home intensive care was available.

I feel our objective should be the establishment of a medical facility within the nursing home operated in conjunction with a geriatric day center for elderly people in the community. This should make available at all times physicians and ancillary services. It should facilitate the mingling of in-nursing home patients with the outside geriatric community, an important element if we aim for rehabilitation in all those cases where it is possible.

In considering rehabilitation, Dr. Kelter and I have made our recommendations in three general categories:

(1) Social rehabilitation, within the nursing home;
(2) Psychiatric rehabilitation;
(3) Physical rehabilitation of the handicapped.

Most of the patients who enter a nursing home, particularly those requiring only custodial care, do so reluctantly, bitterly, even belligerently. You get the impression that they never speak, that they have no contact with one another, that each one is shut up within himself. You can watch them sitting in their wheelchairs looking anxiously out of a window watching the passing traffic. Sometimes they sit this way for hours simply because there is nothing else to do.

They wait anxiously for mealtimes, but they don't eat. They look at television if it is provided. They quickly roll their wheelchairs to the entrance waiting room just to see what is going on, to get a snatch of someone's conversation.

A continuing and ongoing carefully selected program of lectures, movies, musicals, and occupational play periods should be established. It should be developed in consultation with patients so that they have a feeling of genuine participation in planning their own activities, the essential ingredient to counteract the alienation that develops from a sense of being manipulated.

Our nursing home code calls for a recreational director, but it does not specify that he should be full time. He should, and there should be training requirements as a prerequisite for these positions. There should be sufficient space for these activities. Sufficient space should be provided for community dining: the serving of meals in isolated corners or in bedrooms for ambulatory residents should be discouraged.

If a geriatric day center were established within the home or adjacent to it, and nursing home patients encouraged to join with those of their age group from the outside community, it would open new vistas of life for many who are presently shut up within themselves. These are but some of the social rehabilitation steps which should be taken.

Psychiatrically, all elderly people can become easily disturbed. When we place them in a strange environment where many may have gone against their personal wishes, such a mental disturbance is intensified. On the other hand, all elderly patients must not be considered psychotic or even senile because they are somewhat emotionally upset.

It becomes the duty of the personal physician, in conjunction with an understanding nurse, together with the advice of a consulting psychiatrist, to properly evaluate each patient, and set about making his life worthwhile. The patient in the next bed or wheelchair should become a friend rather than an enemy and the nursing home staff, a counselor rather than a jailer. This takes TLC plus time, effort, and dedication. At present it is sorely lacking in many nursing homes. We must develop a system to correct this situation.

The physically handicapped patient; the partially paralyzed patient; the patient with severe arthritis of a chronic nature which has caused deformities of the arm, hand, or leg, are among the most discouraging and distressing problems. In many instances such deformities could have been corrected if rehabilitation methods had been used early enough. This, of course, is not necessarily the fault of the nursing home. Many of these patients arrive at the home in a crippled condition, never having been treated for correction under proper medical management.

When we undertook medical responsibility for these homes we found no program for physiotherapeutic correction. In fact, we found no physiotherapy room or physiotherapy equipment. With the help of Dr. Horowitz and Miss Mark, of the city hospital department, we have begun to make changes. The nursing home owners are now adding proper space for this purpose and are purchasing equipment. Shortly, we will begin rehabilitation treatment on all such patients our orthopedist feels we can help. We hope to get some of our bedridden patients into wheelchairs, some of our wheelchair patients on their feet so that, even though few, those who are able can get out of the homes, into foster homes or into geriatric apartment buildings in the community.

Although the new code for nursing homes provides that there should be physiotherapy equipment and space for it, no provision is made for a physiotherapist. There should be a full-time physiotherapist in homes such as the ones for which we are responsible.

It is not within my province to discuss costs. To accomplish all the things I've mentioned would be costly at the outset and, while long-term substantial savings may be realized as nursing home health standards are raised, enabling more patients to leave their homes and become readapted to community life, the safety, comfort, and well-being of the patient must be the most important consideration.

This committee is to be congratulated for the interest it has shown in the welfare of the aged. The legislative recommendations it makes will, I hope, have a salutary impact not only upon Federal, but State and municipal programs of care for the aging.

Thank you for this privilege of presenting my thoughts on this important subject.

Dr. PICKARD. Briefly, the central group started in 1947. At that time we were 17 physicians with 69 patients. At the present time we have a medical complement of 17 general practitioners, 6 pediatricians, and 20 other specialists covering the various specialties in the field of medicine.

We now have an enrollment of patients—men, women, and children—of 36,000 people. Of these since 1962, 3,000 are recipients of welfare department benefits in medical care and 1,000 of these 3,000 are patients in 4 nursing homes which we cover for medical care under the HIP program in Brooklyn.

Briefly, we work as teams of doctors under a group practice method and in that way have supervision of our medical care program and of our physicians themselves.

I would like to discuss that supervision problem a little later.

For our nonwelfare patients, we have office, home, and hospital care. For the welfare patients, because regulations call for welfare patients being treated in the hospital by the staff of the hospital, they receive only the care in the office, in the home, and in the nursing home. Because this is a difficulty which we recognize, we have managed to establish liaison between the nursing home and the hospital.

I will stress this a little later. I can say here that it was only through the great effort of Dr. Yerby and Dr. Haughton and his staff within the welfare department that we were able to establish such liaison which we think of such value.

We feel that a nursing home must be more than a final postal address for old people who rarely receive any letters. We found certain things at the inception of the program which I will really stress as it appeared in the paper which you have received.

I intend to talk about our initial experiences in 1964, about what we did trying to correct situations which we found, and our particular hopes for the future. We found that the city's code for nursing home care was not really adhered to even thought attempts were made by the hospital department and welfare department to correct situations.

There was no consistent pattern of medical services available to the patients. Although each patient was seen once a month as is a routine requirement, they were seen by many different physicians on a fee-for-service basis. There was no central record of any physical examinations. In fact, there were no real physical examinations that we could find on the charts in the nursing homes. There was no followup system. There was no uniformity or consistency of instructions to the nursing home staffs. There was no coordination as to the proper handling of these patients. There was no direct supervision of the physicians or of the nursing staff by these physicians. There was no apparent attempt on the part of the physicians to have any uniform or real program of rehabilitation. Lastly, there was no liaison with any hospital.

I was fortunate in having the aid of an internist in my group by the name of Dr. Kelter to help organize a program and he started right from the beginning with the thinking of rehabilitation, the thinking of getting these people out of the nursing home into a place that might be better, a happier place to live, and so forth. With him we had the problem of the choice of physicians. All the general practitioners under the HIP program in our group happened to be men who were qualified in internal medicine or who had enough preeducation to be in a position to take the exams as so-called specialists in internal medicine.

Being an internist, I can say so-called.

We had to go a step further than that and the reason was that we had to pick men whom we thought might be dedicated to the care of these patients and temperamentally suited to take care of them.

We were lucky. Only 1 of the men of some 16 who are working in the program found himself temperamentally unsuited and after 3 or 4 months of being in the program, asked me to be excused from it; he just could not take the things that he saw in the nursing homes, he could not take the elderly patient who was ill and for whom he could do very little, and so on.

Our program in HIP calls for easy accessibility of patient referral. Each physician had at hand a list of specialists in the group who could always be called for any consultations that were necessary. This was an important factor in the program.

The last thing that I mentioned before, the matter of liaison with a hospital; here we found that because of the help of the welfare department our relaitonship with a hospital in Brooklyn taking care of at least two of the nursing homes, led to easing of the problem of getting admissions to the hospital and the easement of getting the patient back into the nursing home when the acute illness serious enough in nature to be in a hospital had been taken care of.

We found that our nursing home administrators and our nurses and even the owners of the nursing homes, lent themselves cooperatively to this program. It was a chore for them, they had to redo their methods of history keeping, they had to redo methods of data collecting that we wanted in order to see how our program was developed.

We found they were cooperative. We found they met with us quite often at the beginning and then on routine monthly sessions met with the doctors not only to be oriented, not only to be educated into a newer method of medical approach, but to give constructive criticism as to how the program was working.

In the first 6 months when we were doing complete histories and physicals on the patient, and this meant dictating these complete histories into dictating machines so that they could then be typewritten onto the charts and would be legible—and that legibility is a very important thing in any group institutional care program, so that any doctor following the first doctor will know what has gone on before. This took time. At the same time, we had to take care of the routine monthly visit which is required by statute and also the acute illnesses that occurred.

We did begin to complete this type of programing in that 6-month period. However, although we did this complete workup with lots of extra laboratory and X–ray work which we felt was basic for understanding the initial condition of the patient; although we had specialists taking care of the diabetes in the home, looking for the various conditions where a specialist's opinion is of importance; although we did develop a liaison with a hospital: although our doctors began to be trained in looking for hearing difficulties, walking difficulties; although they looked for psychiatric problems: although we had a program of glaucoma investigation to prevent insidious blindness; we have just begun to scratch the surface.

There is no question that there is so much more to be done that all I can say is we have begun to scratch the surface in this program.

So much for what we did. What are my hopes? There are three things that are particularly important, to correct situations which we have noted. We think there should be an intensive care unit in a nursing home. This means a certain portion of beds assigned for taking care of people with minor ailments which heretofore have been immediately shipped off to the hospital.

When any of you have pneumonia your doctor will take care of you in your home if it is mild enough, and we think it should be done the same way in a nursing home. It simply means the addition of a nurse or two to be in charge of that particular department.

If there are moderate fevers, if there are sores of the legs and so on, things that would ordinarily have been treated in the home, there is no reason to send the patient out of the nursing home into a hospital for care.

We think, too, that there should be not only a liaison with hospitals but a real direct connection with the hospital. We feel that if this were so, the continuity of medical care which is so much needed, particularly in elderly people, would really be enhanced. By such close connection, I mean bringing the resident staff into the program. That staff is actually responsible for the admission of patients to a hospital, admission difficulties arise because the resident staff didn't like the chronically ill, elderly difficult patients, for whom they think they can do very little. We in turn, must assure them that when they discharge a patient from a hospital they have ready access to the nursing home, where they can see what their care has done and what the continuity of care is accomplishing.

In the other direction this liaison will allow the doctors taking care of patients in the nursing home to see these patients, if not be responsible for them, at least to see them and follow them when they are in the hospital.

This kind of direct connection I feel is very important for this continuity of posthospital, extended care which is mentioned in the medicare bill.

I think further, that there should be a geriatric day center connected with, if not in, the nursing home itself. This geriatric day center is for the elderly people in the community near and surrounding that institution; a center which would allow these people to come in, have movies, lectures, and allow the in-patients of the nursing home to mingle with them. This might lead to something which I call rehabilitation in one sense.

If you have ever been in a nursing home you have seen some horrible things which I will mention in a moment. The three thoughts about rehabilitation include social rehabilitation within the nursing home itself, psychiatric rehabilitation, and physical rehabilitation. I think to many of us have thought of rehabilitation only in that latter category.

The first, I think, is even more important. As I said, if you have been in a nursing home you are dealing with people who might have been reluctant, bitter, even belligerent about being placed in a nursing home. You see them sitting around not talking to anybody. You see them tied up within themselves. They sit in a wheelchair and look out the window just to see some people pass by. You watch them waiting for the mealtimes to come and unfortunately, they get there and they don't eat for various reasons.

You see them wheeling their chairs to the front waiting room of a nursing home simply to snatch a it of conversation that is going on in the administrative office. You need a recreationist in a nursing home for this social rehabilitation.

The code calls for a part-time person in this capacity. I feel that you need a full-time recreationist in a home who will organize together with the patients a program, because in so doing they make the patient a living part of such a program. The patient gets away from thinking he has been ordered around, that this is being done for him and he has nothing to say or do about it.

You need such a recreationist to set up programs of musicals, movies, games, occupational play, I call it, rather than occupational therapy because we are not training these people to do anything with the therapy. We are training them to spend time and be happier than they might have been.

Psychiatrically, because they come into the nursing home reluctantly, let us say a good many of them are disturbed but this does not mean that all elderly people in nursing homes are psychotic or even senile; they are disturbed because nothing has been done to correct this disturbance.

Here we need a definite cooperation of the family physician who is taking care of the nursing home patient, the nurse, and the specialist in psychiatry. Patients should be made to feel that the patient in the next bed is a friend rather than an enemy; you might be surprised, as to how many patients think that their next bedmate is an enemy. They should be made to feel that the nursing staff is a counselor rather than a jailer. These are things that could be done in a carefully organized rehabilitation program which aims at corrections of psychiatric disturbances.

Lastly, the problems of physical rehabilitation must be evaluated. Many of these patients who have had strokes, paralysis, crippling arthritis, and have an arm or leg that is not functioning, have entered the nursing home, before anything had been done about these conditions. Actually, the nursing home is not to be blamed for those cases which came in and had not had proper rehabilitation physically beforehand. In the nursing homes themselves, although the code called for a physiotherapy room, apparatus, we didn't find any. Strangely enough, the code does not call for a physiotherapist. I think it should. If this were put into action, we would benefit a good many of these people. We would get them out of their wheelchairs. We would get them into that intermingling in the geriatric day center and we might get them out into the geriatric apartment house in the community or back with their families if their families would take them back.

These are the three things that I think are most important in the correction of difficulties we found. Of course, it is not my province to talk about costs. I realize that the initial costs here are quite high but I feel that if we were able to rehabilitate people, get them out into the community, the difference in that cost would be sufficient to make up for what the cost might be.

I simply want to congratulate this committee for what they are doing in the help of these elderly people.

I want to thank you for allowing me to sound off a little bit.

Senator Moss. Thank you, Dr. Pickard. [Applause.]

Thank you for sounding off. That demonstration of approval reflects my feeling. You have enunciated for us here some of the very pressing needs to appropriately deal with these elderly people that go to nursing homes or other homes for the elderly. So many are just neglected, just stored away as it were; nothing is done, really, to rehabilitate them or to make their lives fuller or more meaningful and pleasant.

What you have said strikes a very responsive note to me.

I don't know whether you were here before the noon recess, but Mr. Barlow was testifying on the affiliation of the nursing home and hospital indicating that he thought it was not a successful arrangement

to have a formal agreement. He advocated just a "gentleman's agreement," a loose arrangement.

I take it from your testimony you would like a very close, integrated arrangement with the hospital.

Dr. PICKARD. Definitely.

Senator Moss. Well, I am glad to have your testimony on that point.

Your group has about a thousand patients now in nursing homes, is that right?

Dr. PICKARD. That is right.

Senator Moss. Well, your experience, then, is practical and it is with a sizable enough sample that I would think great credence must be given to your observations.

I was also interested in your suggestion of a geriatric day center. I tried to raise this once or twice before with other witnesses, because it seems to me that this could be a very valuable addition where older people that can continue to live with their families or even to live by themselves in their apartment and still have a place to come to be examined, to be given some health services, and to mingle with other older people and make social contacts. I think that is a valuable suggestion in your testimony.

Now, one other thing that I did want to ask you about, you indicated that there was only one medical practitioner who didn't seem to be adapted to working with these elderly people out of how many, did you say?

Dr. PICKARD. We started with 16 men in these 4 nursing homes and one of them we found could not take the work that had to be done.

Senator Moss. But for the remaining 15, this was satisfying and meaningful practice for them to work with these older people as much as with the acutely ill?

Dr. PICKARD. Absolutely. They developed a feeling that surprised me, particularly the younger men. They had come into the program thinking that there was very little they would accomplish. This year has shown them that they have accomplished so much and that there is so much more that they can do that they have really become enthusiastic about it.

Senator Moss. This is heartening.

Did you find any large number of people in nursing homes who had been inappropriately referred there, who didn't really belong there?

Dr. PICKARD. I would not say large numbers. I have not yet made the data on that. In fact, we are working on that with a couple of students who come through the Department of Health for the City of New York. One of them is from Einstein and the other is from out in Louisville, Ky., third-year student and second-year student, respectively, and they are now working on a protocol that they set for themselves under the department of health programing.

Dr. Bluestone is in charge of them and they have set their own protocol. They are going to tell me at the end of the summer how many of these patients really didn't belong in the nursing home in the first place, and they are going to criticize the entire program for us, they are going to be a real good critic.

Senator Moss. That will be fine. Perhaps you could let our committee have a copy of that.

Dr. PICKARD. I am sure they would be happy to send it to you.

Senator MOSS. It will add to our store of information.

Dr. ROGINSKY. May I make a comment on that?

Senator MOSS. Certainly.

Dr. ROGINSKY. In a few minutes I will discuss my statement but I have been in two large nursing homes for at least 2 years longer than Dr. Pickard's group has been in nursing homes.

A small percentage of the patients in my two nursing homes—I choose to call them my two nursing homes because I am director of the group—have no place to go. I am sorry to say they are dumped there and allowed to vegetate. Their clothes are atrocious, there are no social activities, and they have no family to care for them. They are at the end of the line.

I cannot confirm and affirm more vigorously than Dr. Pickard has already said about the tremendous need we have for giving these people the lift that they so urgently need. They need to be adequately clothed, they need to wear clean clothes and they need to get more adequate social and nursing activities than they have gotten.

I am going to speak for Dr. Pickard and certainly I will speak for my group. We think that we have done a tremendous job on these two nursing homes as far as the care of these 530-odd patients in the two nursing homes; so much so that if you come into either one of my two nursing homes and discuss the change that has taken place in 3 years—you will find that nurses that will say, "Doctor, since your group came into our nursing home it is like God walking into our kitchen."

Senator MOSS. That is a wonderful expression. I commend you for that. In fact, we would like to have your statement now, Dr. Roginsky, and then we may have questions for both of you.

Dr. ROGINSKY. I am Dr. Roginsky. I am the medical director of the Metropolitan Hudson Medical Group. You have already received my statement.

I am a graduate of Yale, 1926. For a period of at least 25 years before I got into the nursing home program and the care of the aged as a medical director of the group, I did serve as a panel physician and a consultant for the department of welfare.

I am also a founding member of a group, not as large as the central Brooklyn group. My group is only about 11,000 patients, of which 3,800 of them are welfare.

I cannot stress more vigorously than Dr. Pickard has already stressed, the tremendous things he has accomplished and I choose to think I would have been able to accomplish the same type of thing.

Our patients receive a detailed history, physical examination, chest X-ray—if it has not already been done before admission—electrocardiogram, glaucoma test, blood count, urine analysis, and any other examinations that are necessary for their well-being.

Periodically we repeat in our laboratory blood studies and urine analysis in order to determine whether or not they have a disturbed kidney function, diabetes, or if the known diabetics are well controlled. Tests are taken every 3 months or more frequently if it is indicated by doctors.

I am going to speak on subject of drugs.

Prior to the time that my group came into the nursing home, in each of these two nursing homes there were 260 patients in one and about 300 or 275 in the other nursing home. There were approximately 35 doctors in each of the nursing homes. I can just tell you that these patients were very rarely seen by the doctors except if the nurse reported they had an acute illness.

The doctor would come in, write the prescription downstairs and spend 10 minutes and see 10 patients.

I am sorry to say this but frequently they would enter the nursing home and write prescriptions—in duplicate—without ever seeing the patient.

When we came into this program, in the first 2 months we learned there were five patients receiving a drug for arthritis which is well recognized for its potential toxic effects. Not once for a period of 3 to 6 months had a single one of these patients had a blood count or urine analysis to determine whether there was any toxic effect of this particular drug.

As you have read in my statement, patients were receiving three to six different drugs without rhyme or reason. We do have limited amount of time and my doctors come in and spend 3 or 4 hours in each of the nursing homes daily. I have six doctors in the two nursing homes.

The reason I do not require 16 physicians in my homes is that I only have 2 very large nursing homes.

We have two doctors in one nursing home and four in the other. The larger one is the one that I have spent most of my time, and energy in.

We very early in the program learned there was a tremendous waste of drugs. For example, the code says that drugs must be ordered once a month. If a patient has an acute illness and we order antibiotics for 10 days, and then the patient expires or has to be transferred to a hospital 1 or 2 days later, the remaining medication would have to be destroyed.

Now, this a tremendous waste of money. This is something we thought we could correct by stocking large volumes of most medications such as antibiotics and hypertensives and various other drugs excluding barbiturates and narcotics.

In all the offices, namely, in HIP and the department of welfare, we received complete, marvelous cooperation from Dr. Haughton and his staff. The department of welfare and the other city departments thought this would be an excellent procedure. I purchased these drugs and stocked them and before a single tablet could be used, the local pharmacist getting wind of this, notified the New York State Board of Pharmacy. The New York State Board of Pharmacy padlocked the drugs and served us with a summons for attempting to use the drugs.

When I showed them the authorization from these various departments, they realized that they didn't have a leg to stand on because they would have to go after many of the leaders in the city departments. They got the wholesaler to take the drugs out. Now, this to me was not only a waste of drugs, but it indicated that the city and the welfare department would save a good deal of money.

If we ordered a 30-day supply of digitalis, for example, and many of our patients are on digitalis, since this is one of the many degenerative diseases we treat, and the patient expires, the remaining medication is destroyed. Sure it does not cost very much, but frequently we found 15, 20, 25 doses of the drug goes down into the garbage can or down into the toilet bowl. We felt that we could eliminate this waste.

Furthermore, this would allow my doctors more time since they do have a limited amount of time to spend caring for patients and not spending an hour or an hour and a half a day writing prescriptions. Prescriptions must be written as you have noted in my statement in duplicate.

With the cooperation of Dr. Yerby and Dr. Haughton, we met with the officials of the Mount Sinai Hospital and we have a loose connection such as you spoke about, Senator Moss. However, we can only get certain types of patients into Mount Sinai.

We have heart cases, surgical cases, but we are unable to get beds for what we need most, our heart failure. So we have more or less discontinued sending them off to the hospital.

Since our doctors are in every day we treat them in the nursing home, give them oxygen, treat them in a very adequate manner. We think their best interests would be served if we could have a comprehensive care program. By comprehensive care program I mean care in the nursing home and hospital by the same team of physicians. My group has been giving 3 years of service to these welfare recipients in the nursing home, and those that are not in nursing homes are receiving office and home care. We move them from the nursing home or from their home by ambulance to our center or by public conveyance or by taxi, give them whatever X-ray or other examinations are necessary. But when we send them to a hospital, we lose track of them. We have no method by which we can give them—as Dr. Pickard has already indicated is vital—comprehensive care.

We need a full-time rehabilitation department in each of these convalescent homes.

As a matter of fact, HIP in the first 6 months of our program, recognized the need for this and they financed us for a year and a half. They gave me a rehabilitation expert from New York Medical College who came in with his technician and taught our nurses in the nursing home rehabilitation.

We need much more competent and much more careful guidance of rehabilitation than we have had up to now.

Dr. Pickard has mentioned the social activities. He spoke about they need a little buildup. They need clothes. Go see these people in the nursing home and you will recognize how terribly they are sitting there vegetating, nothing to interest them. They need somebody to come in and stimulate them to go to a movie, to have movies in the nursing home. Our two nursing homes are large enough to have this type of program.

I think I have covered most of the matters that I wish to discuss and I am prepared to answer any questions. I would like to thank you for permitting me to give my views.

Senator Moss. Well, thank you, Dr. Roginsky.

I am particularly interested in your discussion of the problem of the distribution of drugs and the waste that you encountered because of regulations not permitting any drugs to be retained.

Dr. ROGINSKY. Yes.

Senator MOSS. Do you think the wasteful use of drugs in nursing homes will increase under the medicare legislation?

Dr. ROGINSKY. The drug utilization, if it is carried by our group coming in or Dr. Pickard's group coming in, it is quite possible that internists will reduce the cost of drugs.

I cannot stress enough that the only way in which I can see that a program such as we have just outlined can function most adequately is if we have group planning, group physicians who can be supervised by physicians in charge.

I go in and supervise the drugs. Frequently we have meetings and discuss our drugs and discuss ways and means in which we can avoid overusage or avoid possible deleterious effects of drugs.

Many of our patients get digitalis. I have a technician in my group who goes to both nursing homes 5 or 6 days a week and takes electrocardiograms, so he might pick up evidence of digitalis toxicity early, and not wait until our doctor finds a coupling of beats by listening to the heart.

Dr. PICKARD. I think supervision of medical care is a thing of the future, should be a thing of the present, and there should never be any unsupervised medical care. In hospitals the doctors are supervised by seniors, by attendings. In group medical practice they are supervised. In industry they are supervised. In university hospitals they are supervised. They get out into practice and they become a law unto themselves.

Now if in nursing homes you had programs which were under an umbrella of the hospital, under an HIP program or any type of group practice where there is such supervision, then your answer to the question, "Will the cost be increased?" can probably be "No" because under such supervision, and under legislation which will allow bulk medications to be stored in a nursing home under the proper overseeing by a pharmacist, and when prescriptions can be written directly on the charts in the nursing home just as they are in a hospital; then your cost element, as Dr. Roginsky mentioned before, is going to be lower.

Dr. ROGINSKY. I reported, Senator Moss, about our experiences within the first 6 to 9 months of our program where between the two nursing homes we were able to reduce the volume of drugs—I don't say the cost, the volume of drugs—by about 25 percent.

Senator MOSS. Thank you. That is an impressive figure to be able to reduce the volume by that much.

I think both of you doctors have indicated that in these homes you found instances of very brief visits by doctors that made it almost meaningless to have medical visitation.

Dr. ROGINSKY. The way it worked was this: The welfare department had a panel of physicians and this panel of physicians was responsible for the care of these particular patients. A panel physician might have 1 or 3 or even as many as 10 patients in the nursing home. If he had 10 patients in the nursing home, as I indicated a few minutes ago, he would spend time just stopping by and asking how does the patient feel, how does Joe Brown feel, or how does Tillie Brown feel? That would be the extent of his examination.

As I indicated a few minutes ago, I am sorry to say that these are the facts. They did not examine the patients.

Dr. PICKARD. What is important here is that although there were many doctors who had 1, 3, and 10 patients each in one of our particular nursing homes—one of ours having 300 patients—there was no consistency or pattern of medical care. Each doctor treated his patient as he saw fit, and there was no supervision even of that. I must give you an example of a time when we took a few of our doctors to the nursing home. This was even before we started learning what the floors looked like and what facilities were available. We watched a doctor who came in, took his coat off, put it on his arm, and about 20 minutes later was leaving the nursing home.

I asked the head nurse how many patients this man had seen. He had seen 20 patients in those 20 minutes. This gives a reason for our present program. We are not any better doctors, I dare say, than that particular doctor. He might have been an awfully good doctor, but in this nursing home he was not. He did not take the time necessary for good medical care. He could do this because no one was there to supervise his work.

This may be one of the reasons why a particular case which I mention in the report that you have shows a patient who had been in the nursing home almost a year who had a hemoglobin of 4 grams (15 grams is normal); investigation proved this to be a malignancy.

Fortunately, it was the type of malignancy that responded to surgery. This man has had some help. Maybe we relieved him of some future trouble.

If that was the only case we had found, we would have done some good. There are innumerable instances of this sort of thing. Drugs used without taking any blood tests to find out if there was any toxic effect is another example of improper medical care.

Dr. ROGINSKY. I would like to speak on one other subject as far as care is concerned. As you know, under the HIP program, our doctors are available 24 hours a day, 7 days a week.

Prior to our coming into the program, the nurses informed me, and I knew this was true from my past experience over the previous 25 or 28 years, that on Saturdays and Sundays and holidays, especially in the summer months, when the patient became acutely ill, they would have to call the city hospital ambulance. Not only was the doctor not available but he was so inadequately covered that there was nobody to see them at the nursing home.

Under our plan, we have not only our own doctors available for 24 hours a day, but we doubly insured it so we will not be killing our doctors. We have an emergency coverage system with a centralized answering service. If the nursing home or if any one of our group patients calls, there is a screening doctor who is available to determine if a house call is necessary.

The orders I have given to the screening physician when a nursing home calls, "Don't ask any questions, dispatch a doctor." When a welfare patient calls who is home, we don't allow them to be screened, we dispatch a doctor.

I will not risk a welfare patient, or any other patient for that matter, not getting treatment, particularly these elderly patients who have serious illnesses. I will not allow them to go through a night being uncomfortable without being seen by a doctor.

Senator Moss. Are there many of these nursing homes in New York where the conditions still exist such as you were describing; a doctor seeing 20 patients in 20 minutes? Is that still going on?

Dr. ROGINSKY. I can only speak for my two nursing homes; it does not exist there.

Dr. PICKARD. I can only speak from the experience in the four nursing homes that we have mentioned, but I have visited other nursing homes in preparation for the medical care of these. I know that I saw similar instances of poor recordkeeping and poor medical care. With the help of Dr. Horowitz and Miss Mark of the hospital department, whose staff supervised the program, we were able to get good cooperation of the administrators and head nurses of our homes.

It was not that they didn't want to cooperate. They needed orientation and stimulation.

Senator Moss. Thank you very much.

Any staff questions?

Mr. FRANTZ. Yes. I was following with interest, Dr. Roginsky, your saga of the bulk drug program. I just want to ask, were you finally frustrated by the board of pharmacy?

Dr. ROGINSKY. Yes. The New York State Board of Pharmacy padlocked the drugs and did not permit them to be used. The only way I could return them after I authorized payment was to get the wholesaler to take them back. The inspector wanted me to destroy $2,000 worth of drugs, and I said, "Oh, no, I will not."

The New York State board, I guess, intimidated the wholsaler so he called me and said, "I will take the drugs back."

Mr. FRANTZ. Now the situations you described in the use of the drugs where there were duplicated and needlessly repeated prescriptions and several drugs were being given to the single patient. Was this just because of inefficiency and disorder or was someone profiting from the situation?

Dr. ROGINSKY. No, disorder on the part of the physician who didn't look to see what he ordered 3 days before or a week before. He perhaps took a blood pressure and didn't look to see what he had ordered previously and he ordered another supply of drugs. Two, three, four, or five days later, this doctor was called again to see the patient because she was complaining of severe headaches. The first and second and third drugs were being used simultaneously until the 30-day supply ran out.

Mr. FRANTZ. One more thing that occurs to me. We have gotten reports in other areas, other parts of the country, and I wonder if you have any knowledge of this: the nursing home operator or personnel accumulating excess drugs, with or without the knowledge of the physicians, and using them at their own discretion, without any order or prescription, for other patients. We have heard this is done particularly in the case of sedatives and tranquilizers.

Have you observed anything of that sort?

Dr. ROGINSKY. I cannot give you an answer. I would not be at all surprised if this were true. I am reasonably sure that somebody had antibiotics that are expensive drugs and something like cortisone which are also expensive.

Senator Moss. Anything else?

Thank you very much, Drs. Pickard and Roginsky.

Dr. PICKARD. Thank you.

Senator Moss. Very helpful testimony.

Dr. Samuel R. Powers, Jr., the chairman of the Subcommitee on Nursing Homes, New York State Medical Society.

Dr. Powers, we are very glad to have you, sir, and look forward to your testimony.

STATEMENT OF DR. SAMUEL R. POWERS, JR., CHAIRMAN OF THE SUBCOMMITTEE ON NURSING HOMES, NEW YORK STATE MEDICAL SOCIETY, ALBANY, N.Y.

Dr. POWERS. Thank you very much. I am very privileged to be here. I would like to mention briefly the reason why I am here. As you mentioned, I am chairman of the Subcomittee on Nursing Homes and Care of the Aged for the Medical Society for the State of New York.

My other background, I am a practicing surgeon. I am professor of surgery at the Albany Medical College, director of medical research there, and have for some time had an interest in the problems of health care of the aged from two standpoints.

One, my interest in vascular surgery concerns itself primarily with surgery on people in the 65-and-over age group.

The second reason was an experience I had in the Army when I was assigned to a Veterans' Administration hospital where there were a great many patients in need of rehabilitation and I participated in the setting up a program for rehabilitation.

I have maintained an interest in this general area of medicine since that time.

In addition to the work with the subcommittee of the medical society, we have in New York State, I believe, an organization called the New York State Joint Council for the Health Care of the Aged which is a combination of professional societies and government agencies devoted to the problems of health care of the aged.

The council consists of the Medical Society of the State of New York, the Dental Society of the State of New York, the Hospital Association of the State of New York, the Nursing Home Operators Society of New York with consultant government agencies as seems appropriate consisting principally of the department of social welfare, the State department of health, and also the Governor's special commission on problems of the aged.

I mention this because it has given us an opportunity for professional societies and government agencies to work together in a very practical and I hope, I can indicate, fruitful way.

I would like to confine my remarks today principally to the problem of nursing homes when defined as places where health care facilities are available. Since there is confusion in definition as to what one person and another means by a nursing home, I will be referring to those in which a full-time nursing staff is necessary because there is some health problem of the patients, if you will, who are there.

I think that the principal problem from the standpoint of the Medical Society of the State of New York has been our concern over some of the problems referred to by the previous speakers which is, if you will, the failure or the difficulty of physicians to adequately supervise the

health care of patients in nursing homes, and as a professional society we have been concerned with the reasons for this. As Dr. Pickard indicated, these people are good doctors and they want to do a good job like anyone else, so we have made some effort to look into the reasons why the situation is as has been described.

First of all, as I am sure you are aware, there is an enormous variation from locality to locality in New York State. In some areas, and I think Buffalo is an extremely good example of this, a splendid program for supervision of nursing homes is carried out by an agency which consists of a very broad representation from the general public and later from industry, and the county medical society. This has been in operation for some time.

In other areas of the State, this has not been so true.

I think again Dr. Pickard hinted at one of the things which may be crucial to the problem and that is the type of medical practice which is required to look after patients in nursing homes.

The bulk of the problems in nursing homes, aside from the occasional acute illness, are essentially problems in preventive nursing and in rehabilitation.

I think most physicians are a little bit uncomfortable when they are dealing with these, and I think for a very good reason. The bulk of physicians do spend their time with a key problem and their task is to solve that key problem and immediately get the patient back to work and back on his feet. Spending most of their time with that type of problem, it is a little bit difficult to make the flip-flop necessary for the type of problem represented by rehabilitation.

Unquestionably another, and I think very important factor, has been the general inadequacy of facilities. It is very discouraging for a physician to go in a health-care facility to see a patient and prescribe certain methods of treatment only to find that either the equipment necessary to carry out this treatment is not available at all or it is outmoded or, if it is there, it may not be handled by people who are properly qualified.

I am sure that this tends to discourage a lot of people who otherwise might carry out these things with considerably more enthusiasm.

Finally, I think there is no question of the problem at the present time. I will get back to this in a moment in connection with the Association of Nursing Homes with general hospitals.

In upstate New York, the bulk of the nursing homes are not in the middle of the cities, they are out in the suburbs, out on the edge of the town, and they may require a considerable distance and time for the busy physician to go. Although this perhaps should not be a reason, I think as a practical matter of fact, perhaps it is.

Now, the problem from our standpoint as a professional society is to see to it that patients in nursing homes receive adequate medical supervision, whatever the possible case. There are many solutions and I am sure you have heard many others, but it seems to me that basically there are at least three ways in which one can do this.

One is to add a full-time attending physician to look at the problems of patients in that home. A second possible way of doing it, which is the way it is generally done now, is to have the patients supervised by their individual or private physicians.

Then the third method would be the affiliation of the nursing home with a general hospital, preferably with the medical center or medical

complex, if you will, in which facilities for all types of care would be available.

Now, as to the first method, having a physician full time in charge of the health care of the patient, I think in the large nursing homes this is not only the ideal method, I think any other method will lead to nothing but chaos.

It is not practical from the standpoint of administration, staff, or anything else to have 50 different physicians coming into the hospital writing different orders in different ways, and so on.

On the other hand, in the very small nursing homes, this is not practical. An extreme example might be in Franklin County in New York State where the entire medical society consists of 12 physicians. There is obviously not medical talent available to assign one of these physicians full time to a small nursing home although the nursing home is essential.

Actually, in Franklin County, this problem has been very well handled from the standpoint of medical supervision by these 12 physicians.

I think as far as the second method, namely having an individual private doctor look after their patient, it probably is only in the very small home that this is a satisfactory method, and perhaps can be a method of choice.

Finally, and I think without any question, the best method is the association of long-term care facilities with regional medical center complexes. I think ideally this should be a geographical association. The closer the actual physical proximity of the nursing home to the general hospital, probably the better, realizing that in large cities this may not be a practical matter where land adjacent to the hospital is just not available.

One should make every effort, I believe, to get it as close as possible. At minimum, there should be a very close administrative association, and by this I mean, for example, that the type of medical records should be identical.

In the two institutions, the charting system should be identical, the way in which laboratory reports are reported should be identical so that in a sense the charting and record system is common for both the general hospital and the nursing home which it serves.

This clearly has other advantages. Getting back to the point I made about the general unfamiliarity of most physicians with problems of preventive medicine, the medical center complex, particularly the university hospital, has specialists in these very fields who make this their lifework and hospital talents would then be available either in consultation at the nursing home or if necessary, having the personnel at the nursing home come to the institution for further training.

Ideally the paramedical personnel, physical therapist, occupational therapist, should actually be a part of the department of physical medicine and rehabilitation of the parent institution.

The other problem which I alluded to, the question of the adequacy of facilities, is certainly a difficult one and has been a difficult one in New York State. Recently, something has been done in New York State which I think bodes well for the future and it concerns a reassessment of, if you will, of minimum standards for nursing homes.

It is a document which I hope will soon become the law in the State of New York which was worked out by a very large number of coop-

erating groups. This program started by the department of social welfare which until recently, as I am sure you are aware, was immediately responsible for the supervision of health care facilities in New York State. They then requested the cooperation of the New York State Department of Health, the medical society, the dental society, the nursing home operators, the nursing association, hospital administrators, and even such ancilliary groups as the American Institution of Architects and others who work together over a period of approximately 2 years to draw up a very detailed document of what, if it is passed into law, would be a requirement for a nursing home to operate in the State of New York.

I think this is important for two reasons. One, the document in itself is important because I think in a sense it is almost a model document of what the facilities of the nursing home should be.

Above and beyond that, I think again it is an example of the fact that when Government agencies and professional societies of various types have a common goal, that they can and will develop a program, in this case a document, which will be satisfactory not only in itself but give all of us who worked on this thing an opportunity to learn a little bit about what the other fellow's problems were and why he viewed things with a particular bias, which, of course, this does.

The New York State Joint Council, which I referred to before, which is a permanent organization which combines the State government health agencies and the professional societies, societies concerned with the health care of the aged, is doing a somewhat similar thing. We have not tried to set up a competing set of standards but we have tried to air some of the problems which will come up in association with such things as the question of whether the nursing homes should be proprietary, whether they should be nonprofit.

One question which has been of particular concern to me and the medical society in the State of New York is the question of accreditation.

As I am sure you are aware, the problem in general hospitals in this country 40, 50 years ago, was really quite analogous to the problem of nursing homes today. Through a joint commission which consisted of primarily the American Medical Association and the American Hospital Association, a joint commission for accreditation of hospitals was set up theoretically without any legal power whatever. Very shortly there was such an enormous amount of prestige about the standards of hospitals in the United States, and I think they are unquestionably the highest in the world, due, I think in large part, to the joint commission.

The medical society in the State of New York would like very much to see a similar joint commission—perhaps even the same one which is currently doing such an excellent job in the supervision of hospitals—extend its field of interest to nursing homes with the expectation that by so doing, the standards of nursing homes could be brought up to the hospital standards.

Finally, I would like to again say very sincerely that I am very grateful for being here and would like to state as strongly as possible that as an official society of medicine in New York State we would welcome each and every opportunity to work with, cooperate or assist in any way with what your subcommittee is trying to do.

Senator Moss. Thank you, Dr. Powers, for your testimony and for representing the State medical society here.

You indicated the need for having an identical record on a patient in the hospital and the nursing home. What has been done to implement that recommendation here in New York?

Dr. POWERS. As of now, nothing has been done because unfortunately the mechanism up until now has not been available to do it. If this document that I mentioned which was worked out under the leadership of the department of social welfare should go through, at least all of the nursing homes in New York State will have identical charting methods and so on.

We would hope by some mechanism, either through legislation or perhaps on a voluntary basis, that this could be adapted to a general hospital.

Senator Moss. You used the term "affiliation with medical complex." You mean in general, an affiliation with a hospital?

Dr. POWERS. Yes, sir; it would be at a minimum a general hospital. Preferably, it would have associated with it also some of the parimedical ancillary facilities, ideally, perhaps, around a teaching hospital with an active training program in postgraduate medicine. Not only would this be good for the patients, as has been shown in general hospitals, but it would be excellent training for future physicians who were going to deal with problems of the aged.

Senator Moss. How long has the New York Medical Society had a subcommittee on nursing homes? Is it a fairly new innovation?

Dr. POWERS. No, sir. I have been a member of the committee for 7 years. I have been chairman for 5 years. It has been at least that long and I don't know how much preceding that.

Senator Moss. I wondered if this has been a longtime project of the medical society?

Dr. POWERS. Yes, sir; it has.

Senator Moss. Does your testimony for your committee represent generally the medical society view?

Dr. POWERS. Inasmuch as any individual can speak for a large group, I can say, with that qualification, yes.

Senator Moss. Do you have any questions of Dr. Powers?

Mr. MILLER. Doctor, you made the observation about the appropriateness of a supervising physician in large nursing homes. This raises a question concerning which I wonder if any study has been made; that is, the number of nursing home patients recognizing the possibilities of variations in different situations that a single physician might adequately supervise.

Have you made any investigation of this?

Dr. POWERS. Indirectly; yes, sir. There is in our Veterans' Administration hospitals a situation in the so-called chronic medical wards, which is, I think, quite analogous to this. Most of these patients are in fact over 65 in what would almost be called an ideal type of nursing home situation.

Ordinarily, assuming that the nursing home is now backed up by a general hospital for the treatment of key problems as they come up, one physician, I think, could easily handle 250 patients, perhaps more.

I might mention parenthetically here that the ability of a physician to handle a large number of patients depends a great deal upon the

paramedical facilities which back him up. If these are readily available we can deliver a higher grade of medical care to a greater number of patients than otherwise.

Mr. FRANTZ. On the point of the adequacy of the system that is in use in most States, the care of patients being handled through individual private physician arrangements, you indicated that you do not think this is a very good system except in the smallest nursing homes.

Dr. POWERS. Yes.

Mr. FRANTZ. Do you think that doctors in general in New York State would agree with this conclusion?

Dr. POWERS. I can tell you that I have expressed this opinion to the Council of the Medical Society in the State of New York very emphatically. At least in that group, which is the group which has been chosen by the doctors of New York State to represent them, I think you would find essentially unanimous agreement with the statement that I made.

Mr. FRANTZ. There would be an acceptance, then, on the part of the medical community of care being rendered in the home through a hospital-based program?

Dr. POWERS. Care in the home, or nursing home?

Mr. FRANTZ. Nursing home.

Dr. POWERS. Oh, yes. I am sure that there are many physicians who will object to this as there are many physicians who objected to a number of innovations in medical practice in the last few months, but I think again you will find that the bulk of physicians do indeed support the policies I indicated since we as their officers have been expressing these policies and I still remain chairman of the subcommittee. That is my only evidence.

Senator MOSS. Thank you, Dr. Powers. We do appreciate your testimony.

Our next witness is Prof. William Thomas. I understand Dr. Eugene McCarthy will accompany him. I have been anxious to get to this Dr. McCarthy since he has the same name as my colleague in the Senate, Eugene McCarthy.

Dr. McCarthy and Professor Thomas, we are happy to have you here.

William Thomas is professor of public health practice in Columbia University School of Public Health and Administrative Medicine.

Dr. McCarthy is a professor of administrative medicine in the School of Public Health, Columbia University.

STATEMENTS OF WILLIAM THOMAS, PROFESSOR OF PUBLIC HEALTH PRACTICE, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE; AND EUGENE McCARTHY, M.D.,[1] PROFESSOR OF ADMINISTRATIVE MEDICINE, SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY

Mr. THOMAS. Thank you, Senator.

My interest in long-term care stems out of my own academic background. It is in political science and public administration. I have looked at this matter from the standpoint of the development

[1] See p. 565.

of public policy and organizational ideas. In our modern study of administration we have made great advances in what we know and understand about organizational patterns. I have tried to put together these fields in drawing some conclusions about the long-term care health field in general.

You have a statement from me, I believe.

Senator Moss. Yes, sir.

Mr. THOMAS. I intend to cover just some high spots of that at this time and then later on I would like to expand a little bit if there is time.

Senator Moss. You may do that and your full statement will appear in the record at this point.

(The statement follows:)

STATEMENT OF WILLIAM THOMAS, ASSISTANT PROFESSOR OF PUBLIC HEALTH PRACTICE, COLUMBIA UNIVERSITY, SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE

Mr. Chairman and members of the subcommittee, my interest in chronic care facilities developed primarily through a study I did for the New York State Health Department during 1962 and 1963. The aim of the research was to determine the extent to which governmental policies had, from a historical point of view, influenced the development of various types of nursing home facilities in New York State, and to identify what policies, if any, had been important for that development and the influences they had had. My study made clear, at least to my satisfaction, that Government laws, rules, regulations, and administrative policies had played a significant role in shaping the pattern of nursing home and related facilities and had been greatly responsible for the enormous and sudden growth of proprietary institutions in this field, although this consequence was quite unintended.

Modern health care institutions have evolved from medieval precursors that were fundamentally ecclesiastical in character. Public dispensaries and hospitals emerged as urban populations developed. In time secular voluntary organizations appeared alongside these and the church-sponsored hospitals. Though different kinds of facilities grew, they had a common quality. All were, in the language of modern organizational theory, "service organizations."

In chapter 2 of their book "Formal Organizations," Peter Blau and W. Richard Scott distinguish between four kinds of organizations:

(1) "Mutual-benefit associations," where the prime beneficiary is the membership; (2) "business concerns," where the owners are prime beneficiary; (3) "'service organizations," where the client group is the prime beneficiary; and (4) "commonwealth organizations," where the prime beneficiary is the public at large.

The authors then explain: "The dominant problem of business concerns is that of operating efficiency—the achievement of maximum gain at minimum cost in order to further survival and growth in competition with other organizations." With service organizations, "the crucial problems * * * center around providing professional services." And, after a lengthy examination of these matters they say, on pages 244–245: "Only in the case of service organizations do the ultimate objectives of serving clients and serving the organization coincide."

For centuries institutions providing health care have been almost exclusively of service, and not business, character. Hospitals remain predominantly nonprofit institutions today. With the sudden growth of nursing homes and related institutions as prominent resources among health care facilities, however, a different pattern has appeared. Around three-quarters of the nursing-home-type beds in the United States are under proprietary, or profitmaking management. Largely because of strong charitable and philanthropic traditions in New York, proprietary holdings do not constitute so large a proportion of the whole in this State as in the Nation at large. They run at a figure slightly over 50 percent. But even this, you will agree I am sure, is strong representation.

As recently as 1935 there were only 557 proprietary beds in the State—116 in New York City and 441 in the upstate regions. Today there are some 25,000 beds. Their explosive growth came particularly late in New York City—in 1952 there were 2,801 beds, by 1958, 9,489.

How does one account for this abrupt and profound departure from established patterns of organization? It has been argued that voluntary and public organizations could not meet the massive expansion in need for care of the aged and chronically ill. If this is so it leaves unanswered the question of why they could not. The findings of my study were that governmental policies of regulating medical care institutions and reimbursing them for the care of public charges significantly limited the ability of voluntary and public institutions, and were by far the most important determinants promoting the mushroom growth of proprietary institutions. But Dr. Luther Gulick, who in 1929 was director of research for the New York State Commission on Old-Age Security and thereby a key participant in the decisionmaking process affecting nursing homes, has said of the consequences of that commission's work: "We didn't know what was going to happen."

Pursuant to recommendations of the commission the State legislature enacted, in 1930, an old-age security act which provided 50 percent State subsidy of the costs to local governments of pensions for aged persons. Primarily to discourage the use of the public almshouse the commission had recommended, and the legislature determined, that pensions would not be available to persons living in any kind of institution. However, the commission recognized that there was a need, and one that would grow, for long-term institutional medical care and recommended the legislature provide for "* * * the building of modern and up-to-date institutions more in the nature of hospitals or infirmaries rather than almshouses * * *."

With concern about the depression preoccupying most attention, the recommendation for public infirmaries received no support. When the categorical public assistance sections of the Federal social security program were being shaped, during the midthirties, the New York arrangement for old-age pensions was taken as a model—persons in institutions were not to receive federally aided assistance. A last-minute amendment did allow public assistance reimbursement for persons in private institutions. The New York State Legislature followed suit in 1936. But any State or local government giving public institutional care would have to do so without Federal help. This created a decided advantage for private institutions.

One kind of private facility that could give long-term care, for which there was every increasing need, was the proprietary nursing home—only a nascent institution in the thirties. Although there was some regulation of proprietaries as to physical and other standards in New York City, throughout most of the rest of the State there was virtually none. State regulations for this purpose were not established until 1951, although a procedure for "certification" by local government was set up in 1944. Welfare clients were extremely important for these new homes, comprising about half of their business. Welfare rates were negotiated between the proprietors and local public welfare commissioners, although State and Federal aid paid as much as 80 percent of the expenses. Cost accounting to support cost claims was virtually nonexistent. With extremely loose supervision as to the maintenance of standards and an opportunity to negotiate rates with the local welfare commissioner, proprietary nursing homes prospered and grew. In upstate New York the number of proprietary beds swelled from 325 in 1935 to 11,027 in 1952.

A second kind of private institution that could offer the needed care was the voluntary homes, either the nursing home or the home for the aged; many of the latter had infirmary beds. The story here was different from that of the proprietry homes, however. As charitable institutions, the voluntaries expected to carry some of the costs of caring for their patients; probably more important, government policy expected them to carry some of these expenses. Capital costs for the building or physical maintenance of infirmary facilities were excluded from governmental reimbursement for public assistance cases. Although residents of these homes could be eligible for public assistance, they could receive no more than the average grant given in the old-age assistance district; yet, infirmary care cost more than the average OAA recipient needed. And until 1956, no more government money could be paid for infirmary care than for the domiciliary care a home gave. Moreover, the State established "standards of suitability" early for voluntary old-age homes; by mid-1942, 100

of the 129 such homes in upstate New York had met the standards. Standards came earlier for voluntary institutions than for proprietaries because the former were long established and recognized. Quite in contrast, proprietary nursing homes exploded onto the upstate scene—and were thought for a time to be wartime phenomena—before much appreciation of their significance could develop. Operating with relatively high standards for the times, and as charitable institutions ineligible to have all of their costs for welfare patients reimbursed, voluntary nursing home-type facilities did not grow fast. The 1,500 of these kinds of beds in upstate New York in the mid-1930's expanded to only about 2,500 by the early 1950's.

Meanwhile, neither State nor Federal money could be used to maintain paitents in public infirmaries. Despite this difficulty these facilities grew somewhat upstate. Their expansion from about 2,000 beds in the midthirties to some 4,000 in the early fifties paralleled that of the voluntary facilities. After an amendment to the Social Security Act, Federal aid for care in public medical institutions became available in 1951. State aid finally followed in 1954. Hill-Burton money for construction became available in limited amounts in the later fifties. Public infirmary beds upstate had expanded by less than 1,000 during the 1940's; during the 1950's the expansion was nearly 2,000 beds. But in the early sixties the 6,000 public infirmary beds compared to 14,000 proprietary beds.

Hill-Burton money, and a special rate of reimbursement for welfare cases in infirmaries of voluntary nursing home-type institutions, also modestly stimulated upstate voluntary growth during the fifties; the number of beds in these facilities rose from about 2,500 to almost 3,500 during that decade. The special infirmary rate was, and is, based upon cost—and thereby requires cost accounting—but it is limited by a ceiling that is not as high as the costs many of these institutions incur giving good quality care to welfare patients.

The prospects for voluntary expansion are not bright. Even if the ceiling did not limit the amount of money available, there are serious governmental policy limitations upon the spending of reimbursement money for plant replenishment and expansion. There is still a governmental welfare policy that philanthropy should carry such financial loads. Moreover, voluntary organizations, particularly in New York City, are at present operating with an enormous backlog of plant obsolescence in hospitals. The Regional Hospital Review and Planning Council for Southern New York has recently estaimated that nearly $400 million is needed to modernize the city's voluntary hospital plant. These organizations are reluctant to assume new financial burdens for nursing homes with their acute care plant in such a state of disrepair.

The State code for the regulation of proprietary institutions was strengthened somewhat in 1957, although it could still not be called strong and enforcement remained admittedly inadequate. Meanwhile, some local governments were stiffening their supervision of nursing homes. Increasing regulations upstate undoubtedly had some effect upon growth; the expansion in proprietary beds there decelerated. In the early 1950's there had been 16.88 proprietary beds upstate for every 1,000 persons 65 years of age and older. In the early 1960's the ratio was 16.07. The ratio for voluntary beds remained the same in the early sixties as it had been in the early fifties—3.95. That of public infirmary beds increased slightly, from 6.42 to 6.99.

While the great increase in proprietaries took place in upstate New York during the 1940's, New York City's use of these institutions was minimal. In January of 1950 there were only 38 public welfare recipients in proprietary nursing homes here, and only about 2,500 of these kinds of beds. (In upstate New York there were by this time around 9,000.) The city had a strong tradition of municipal hospital service and there were many long-term care patients in its hospitals; largely or solely at city expense. Grave overcrowding developed in the city hospital system, however, and the city commissioner of hospitals reluctantly elected, in 1952, to have all eligible patients for whom nursing home care could be suitable apply for public assistance and to transfer them to nursing homes. With the same kinds of limitations upon voluntary institutions operative in the city as have been described for upstate, little expansion in the numbers of beds in such facilities resulted. The responsibility for regulating proprietary health care institutions is the city's It had an inadequate inspection force. The city welfare department negotiated rates with proprietary institutions but not on the basis of well-developed cost statements: it receives no full cost statements from proprietaries until 1962. In 6 years the proprietary beds more than trebled.

The growth was arrested abruptly when a scandal erupted. At issue was whether some homes were rendering the services they had contracted to render to welfare patients, and that the hospitals department code required. A reform campaign was instituted by the city administration. A strong code was adopted, enforcement was improved and eventually complete, audited full-cost statements were required. The number of proprietary beds shrank. There are less today than there were in 1958.

The findings of my study, briefly outlined above, indicate that proprietorship grew in the health care field not because of any superior ability to accomplish health care purposes but as an unintended consequence of government policy. Given the inherent conflict of purposes found in a business concern assigned the responsibilities of a service organization, I believe it would be sound to develop a more equal balance between governmental, voluntary, and proprietary activity in the nursing home field. Governmental and voluntary organizations should be strengthened in this respect.

Neither of these latter two kinds of organizations is completely free of problems in administering nursing home-type facilities. Public homes and infirmaries in upstate New York are under the supervision of local public welfare commissioners, most of whom are elected officers. A report by Greenleigh Associates in 1962 to a State investigating commission looking into the State's welfare administration emphasized the lack of professional qualifications of most of these commissioners. In my own research I discovered that at least 17 wives of local welfare commissioners, and 2 wives of deputy commissioners, were holding posts as matrons of county homes or infirmaries in mid-1963.

As to voluntary agencies, medical care institutions cannot rely as fully as they did in the past upon charity and good will. Dr. George Rosen has said that the provision for the primary goals of the hospital today "* * * is governed chiefly by scientific-technological norms and the requirements of organizational rationality and economy." As with hospitals, nursing homes are medical care institutions and there is a demand for organization, particularly for systematic provision of resources, such as did not obtain in the past. The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy, entertained today by government welfare administartors and legislators more than by such institutions themselves, is largely anachronistic. Philanthropy, though increasing, has not been able to match the redoubled demands for health care. Too much of the responsibility for bearing the cost of financing voluntary health organizations remains unassumed and unassigned; remains, in other words, unorganized. This is why obsolescence reigns among New York's hospitals, where voluntarism has been unparalleled.

It is philanthropy, the method of financing, that has been unable to expand to meet the growing needs for nursing home care. It has not been voluntarism. Voluntary organizations can be service organizations, with their patient group as their prime beneficiary, and still have the costs paid by nonphilanthropic sources. "Voluntary" may include "philanthropic" but also it may mean merely "nonprofit." There are assets in voluntarism that should be continually exploited; values of dedication, service, compassion. These, and not the money from philanthropic sources that have historically been associated with voluntarism, are its richest values. Voluntary organizations have failed to make this clear, perhaps failing to realize it clearly themselves.

Governmental welfare administration should be straightforwardly reformed where such reform is needed, and a modified concept of voluntarism should be developed. Voluntary organizations should lay their cards on the table, making clear their financial limitations and their organizational assets.

I believe that much more public support, in operating and construction costs, should be supplied to public and voluntary institutions for activity in the nursing home field. Although the Federal medicare legislation may improve the financing of long-term care facilities somewhat, it strikes only a glancing blow at the problems related to the mass of such care to be given. As I understand it, it provides for 100 days of nursing home care. In their classic study of nursing homes in 13 States, published in 1957, Solon, Roberts, Krueger & Baney reported that at the time of their survey the average patient encountered in a home had been in the home for a full year. A 1962 study by the New York State Department of Social Welfare reports that the average proprietary nursing home patient at the end of 1961 had been a patient for 1.4 years. By far, most nursing home care now given, and probably most of that to be given in the future, will not be financed by medicare.

New York State is not standing still on this matter. A number of steps are being taken that, hopefully, will mitigate the financial malnutrition of public and voluntary institutions. Even if realized, however, the projects now in the mill will fall short of giving all the support that is needed. In my opinion, the least called for at the Federal level is a substantial increase in Hill-Harris financing for the construction of voluntary and public nursing home facilities.

Mr. THOMAS. The bulk of my statement is an abstract of a study that I did a couple of years ago in which I was able to describe the historical forces that have contributed to the particular configuration of various kinds of nursing home type facilities in the State.

As we know, about three-quarters of the nursing home beds throughout the country are under proprietary management and the voluntary institutions and governmental institutions, which have historically played a prominent role in the health care through institutions, have not grown in the long-term care field.

This represents historically a rather abrupt and profound departure from the traditional styles of organizing for health care. I pose the question, "Why did this happen?" In looking through the literature I have often seen it asserted that the voluntary and governmental institutions could not do the job. I go a little deeper to ask why they could not do the job.

In our modern literature in organizational theory there are some books that indicate that there is an inherent conflict in a proprietary organization attempting to accomplish what are called "service goals." One book that I cited here in my statement distinguishes between four different kinds of organizations.

Two of these organizations are what the book terms "business concerns" and "service organizations." With business concerns the owners are the prime beneficiary, and with service organizations the client group is the prime beneficiary.

After many pages of discussion and exploration about these different kinds of organizations and related matters the authors of the book explain that:

The dominant problem of business concerns is that of operating efficiency—the achievement of maximum gain at minimum cost in order to further survival and growth in competition with other organizations.

With service organizations—

The crucial problems * * * center around providing professional services.

Then they conclude:

Only in the case of service organizations do the ultimate objectives of serving clients and serving the organization coincide.

Now when these fellows, Blau and Scott wrote their book, they were not talking about nursing homes specifically, they were discussing general organizational principles. There are many different kinds of organizations. This is not the only source, I can give you others. For example, there is a book called "Complex Organizations," by Etzioni. Though his approach is different, he nevertheless implicitly reaches similar conclusions—that there are inherent conflicting motivations in a profitmaking organization attempting to accomplish service purposes.

This raises questions in my mind about whether it is some kind of inate superiority that has enabled proprietary institutions to grow as they have.

This theoretical explanation I am expounding now comes in only after historical study as to what actually happened in New York State that gave rise to the great number of proprietary institutions.

It is important to understand the suddeness with which this occurred and the recency of this development. In the 1930's, nursing homes were hardly recognized, no one was quite sure what a nursing home was. We had voluntary homes for the aged, we had public homes for the aged, and then we had a place where a lady took care of some sick old persons in her home to help pay the bills and that seems to have been the historical origin of the proprietary nursing home.

Because of the peculiarities in the way that public assistance could be administered, because of the way that legislation was drawn up—primarily to get away from the image of the almshouse and to emphasize what was called "outdoor relief" rather than "indoor relief"—because of the evolution in the welfare philosophy, the laws that were passed first in New York and then at the national level with the Federal Social Security Act precluded the giving of public assistance to people in public institutions, and for a time those in private institutions as well were precluded from receiving such assistance.

Well, in the face of need of some place to put people, the welfare people in the State started putting their clients in these little four- or five-bed places where a nice, old lady, possibly a nurse, quite probably a nurse, took care of them.

The administrative regulations read that these were not "institutions," which took care of some of the legal questions about the appropriateness of it, but this thing swelled, it grew, and in a little while in Upstate New York there was a great expansion in the number of proprietary nursing homes and beds.

Now, it is very important to note that it was in Upstate New York that the expansion first took place, and this was during the 1940's and it happened so fast that the people who are responsible for this sort of thing were caught behind and no satisfactory systems of regulation or supervision were established.

There were steps made in this direction in 1944, and finally as late as 1951, the State legislature, after some examinations and some studies, gave the social welfare department the power to regulate proprietary institutions.

Now the welfare department had had this power over voluntary institutions for years and years and years because they had long been established.

Now the supervision of these proprietary institutions was slow and halting and there was hardly ever enough inspection staff. There just was not enough inspection staff and the nursing home was beginning to find itself and was not quite sure what it was supposed to do and was supposed to be, and under these kinds of circumstances standards were not established and where established they were weak and weakly enforced.

The way of compensating these institutions for their care of public welfare patients has also been an important part of the business. There was no cost analysis, there was no accounting. Still people had to be taken care of.

New York City had a long-established tradition of taking care of its patients in its hospital system. It has an extremely liberal hospital care policy and there were very, very few people in proprietary nursing homes in New York City who were welfare patients in the early 1950's. Without consulting my figures, it was something like 38 or some very small figure. But with the postwar hospital crowding situation, the city, in trying to build hospitals to take care of its patients, some hospitals were operating at very high occupancy rates and it became necessary to do something about the backlog of long-term care patients who were in the city hospitals.

Under these circumstances, quite reluctantly, the commissioner of hospitals in New York City decided to have those who were eligible in the city hospitals apply for public assistance and move them into nursing homes.

Now they could have gone into proprietary nursing homes, they could have gone into voluntary nursing homes. Once again, the things that operated in upstate New York operated in downstate New York and the voluntary institutions did not grow very much in long-term care.

As of 1956, some encouragement was offered voluntary institutions to build a little bit faster by the establishment of a special rate that paid the cost for the care of long-term patients in voluntary nursing home institutions up to a ceiling; however, there was a ceiling. No matter how much the care cost they could not get any more than the ceiling.

So these have been factors in the growth of voluntary institutions. As the strength of the regulation upstate has grown, the expansion in the number of proprietary facilities has decelerated. At one point it actually turned back. From 1958 to 1959, 1960, there was a decrease in number of proprietary beds upstate and a slowly increasing number of public beds and voluntary beds.

By the way, I neglected to mention that in 1950 there was an amendment to the Social Security Act that allowed public assistance to be paid to clients in public medical care institutions but the proprietary growth upstate had already taken place. It was 1953, effective January 1, 1954, that the State of New York began to contribute toward the care of patients in public homes in New York. These were a good way behind.

Supervision has never been as strong upstate as it was in New York City. Upstate has lagged. New York City lagged for a while. In the 1950's, when the growth began to occur in New York City, there was an inadequate inspection staff, the public was not really very concerned about it and there was an enormous growth in New York City proprietary institutions. The number of beds trebled between 1952 and 1958, 6 years.

Then the story broke in the newspapers and alleged that the homes paid some of the money back, so I assume the allegations were true—that the homes were charging the welfare department for services they were not rendering and were in this respect also in violation of the city hospital code.

There was a reform instituted by the city administration and a number of steps were taken. I am sure you have heard of them before. With reform came a reduction in the number of proprietary beds and

there are less of these beds today in New York City than there were in 1958. The same story was repeated in New York City as had occurred in upstate New York. As supervision was strengthened this quick, sudden, and mushroom growth of proprietary institutions was slowed and even stopped; it is the weak supervision and the method of financing that has been responsible for the enormous growth of proprietary institutions.

There are some difficulties in public institutions and in voluntary institutions in the long-term care field. Of course voluntary institutions have a good deal of trouble in financing, they are in trouble in financing their hospitals in New York City. A recent study by the regional hospital and planning council has indicated it would take almost $400 million to renovate the city's general hospital plant, and with this kind of backlog of obsolescence voluntaries find it a little bit difficult to get excited about building many nursing home care facilities.

The public institutions could be improved, particularly upstate. There are some very good public institutions upstate—without my taking the time to name them. But many upstate public institutions could use a good deal of strengthening. The public homes are under the supervision of the welfare officials in upstate—the local welfare officials—and these men are elected, they are not appointed. A State commission study a couple of years ago emphasized the lack of professional qualification of the welfare commissioners upstate. I, myself, in my looking about into this long-term care thing, learned that about 17 of the wives of the welfare commissioners are matrons in the public homes and 2 wives of deputy commissioners are matrons in public homes.

Now this would not happen if we had a merit system with professional appointments for these kinds of people who have very responsible positions. There is a need to strengthen the professional level of administration in the public welfare. However, in neither the public field nor in the voluntary field do I find inherent organizational conflict between the purposes of the organization and the purposes of the prime beneficiary and their clientele that I find in the proprietary institutions.

Now that, in general, is a summary of my statement but there are a couple of other things. I recently served on the staff of the Folsom committee. I am sure you have heard of the Folsom committee, Governor Rockefeller's Committee on Hospital Costs. I was on the staff of this committee and worked for about a year and there was concern with the financing and organizing of medical care facilities. I am not speaking for the committee but only for myself, of course, but it impresses me that we must concern ourselves with the whole span, the whole spectrum of medical care organizations, and these things must all be looked at together.

There has been a good deal of talk here at the hearings, and quite properly so, about association of long-term care institutions with general hospitals but even that is only part of the picture and comprehensive planning clear across the board is of the utmost importance to make a real system out of these various medical care kinds of facilities—and not only planning, but their administration as well.

The welfare and the health administration here are so intertwined that it does not make sense to separate them and look at one of them or look at the other.

I was unfortunately not here this morning but Dr. Yerby may have discussed the steps that he has managed to take in integrating welfare and health administration here in New York City. He has accomplished great things but we need to do much more of this at the State level. I think we need to do it at the State level and it needs to be strengthened and institutionalized to make it part of the pattern at the city level as well.

May I say one more thing? We have mentioned and we have been concerned about the impact of medicare upon the long-term care, and undoubtedly there will be some. There will be stimulation.

I have learned that about a month ago—well, this takes a bit of explanation. As of October 1, 1964, in New York State a new law went into effect requiring any institution, any health care institution, to apply for permission to construct a new institution. About a month ago there had been 46 applications for nursing home-type institutions. Forty-four of them were applications from proprietary institutions, one was an application from a voluntary institution, and one from a public institution.

It seems to me that the proprietaries are still interested in expanding and that the voluntary public institutions need a great deal of help.

I am interested in the restoring of a better kind of balance in the distribution of these different kinds of facilities between governmental, voluntary, and proprietary.

The Medicare Act, as I understand it, provides 100 days of nursing home care. Well, as I have cited here in my paper, the classic study done a long time ago of nursing homes, their patients and their care, learned that the average stay of a nursing home patient in a home—the average patient had been there for a year. And a more recent study in New York State in 1961 says that at the end of 1961 the patients who were found in proprietary nursing homes had been there on an average of 1.4 years.

Most people in nursing homes are not going to have their way paid by medicare. The bulk of long-term care is still to be dealt with and there is going to be a considerable need for more financial help for the voluntary and public institutions for construction and then for operating costs as well.

I say as my concluding statement in my written statement:

> In my opinion, the least called for at the Federal level is a substantial increase in Hill-Harris financing for the construction of voluntary and public nursing home facilities.

Senator Moss. Do you foresee the continued predominance of proprietary institutions or do you think that the public and voluntary will assume larger proportions in the field?

Mr. THOMAS. It depends on what is done. If things were left as they are—in some places there are virtually no voluntary institutions—in New York we are taking some steps. In New York, things may look up a little bit in this direction. A proposed constitutional amendment has gone through two sessions of the legislature, for example. There was an appropriation by the State legislature, which just finally adjourned, to give some money for the construction of public institu-

tions. All of these State efforts together, however, even if all of those that are now being talked about come through, they are still going to be just a drop in the bucket compared to the need.

I have not heard any efforts as strong as those that were being taken in New York and this leads me to believe there will be a continued expansion of proprietaries—they dominate the field now—until they are virtually exclusive operators in the field.

Senator Moss. Thank you, Dr. Thomas. That is a very scholarly statement and we appreciate having it and the research done on it. A commentary of this kind is most helpful for us to have.

We may have some more questions. I think we will hear from Dr. McCarthy first and then we may have questions for both of you.

Dr. McCarthy. I am not in any means related by blood to Senator McCarthy, but like most Irishmen, we probably both descended from one of the Kings of Ireland.

I want to pick up partly where Dr. Thomas finished on this question of financial stimulation to voluntary institutions. I am adviser to the archdiocese of New York for health and hospitals, therefore I am familiar with the problem of trying to stimulate voluntary institutions to expand into the nursing home field.

I do not speak of proprietary homes in any derogatory sense, yet I do feel that we should have a proper mixture between proprietary and voluntary nursing homes in the United States.

Now I would like to discuss three points. One, the financing need, manpower need, and quality standards as they relate to nursing home care.

The national need as regards to beds, has been quoted as 300,000 to 350,000 beds, the cost of construction running from $8,000 to $20,000 depending on the location in the country. Thus we must raise approximately $3.5 billion to meet this shortage of beds in the next 5 years.

As Commissioner Ball has stated:

> Medicare will be the foundation for adequate health insurance coverage as has been the social security retirement benefits for the structuring of adequate retirement plans.

Both the vice presidents of Metropolitan Life and Travelers have indicated that the private sector of the health insurance industry will posture their postmedicare plans to extend their coverage in the area of long-term care and home care. Thus both medicare's benefits and the new supplementary plans of the health insurance industry will increase the demand for long-term-care beds.

There is a justifiable comparison between the present situation concerning long-term-care beds and the shortage of acute hospitals beds in 1948. In 1948 the United States had only 60 percent of the needed acute hospital beds with a particular shortage in the rural areas. This situation gave birth to the Hill-Burton Act now known as the Hill-Harris. Since that time, approximately 16 or 17 years, we have spent, the American people, both from Government funds, Federal, local, private funds, $6.6 billion to reduce this acute hospital bed shortage.

What is needed now is a similar type program as the Hill-Burton, to meet the long-term-care facility shortage. At present only $70 million in the present Hill-Harris Act are authorized for the construction of voluntary long-term-care beds. I would, Mr. Chairman,

recommend increasing Federal grants for the construction of voluntary long-term-care beds to $250 million per year for the next 5 years. Of paramount importance is the level of these grants. I suggest that the percentage of these grants be 60 percent for those voluntary institutions in our wealthier States and 80 percent for those in our poorer States. The 80-percent-grant formula as I understand is the percentage that is now being used in the Appalachia program. Under the Appalachia program, Hill-Burton funds and other Federal grant funds, could be supplemented from Appalachia funds for an 80-percent grant in aid to these poorer States.

At present the FHA and Small Business Administration programs of the Federal Government give an adequate stimulus to proprietary nursing homes. I am under the impression that FHA will not guarantee loans to voluntary institutions. I have asked that question at various times but I never have been able to find out why. What I am saying is basically this then: two agencies of Government, namely FHA and Small Business Administration, are adequately stimulating proprietary nursing homes. We must look to the Federal Government through a new Hill-Harris formula, to adequately stimulate voluntary institutions to construct in part the country's need for long-term-care beds.

By stimulate, I mean that you adequately finance the capital development of a nursing home. Yet the other side of the same coin is naturally a reimbursement formula that is realistic and will meet reasonable costs as are defined in the present medicare bill. Now the wings of rumor from Washington indicate that possibly the reimbursement formula for nursing homes will only recognize the 75-percent amortization. Now I believe an adequate reimbursement formula is extremely important because of the simple reason that if you desire to adequately stimulate our voluntary institution, we must assure their board of directors that there will be adequate compensation for their costs of developing and maintaining long-term-care facilities.

In the last 9 months of 1964, the Public Health Service reported that 1,342 nursing homes were established in the United States. Less than a hundred of these were voluntary institutions. This statistic emphasizes the existing unbalance in the construction of long-term facilities.

I wish to comment on the manpower requirements that must be met to insure that medicare will be a success.

The Nursing Training Act of 1964, I believe in the face of medicare, is inadequate. As you are aware this act allocates to degree schools $10 million for construction and only $15 million to diploma schools.

At present, we need 70,000 nurses in the United States. The medicare bill specifies that a nursing home must have a full-time nurse on the staff. Yet we are aware now in many of our communities certain wards of acute hospitals have to be closed because there is not adequate nursing manpower. Where will the required nurses for these new long-term-care facilities be found?

We not only need funds for the construction of more nursing educational facilities but also through grants we must attempt to attract women who are in middle age to reenter the nursing field. A very adequate stipend of $200 a month plus $30 for dependents under age

18 is offered for a woman to return to a degree program but there is no such stipend for women to return to a hospital or diploma program. Now I have a home in Lincoln County in Maine. There is no university nearby, nor is there a junior or community college within our region. The only hospital serves a 50-square mile area and that is the community hospital. There we have an unemployment level of over 10 percent. If this hospital could grant a stipend of $200 per month per candidate for their diploma program then we could attract the adequate number of women to answer all of this area's nursing needs. At the same time help to reduce the level of unemployment which is twice as high in the county as compared to the national unemployment level.

Now, as to the quality of care within nursing homes: We have had a great deal of discussion yesterday and today about the question of the necessity of 3 days of acute hospitalization for all medicare recipients prior to their entrance into a nursing home. Dr. Yerby elucidated the principal reason for this requirement, he testified that at least in those 3 hospital days the individual would be given an adequate medical workup. The Young amendment which addressed itself principally to the development of minimal Federal standards for nursing homes emphasizing Federal fire code. Also this amendment had phraseology that would permit HEW to develop at least minimal standards as regards requiring an adequate medical working up, records, staff, and so forth. Unfortunately the Young amendment was deleted from the final draft of medicare during the Senate-House conference. By requiring 3 days of acute hospitalization as a prerequisite for admission to a nursing home for the purpose of insuring an adequate medical workup, we are admitting the need for some minimal Federal standards of care for long-term care institutions. Why would we not expect in 1965 that a nursing home have the medical competency to care properly for its patients? Likewise a physician should have the right to be able to dictate the level of care of his patient as he does have the right to indicate what type of medication the patient requires.

Within a period of time after medicare is in operation I believe that this Congress should review this requirement of prior hospitalization for qualifying for long-term care under medicare.

Finally the Federal Government should have as a minimum the authoriy to develop standards of care for long-term-care units as outlined in the Young amendment. I would hope that this amendment would be reintroduced in the next session of the Congress.

That is the gist of my remarks at the present time.

Senator Moss. Thank you, Dr. McCarthy, for your testimony.

Like you, I was puzzled as to why the FHA program did not include the voluntary institutions. We urged an amendment to the program which was included in the housing bill last year. So, this has been changed. Voluntary organizations can get mortgage insurance if they borrow money for building a nursing home.

I appreciated your testimony about the needs which we have in the field and now how they must be coordinated. I am not sure that I have any specific questions for you. Maybe the staff has.

Mr. FRANTZ. Mr. Thomas, I wanted to ask you this in connection with the emphasis you gave to the need for across-the-board planning for health services within the community. I take it you have included

in this the idea that the need for institutional services will be affected by the alternatives.

Mr. THOMAS. Indeed, I do.

Mr. FRANTZ. And you need a balanced mixture within the community.

Mr. THOMAS. Yes, and I go a long way with this, too. It is not only the institution, it is the whole of the community facilities.

We heard about this—the last speaker yesterday emphasized community services. Usually this outside service involves homemaker service, for example. I was pretty astonished to learn that there are more homemakers in tiny Sweden, which is the size of New York City, than there are in all of the United States? What are we doing? We have not got our backs into it.

Mr. FRANTZ. Well, now suppose, for the sake of the question, that the subcommittee accepted as a principle that this coordinated planning should be promoted, how would one go about promoting it through a governmental program?

Mr. THOMAS. Well, it is going to be difficult, I am sure of that. We have done something in New York just recently. A bill was passed by the State legislature as a part of the outcome of the Folsom committee report and has taken some steps toward integrating the various aspects of health.

The Folsom committee concluded that New York had been without a State policy. As far as health care facilities are concerned, this responsibility was parceled out to that organization and that responsibility parceled out to this organization and there really was not any organization who had the primary responsibility for looking at the whole picture.

I think that precisely that same kind of situation obtains at the Federal level.

You have many agencies involved, and I don't mean that these various responsibilities should be consolidated in one agency but there ought to be an agency some place that has the responsibility for knowing what is going on in all of the rest.

That kind of thing is our problem. Organizationally, we are not equipped to deal with our goals. We have this goal—comprehensive, integrated care and planning, but we have not set up the administrative structure that will bring it about.

Now, what can we do about it? We can watch with great care. I hope that it is pushed aggressively and developmentally so that we will accomplish the kind of things that almost everyone seems to believe are needed.

New York needs to be watched. We need to be alert. We need to be watchdogs to see what is going on that will help the officials do a better job. Whatever is learned in New York can be applied elsewhere.

California has also gone in some direction, here but the cases are few and far between. More integrated administrative machinery is needed.

Dr. MCCARTHY. The one thing that strikes me is for the Federal Government now to begin to develop grants for the development of regional hospital councils; it is to their interest particularly in view of medicare and the magnitude of the funds this could signify.

In other words, we want planning at the local level as well as at the State level.

Senator Moss. Mr. Constantine.

Mr. CONSTANTINE. Professor Thomas, in terms of examining visibility, the desirability of planning for comprehensive care, there is, of course, a second advisory body established by the new Medicare Act which is intended to review health care as a whole.

I don't know whether that is sufficiently high level but, anyway, it is there.

Another question: In your surveys I understand that you went into quite a few nursing homes?

Mr. THOMAS. I went into some; yes. How many is quite a few?

Mr. CONSTANTINE. Well, more than one.

Mr. THOMAS. Yes. My study was not one of conditions in nursing homes, it was a statistical study. But I went out and talked to a good number of people in nursing homes; yes.

Mr. CONSTANTINE. The question is you did do some review of accounting methods, isn't that correct?

Mr. THOMAS. Yes.

Mr. CONSTANTINE. How would you evaluate the accounting methods in nursing homes as compared, say, with those in hospitals?

Mr. THOMAS. Well, there are great gaps in hospitals. But some turn out a lot of information, for Blue Cross use, for example. But health insurance prepayment systems have not gotten very deeply involved in a long-term care and there has not been much to promote cost accounting in a long-term care field. There have been some sporadic attempts and I understand the people here in New York City have made some progress in this regard.

The New York City Department of Welfare gets complete cost statements now, as of 1962, from the proprietary institutions with which they do business, but it was an absence of such information that was, in past, responsible for the troubles of the late 1950's and there is no comprehensive systematic cost accounting across the State today.

In upstate, to a great extent, this is done simply by negotiation between the local welfare commissioner and the nursing home proprietor. The nursing home proprietor figures out what he thinks he can get and the local welfare commissioner figures out what he thinks he has to pay, and that is about as close as it comes to cost.

The bargaining position is what is important here rather than the actual costs involved which is sometimes—maybe always, to a certain extent—inevitable, but I think we can do much more to rationalize some of it.

If you can show that such-and-such cost is so much, you are in a good position for paying that much instead of worrying about other kinds of considerations. Again, there are the recommendations of the Folsom committee. The health department has been given rather comprehensive powers now to gather financial and other kinds of information from health care institutions in a State, and we hope that this will be aggressively pursued and developed; and if it is, it will be in a much better position to know where we stand.

To a great extent, the problem is that we are operating in the dark, we don't have enough information.

Senator Moss. Thank you, gentlemen, very much. Your testimony is appreciated, very helpful.

Dr. Solomon Geld, executive director, Daughters of Miriam Home & Infirmary for Aged, Clifton, N.J. Dr. Geld is also president of the National Association of Jewish Homes for the Aged.

I understand Mr. Herbert Shore, president of the American Association of Homes for the Aging is accompanying you.

We are pleased to have both of you gentlemen before us.

STATEMENT OF SOLOMON GELD, EXECUTIVE DIRECTOR, DAUGHTERS OF MIRIAM HOME & INFIRMARY FOR AGED, CLIFTON, N.J., AND PRESIDENT OF THE NATIONAL ASSOCIATION OF JEWISH HOMES FOR THE AGED; ACCOMPANIED BY HERBERT SHORE, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Dr. GELD. Senator Moss and members of the staff, in my prepared statement which I submitted to you in advance of this session I describe the activities of the National Association of Jewish Homes for the Aged, so in the interest of saving time I will not dwell on that but I do hope the statement will also include the references and bibliography which I tried to document it with.

Senator Moss. It will, sir. The statement will be included in its entirety in the record.

(The statement referred to follows:)

STATEMENT BY SOLOMON GELD, PH. D., EXECUTIVE DIRECTOR, DAUGHTERS OF MIRIAM HOME & INFIRMARY FOR AGED, CLIFTON, N.J.; PRESIDENT, NATIONAL ASSOCIATION OF JEWISH HOMES FOR THE AGED

Senator Moss and gentlemen, my first reaction to your invitation in response to my letter was "only in America." Only in this country can a naturalized citizen who believes he has something to say to his Government get a prompt hearing as I did. I am grateful beyond words, especially so since, but for the grace of God, I might have been smoke and ashes in the chimneys of Auschwitz with the rest of my immediate family instead of sitting before you. I am very mindful of the privilege and the responsibility attached thereto; therefore, what I have to say I utter with "fear and trembling" in the awareness of the presence of a Member of the august body—the U.S. Senate—and in the knowledge that some ideas about which there is substantial agreement among my fellow workers in the field of comprehensive sheltered care for the aged are either unknown, unacceptable, or unpopular among lay and professional leaders in other areas of concern with the aged.

I am the administrator of a 174-bed comprehensive care facility for Jewish aged under Jewish auspices in Clifton, N.J., but I am addressing you as the president of the National Association of Jewish Homes for the Aged, with a membership of 93 nonprofit homes, all of which are comprehensive care facilities under Jewish philanthropic sponsorship with a predominantly sectarian intake. These agencies have a current bed capacity of over 16,000 both well and chronically ill aged men and women. Most of them are either planning or are in the process of construction of additional facilities which in the next 5 years will probably double that bed capacity. The activities of the association such as conferences, institutes, and seminars; publication of a directory; and quarterly progress reports, are carried out by the professional heads of the member agencies. We are actively involved in many national health care associations such as the American Hospital Association, the American Association of Homes for the Aging, the National Institute of Mental Health and others. Our members have contributed articles and studies in the leading periodicals devoted to medical and social care of the aged. Our major purpose is to interpret to the public the unique character of the comprehensive care facilities beyond the popular and misleading name "home for the aged" and/or "nursing home," and to advance

the standard of care within our member homes through a continuous process of education and discussion.

It is in the relation to the concept of comprehensive care as we understand it and its relevance to the concern of your subcommittee that I would like to devote the time alloted to me.

In 1958, I presented a paper at the annual meeting of the Gerontological Society in Detroit on the subject "Toward a Definition of a Home for the Aged," parts of which appeared in the governmental publication of the hearings of August 4, 5, and 6, 1959, of the Subcommittee on Problems of the Aged and Aging. In the same publication, my presentation was preceded by a short statement of my colleague, Mr. Herbert Shore, currently president of the American Association of Homes for the Aging, which reads as follows:

The modern home for the aged is a comprehensive care facility serving as—

"A group living arrangement in a protective environment (for 'well' aged, long-term chronically ill, senile, and rehabilitative aged).

"A skilled quasi-hospital (with medical, psychiatric, nursing, dietary, occupational and physical therapy, and all preventive, curative treatment, and social services).

"A social agency providing casework, group work, adult education, recreation, and day care services for nonresidents.

"A rehabilitation, training, and research center.

"A spiritual facility (with a well-rounded religious program).

"A diagnostic center (for study and evaluation of older people and their adjustment).

"These multiple functions, services, and programs are structured to achieve satisfying, well-rounded opportunities for older people, meeting their social, emotional, physical, and spiritual needs."

Interestingly enough, the last issue of the Gerontologist, the official organ of the Gerontological Society, contains a very significant paper coauthored by Morris Zelditch, who has an outstanding record of planning and research of Jewish communal services to the aged, and Howard Bram of Cleveland, executive director of the Orthodox Jewish Homes for Aged. The title of that paper is "The Modern Home for the Aged—Principles Underlying Design of Program and Plant." It confirms the growing fact that the retirement home of yesteryear for the well aged has become a service center geared to the need of people whose impaired physical and/or mental function ranges from nearly total self-sufficiency to complete dependency; hence, the variety and complexity of program, staff, and facilities which eludes any attempt to fit it into the well-known category of health and social care agencies. Such a service center has a valid medical program, yet it is not a full-fledged hospital. It has a nursing service but it is more than a nursing home in the popular sense of the word. It has physical therapy, but it is not a short-term rehabilitation center. It has work therapy, social service, day care, day center, a wide range of professionally supervised leisure time activities, but none of these elements constitutes the predominant or accentuated factor of the center at all times. Each of the elements is accentuated sometime, depending on the needs and/or ability of the aged person any given day, week, or month. We consider the very elusiveness of the entire gamut of service from the usual nomenclature as its unique strength, precisely because it corresponds to the nature of the aged person about whom we can say that the only constant factor of his psychophysical status is the fact of his frequent and at times imperceptible change. He is a person today and a patient tomorrow; active today and passive tomorrow; outgoing today and withdrawn tomorrow; self-sufficient today and helpless tomorrow; and vice versa.

In a major address before the National Conference of State Executives, Dr. Donald Kent, Director of the Office of Aging, U.S. Department of Health, Education, and Welfare, asks a provocative question: "Should we not be more concerned with the movement, the flux?" I respectfully submit that of all agencies concerned with the aged, the progressive, nonprofit home for the aged under church and/or fraternal auspices is the outstanding and pioneering affirmative answer to that question for a certain segment of the aging population over an extended period of time.

The connecting link between the various services within a home is not just a plus sign. We speak of a spectrum of care, of a synthesis of colors where each element influences the other. An anatomy student can separate the muscle, the nerve, the bone, the gland, and the artery, but in a living organism they exist intertwined, interrelated, and mutually dependent. So it is with the comprehen-

sive care program of service to the aged where at all times there is some degree of interaction of facilities, staff, and program. This, in turn, is responsible for the fact that there is also a process of interaction among the aged people living there which we consider to be of crucial importance.

In my letter and the material which I have forwarded to you, I have attempted to describe the nature of that interaction based on similarity of background, historically determined attitudes, similarity of language, folkways, modes of living of the aged prior to their entry into sheltered care facilities. So I need not dwell on what seems to us the outstanding feature of our type of health service—namely, its social component which reflects the social, cultural, and religious milieu of both the sponsor and the recipient of such service. The social component adds a welcome dimension of living together, with each other in a long-term community of the aged instead of just being treated as passive patients in an amorphous conglomeration of people who socially and culturally have no affinity to each other whatsoever. The latter is the hallmark of a general hospital, a convalescent home, and many nursing and boarding homes by design. It is the profound conviction of comprehensive care facilities under Jewish auspices that that social component of care which corresponds to the social component of its clientele is a condition sine qua non of group living, and we have many allies in this conviction among other denominations. Without it a process of depersonalization sets in where even the efficient dispensation of services stripped of the color and tradition of a given group is accepted in quiet desperation.

The next meeting of the American Association of Homes for the Aging in Los Angeles will have as its theme "The Social Component of Care." I am particularly delighted that you, Senator Moss, are scheduled to speak on "The Social Issues of Serving the Aged as Viewed by the Federal Government."

That these unique features of comprehensive care of the aged are far from being understood generally despite the many attempts of its adherents to articulate them is reflected in the following practices based on extant legislation:

(1) Where Federal and State reimbursement for cost of nursing care through MAA is uniform within a State, meaning that it is applicable equally to all proprietary nursing homes and our comprehensive care facilities without reference to accounting of allowable costs, our facilities draw the short end. A national policy of Federal-State reimbursement of cost of care based upon cost accounting would reflect the size and intensity of the program within the given setting. I know of proprietary nursing homes whose clientele are welfare recipients and who make a profit on these rates, whereas in my own setting every welfare client costs the institution an additional $100 to $150 a month, and I think I am as thrifty and economically efficient as they are. Moreover, I am not including in the per diem cost the large outpouring of goods and services which only a nonprofit enterprise can get free of charge. The difference lies, of course, in what is being spent for the people.

(2) Every governmental classification of sheltered care facilities fails to do justice to our concept of the synthesis of services and their mutual interdependence and pollination. With a notable exception of Cleveland, attempts to obtain special classification which would reflect this synthesis have not been successful.

(3) The accentuation of the social component which mirrors both the milieu of the nonprofit sponsor as well as that of its clientele makes it well nigh impossible for the nonprofit home to apply for Federal funds for construction purposes because of the provision of open intake. This is contrary to the deep-rooted conviction of such sponsors concerning who should do what to whom, how and why. It is also contrary to the desires of the aged who, far from being an amorphous group with only one common denominator of chronological age, are very heterogenous in social terms and all it implies. Thus, we find that contrary to the purpose of these open intake provisions of Federal legislation as exemplified in Hill-Burton criteria and in title VI of the Civil Rights Act, the intake of the few nonprofit homes which accepted Federal funds and satisfied such criteria continues to be predominantly sectarian. To be sure, not by restrictive measures of the administration of such homes—Heaven forbid that I should accuse them of violating the law—but by the choice of the client who, exceptions notwithstanding, seeks his own social, cultural and, yes, racial and religious milieu for the last decades of his life. Thus, the purpose of integration is not accomplished at all, and I question the practical wisdom and the ethics of achieving it with the lure of Federal funds. It is gloriously accomplished in general hospitals and it has been so long before Hill-Burton funds came into being. In a

general hospital, the concept of acute short-term medical needs makes the social component of the patient irrelevant. On the operating table, the anesthetized patient is a mass of anatomical, biological, and pathological data. His personality and preference are for the time being unimportant. The difference as to whether the social component matters or not lies in the length of stay. The longer the stay, the greater its importance. And in comprehensive sheltered care facilities, it is the longest.

The inconsistency and ambivalence of the antidiscrimination legislation in relation to health care is evident in the glaring discrepancy between the language of title VI of the Civil Rights Act and that of Hill-Burton. The pertinent wording in title VI refers to discrimination on the ground of "race, color, and national origin of any program or activity receiving Federal financial assistance." The Hill-Burton legislation forbids discrimination on the basis of "race, creed, and color." Whereas the former omits the word "creed," the latter omits the words "national origin." That this is not accidental is demonstrated by the fact that in a statement prepared for and distributed by the American Hospital Association, no less a person than Dr. Terry, Surgeon General, consistently uses the different language in his review of title VI and Hill-Burton—namely, race, creed, and color in the case of Hill-Burton, and race, color, and national origin in title VI. Now, which is the law of the land? Several questions present themselves which ought to be answered:

(a) If title VI is the major piece of legislation, one would have to assume that a health agency receiving Federal assistance through Hill-Burton funds may discriminate on the basis of creed. Obviously this is not the case. On the other hand, if Hill-Burton legislation contains the broad objectives of nondiscrimination, why are the words "national origin" omitted from its text and why is the word "creed" omitted from title VI?

(b) Are we to assume that in a possible reconciliation of this very significant discrepancy betwen the two texts, a distinction is implied between Federal assistance for capital structures for which, among others, Hill-Burton funds are designated, and Federal assistance for operating costs of health agencies in form of vendor payments to hospitals and related health agencies such as the Kerr-Mills legislation. If this is the case, how does one explain the language of title VI "any program and activity receiving Federal financial assistance."

And another question: At the annual meeting of the National Council for Aging, held in Washington on March 3 of this year, the Honorable Dr. Weaver, HHFA Administrator, gave the following interpretation to the proposed 1965 housing legislation of President Johnson: "The President's intent is to maximize the effective choice by which an individual can determine his own destiny within the bounds of social consensus." Now why is "effective choice" and "bounds of social consensus" significant in housing legislation and apparently insignificant in housing with in-built comprehensive care program? If anything, experience should indicate that the reverse is true. Besides, how does one square "social consensus" with title VI of Civil Rights which governs both direct low-interest housing loans and mortgage insurance under HHFA terms?

I wish to assure you that I am not engaging you in an academic discussion of hairsplitting semantics. The different wording may be of little importance to general hospitals or to proprietary nursing homes, but it is very pertinent to those of us working in long-term church-sponsored health facilities such as sociomedical settings specifically designed for a certain age group with the objective of creating a therapeutic community in which both the medical and social component play an equal part in advancing the physical and mental health of the individual receiving such care.

4. This lack of appreciation of the unique character of nonprofit homes is also responsible for the scale of priorities which governs the allotment of Hill-Burton funds within a given State to respective counties which is based on statistical evidence of available and needed nursing beds. The point is that availability of beds for our type of clientele is not coextensive with their desirability. Passaic County, N.J., happens to occupy the low space on the totem pole of examined needs for beds, presumably because of the mushrooming growth of proprietary nursing homes in our area, some of which have empty beds. A recent article in the Wall Street Journal, March 25, 1965, had some interesting information on the subject. But how come that a nonprofit enterprise such as ours with a limited intake of Jewish aged who must be residents of Passaic County for at least 3 consecutive years prior to admission has a 50-percent waiting list in relation to its present bed capacity, 85 to be exact, so it takes a year to get in. The

answer is that our people will not go into a proprietary nursing home except for transitory stay because (*a*) where the standard of care is good, the price is exorbitant and (*b*) they do not wish to live in a catch-basin environment of unrelated people.

Far be it from me to question the noble motives of effective civil rights legislation in relation to public accommodations, but I sadly and respectfully submit that as far as the segment of the aged people who seek comprehensive sheltered care for an indefinite period of time, the effort is very much misplaced. In practical results it is ineffective, but there is a moral issue involved. In a tragic inversion of the golden rule, we are asking the aged to live in sheltered care facilities which becomes their permanent home while we are not prepared to practice what we preach in our own homes. This is especially painful because the aged who reside permanently in such facilities and who are in the process of gradual disengagement from the turmoil of society as a whole are much further removed from the import of this great social issue than we are who are in the midst of it.

5. Finally, the lack of appreciation of the unique character of nonprofit comprehensive care facilities is responsible for the rampant and deprecating canard that we are serving only a small fraction of the aging population (I think the number is 4 percent) and, ergo, we should not make so much noise. This is a half-truth which is worse than an outright lie. Curiously enough, the 4 percent of the aged under sheltered care is never accompanied by the national percentage figure concerning the services to the aged of other communal resources such as family agencies, community centers and a corollary percentage figure concerning the vast majority of the aged who never see the inside of any agency, public or private. Only our percentage is known and used against us. The availability of other percentages would probably disclose that the 4 percent of aged under sheltered care are at least 25 percent of all aged touched at one time or another by the net worth of health and welfare agencies.

Furthermore the half-truth of 4 percent skillfully conceals the fact that in term of service time given to an individual, the sheltered care facilities far outweigh the service of other communal facilities, not to speak of the enormous investment of money and energy which the continuity of sheltered care in all its aspects calls for. Last but not least, one conveniently forgets that behind the so-called 4 percent there is another 4 percent of children, another 4 percent of grandchildren and still another 4 percent of brothers, sisters, relatives, and friends, all of whom are experiencing various degrees of anxiety concerning the permanent placement of an old and sick father, grandfather, uncle, brother, and friend, to all of whom the sheltered care program of their aged relative brings indirect relief and enables them to function normally. We, too, can play the numbers game. But this is not really important. What is important is our philosophy in relation to the cracked and broken tablet of Sinai to which our aged are compared in Jewish tradition and which tells us that even the broken tablets were preserved in the Holy Ark. Translated into contemporary language this tradition means to us that in a generation living in the shadow of total destruction, the total attention to sparks of life is its redeeming feature and, hence, an ongoing responsibility which Government ought to strengthen in every way possible. We who labor day in and day out in sheltered care facilities, often within nerve-racking and heartbreaking situations have no panacea for all problems of the aged. We see the trees in front of us rather than the orbit of the entire forest. We see the tired and the poor, the sick and the forlorn, the hard core of the problem. We want to play our part in partnership with Government based on a continuous dialog and fully aware that the millenium of aging being a reward for life rather than a punishment is still far away. But we console ourselves with the wise admonition of our sages that while it is not given to us to complete God's work on earth, just the same we are not allowed to free ourselves from it entirely.

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Dr. GELD. Since I live and work in New Jersey, I ought to explain the reason of my appearing before you at a session which revolves around the problems of the nursing homes in New York City and State as part of your general examination of the Nation's nursing homes in preparation for pending legislation. I have read the pro-

ceedings of similar hearings conducted in Indianapolis, Ind., and reacted to the passage on page 15 of the above proceedings relative to a conversation between Dr. Offut, State of Indiana health officer, and your staff member, Mr. Miller, concerning the fact that very few nonprofit nursing homes avail themselves of the Hill-Burton program. Dr. Offut could not think of any reason for this lack of initiative in nonprofit homes. Neither did he think that anything in the Hill-Burton program would "preclude the applicant getting along with us."

I have addressed a letter to you, Mr. Chairman, and some members of this committee and your staff, with a reprint of an article which I wrote for hospitals, the journal of the American Hospital Association, where I tried to point out the functional difference between a patient and a person, and the need of a social milieu corresponding to the one to which the aged person is accustomed prior to his entry into a protective environment for permanent residence. Your encouraging response to me is the reason for my being here.

In terms of social needs, the sheltered care setting for the aged person with intermittent and prolonged illness is the social substitute for his family. Therefore, its social task, in addition to the medical and nursing task, is to transform a hetergeneous crowd of long-term patients living in the institution next to each other into a community of people living with each other. Community means that its members have something in common. The more common denominators, the more cohesive the community and the greater the chances of adjustment of an aged person to congregate living. Adjustment to group living is a major concern of social work with the aged.

In my prepared statement I elaborated on this contention, based on 26 years of experience in the field, that the desire of the great majority of church sponsored comprehensive care facilities and programs to preserve and to promote the kind of environment to which an aged person was accustomed prior to his entry for permanent residence in the comprehensive care facility prevents them from applying for Hill-Burton funds because certain provisions of a Hill-Burton grant militate against the concept of a therapeutic community where the nursing, medical and social program combine in equal measure toward creation of a homogeneous community of the aged.

We have strong conviction—and I am indeed glad that Mr. Herbert Shore, the president of the American Association of Homes for the Aging, in which I serve as a board member, is here because there is identity of views on this subject.

I say we have strong conviction concerning the character of the aged person with prolonged illness and variety of needs, some of which are related to cultural factors and historically determined lifetime habits. These factors may or may not be of importance to proprietary nursing homes. There the decisive and legitimate factor is commercial supply and demand, with little, less, or no attention as to what happens to the self of a long-term patient placed in the catch-basin of unrelated people. These factors do not matter in a short-term general hospital precisely because of the short duration of stay, but they matter very much for a stay of several years and, more often than not, for the rest of their lives.

Because of the relatively short time between my letter to you and your invitation to appear here, I did not have an opportunity to mail the written statement to all of the 93 homes who are members of our association so as to ascertain whether there is agreement with every word I say. But I am convinced that while there may be some who will take issue with my views concerning the nature and future of our institutions and the governmental financing program through Hill-Burton and HHFA Community Facilities Administration, there is substantial agreement on the issue among the overwhelming majority of Jewish homes and infirmaries for the aged and we are in very good company in this conviction among other denominations. Certainly there is among us agreement on the nature of comprehensive care for the aged.

In preparation for my statement, I have read through thousands of pages of proceedings of your hearings in Cleveland, Los Angeles, Denver, Indianapolis, and Hartford, both of this year and previous years, and I find that whenever a representative of a nonprofit comprehensive care facility sponsored by a church testified before this committee, such as Reverend Bosse, Dr. and Mrs. Weil in Cleveland, Ted Rosen in Los Angeles, Dr. Clark Wood in Denver, Martin Freeman in Hartford, William Eggers who spoke on behalf of the American Association of Homes for the Aging, the character of such comprehensive care facility was described again and again.

What runs through their testimony is the fact that these agencies have become complex sociomedical care and service centers with a variety of extant functions for their resident population and with a growing potential to include in their operation a segment of the aged residing in the community and last but not least to engage in applied research. This is reflected in their allocation of financial resources for various physical facilities, for a variety of professional staff of many disciplines, and a variety of programs, both nursing and social. This is also reflected in their multiple liaison with related health and welfare agencies on a local, State, and national level.

There are certain basic concepts which we have introduced in relation to the overall care of the aged and they are as follows:

1. Change of the aged person.
2. Continuity of care, each according to his changing needs.
3. Comprehensiveness of care, including many medical and social disciplines.
4. Permanency of extended care and its implication in terms of social coexistence.
5. Intramural and extramural programs as indicative of growth and potential as a prime resource confluent with the mainstream of community concern with the aged.

In terms of his physical and mental status, the aging person is a changing person and that change occurs not once but several times with relapses and remissions, which calls for a program of continuity of care ranging from near total self-sufficiency to total dependency, and vice versa. As Dr. Kent sagely observed we have three groups; a group that is entering the aging, a group that is aging within the aging, and a group that is leaving the aging through death.

The connecting link between the various services in a home is not just a plus sign. When we speak of comprehensiveness and continuity

of care we mean a spectrum of care, a synthesis of colors, where each element influences the other. An anatomy student can separate the muscle, the nerve, the bone, the gland, and the artery, but in a living organism they exist intertwined, interrelated, and mutually dependent. So it is with the comprehensive care program of service to the aged where at all times there is some degree of interaction of facilities, staff, and program. This in turn is responsible for the fact that there is also a process of interaction among the aged people living there, and this we consider to be of crucial importance.

The outstanding feature of our type of health services is its social component which reflects the social, cultural, and religious milieu of both the sponsor and the recipient of such service. The social component adds a welcome dimension of living together instead of being just treated as passive patients in an amorphous conglomeration of people who have no affinity to each other whatsoever. It is the profound conviction of the majority of comprehensive care facilities under Jewish auspices that the social component of care which corresponds to the social component of its clientele is basic to good nursing care. Without it, a process of depersonalization sets in where even the efficient dispensation of services stripped of the color and tradition of a given group is accepted in quiet desperation.

I was warned by some of my colleagues that by saying this I am raising the ugly specter of discrimination. With all my heart I hope that I will not be misinterpreted. Selectivity based on elective affinity of the existing and prospective clientele with the objective of maximum personalized care should not be confused with the loaded slogan of discrimination and the popular slogan of antidiscrimination in public accommodations. I am only trying to explain that selectivity of comprehensive care facilities under church auspices is concerned with the individual who in a long-term setting is alternately and intermittently a patient with the accent on medical-nursing needs, and a person with the accent on sociocultural needs.

This is also in consonance with the desires of the aged person himself who, far from being a member of an amorphous group with only one common denominator of chronological age, has a personality of his own to whom attention should be paid. This, of course, does not preclude the crossing of denominational lines in certain settings where the process of acculturation among aged people has set in, but where it has not set in (and I submit that it has not set in in many places across the length and breadth of this land), effective choice of individuals as to where they wish to live should be circumscribed within the bounds of social consensus. Now this is not my language; that is the language of Dr. Robert Weaver, the Administrator of the Housing and Home Finance Agency, who in an advance interpretation of President Johnson's proposed housing legislation says, and I quote:

> The President's intent is to maximize the effective choice by which an individual can determine his own destiny within the bounds of social consensus.

I find a corroboration of this conviction in the undeniable fact that even those few instances where philanthropic church sponsored homes have availed themselves of the Government's financing program for capital structures, a natural selection takes place by the aged themselves, based on denominational lines with only nominal exceptions.

I wish to emphasize that these exceptions take place not by restrictive measures of the administrations of such homes, but by the choice of the aged client who seeks his own social, cultural, and religious milieu for the last decades of his life.

One may ask in view of the multifaceted character of our institutions why do we still keep the misleading and, by misinterpretation, tarnished name of "home for aged." The answer for us was given by my predecessor, Mr. Jacob G. Gold of Chicago:

> Despite the growing importance of the medical division of our multifaceted services, we will not forget that as the Jewish Home for the Aged, "Home" is our middle name. Thus, wherever we may venture, whatever direction the trends may take, however we may plan, the focus will be for a warm, supportive, and therapeutic environment.

According to Dr. Maxwell Jones, author of the book "The Therapeutic Community," in such a community all of the patient's time, not just that devoted to nursing care, becomes part of his therapy. That is why we welcome the multilateral accreditation program called into being by the American Association of Homes for the Aging with its representation of many medical and social disciplines against the, in our opinion, one-sided accreditation program of the American Medical Association for proprietary nursing homes. That is why we subscribe to the aims of the American Association of Homes for the Aging, in which many of our member homes participate, that it is our purpose to protect and advance the interest of the individual aged we serve.

In my written statement I have tried to point out the inconsistency between the provisions of the Hill-Burton legislation and title VI of the Civil Rights Act, and the inequality of vendor payments because, unlike New York City, most of the States do not call for cost accounting, and the regrettable priority system of Hill-Burton funds based on the existing nursing beds within a given county, irrespective of whether these beds are desirable or not, fully utilized or not.

Now I have no specific recommendations at this time. Such would require the written consent of our member homes, but I thought it might be of some value to raise these issues in view of the previous speakers' comments. I would like to raise the following long-range objectives:

1. Government financing for both capital purposes and cost of care should recognize that the principle of social consensus which guides the operation of the majority of nonprofit homes under church sponsorship is an asset designed to advance the interests and the personalized care of the individual.

2. Government financing for capital structures should be based on the performance record of the applicant, not on his good intentions.

3. Government financing of cost of care should be based on cost accounting everywhere. Such financing, though labeled as a vendor payment made out to the agency which gives nursing care, is meant to be for the individual, leaving him the choice of where he wishes to be. This choice should be circumscribed only by the standard setting procedures of the licensing governmental agencies concerning the quality of care and not by requests of certain compliance orders which for all practical purposes nullifies effective choice. Choice is not a unilateral proposition, it is a bilateral proposition. The jurisdiction

of the individual concerning his destiny should be compatible with the jurisdiction of the social setting in order to help him to achieve it.

4. There should be greater understanding of the unique character of progressive comprehensive care facilities for the aged under church sponsorship as the pace setter par excellence of what nursing care should be in a sociomedical setting.

Here is the 93-page directory of nonprofit Jewish homes for the aged. Now you may wonder why do we need a 93-page directory for 93 homes. Because each home is given here a profile. The editor of that directory summarized the kind of services which are offered in these comprehensive care facilities. I will give you only an example because I realize the time is short.

Medical and paramedical facilities: 67 offer psychiatry; 67 offer dentistry; 78 offer podiatry; 77, physiatry; 43, pharmacy; 49, laboratory. Then we come to social services. There are 45 homes who have both casework and group work; 27 homes in addition to the 45 have casework only. Leisure time programs, hobby shops, 75; hobbies and socials, 87; holiday celebrations, 82; movies, 80; and so on.

Then we come to religious programs, special service programs, residence council for committees. Participating in the decisionmaking processes of what comprehensive care is, 59; beauty shop, 75; barbershop, 69; sheltered workshop, 32. Our homes have sheltered workshops licensed by the Labor Department. What happens in the Jewish denomination I am sure happens among all the other denominations across the country. Therefore, I say that we are the pace setter of what nursing care should be in a social-medical environment.

The next point, 5. The fundamental goal of both government and philanthropic concern with the aged and aging should be the enhancement of the personality of the individual aged person within a given community, within a given articulate setting, and not the amorphous and anonymous mass of the aged.

6. Finally, all of the above, but especially the matter of choice, should not be as of sufferance, not as of tacit understanding, implied "gentlemen's agreement," nebulous expectation, or verbal assurance from some sources, State or Federal, that somehow it is going to work out anyway, but as of explicit and inalienable right.

Thank you very much.

Senator Moss. Thank you, Mr. Geld, for a very excellent statement. You have done a great deal of work in compiling this. I am referring to your prepared statement where I see a rather lengthy bibliography.

Mr. Shore, do you wish to say something at this point?

Mr. SHORE. I have no comments to make. Dr. Geld asked me to come along as sort of a security blanket, I guess. I wanted merely to point out that we concur strongly in the philosophical base, which we think derives from our Government's concept of sectarian agencies. I would underscore that we were not trying to argue the issue of discrimination at all, but rather the right of group identity in the sectarian nature of our facilities and services which we think are very important to the older person in a long-term care setting.

We would also make the point that perhaps the distinguishing feature of the agencies that we are concerned with is that we are interested in the "social needs of the patients" and the "health needs of the residents." Now that may sound like an oversimplification, Senator, but

I think if you ponder on it a bit you recognize that the individual is more than an ache and a temperate and a blood pressure but is a human being.

In terms of total care it was said earlier today that rehabilitation took in social and psychiatric and physical care. This is really our concern. We are not merely concerned with standards. We know they are necessary, we fought for them, we offered them. We wanted them long before the Government recognized the need for them. We wrote them.

I would underscore what Dr. Geld said. When we scratch the history of care in this country it was the voluntary denominational eleemosynary home that set the standards, set the pace, looked upon the older person as a total human being. We applaud your efforts to give him that care, that protection, and that safety.

Thank you.

Senator Moss. Thank you very much. I think you have both rather eloquently made the point that the homes for older people are not simply for the care for the physical infirmities they may have. We try to keep the whole person and keep his life meaningful, keep him as a functioning social being with the desire and the spark of life. One of the important factors, as you point out, is to keep him in a group environment where he feels at home in accord with his standards.

I am glad to have your statement as part of the record since we must keep in sight at all times the social needs, the cultural needs of our people.

Mr. GELD. Thank you.

Senator Moss. I do not know that I have any specific questions.

Any staff questions?

Mr. MILLER. Senator Moss, as you know I customarily limit myself to questions, but I cannot resist the temptation to comment. When a witness like Dr. Geld appears, and others like him, this is one of those most thrilling, satisfying experiences of work with this committee that a person can have. I am sure you feel that very same way. [Applause.]

Mr. GELD. Thank you.

Senator Moss. Thank you both very much. You have been very kind and helpful to come here.

Now we come to the end of our list of witnesses. This hearing has been a most comprehensive one and one that is very useful to the committee. We recognize that our time has been limited. We could very well spend a week or 2 weeks perhaps in New York City taking testimony. As I announced yesterday, we would be very happy to receive statements from others who may wish to put into our record pertinent material that would be helpful to us. We do not want to just burden the record, but anything that would add to our consideration or understanding the problem we are happy to have.

Now our time is spent. I do not know if anyone has prepared a statement and would like to hand it in at this time.

VOICE. I would like to ask you a question, Senator Moss. I am sorry I did not have the opportunity——

Senator Moss. What is your name?

VOICE. I am president of the Nightingale Aid Association. That was organized only for one purpose, and the purpose is for better bedside care.

It seems that the time is short so I will make my question as short as I can. This is a very, very important committee for the entire Nation. We have heard various speakers talk about the beautiful buildings, the wonderful things that they accomplish. We also talked about quality medical care. There does not seem to be any program for better bedside care. I have a recommendation and I wish that you would consider it very carefully.

As a matter of fact, Senator Moss, I have sent you a letter to New York and a letter went to Washington. I want there to be a statement here today. I am talking about the actual cases of these people in their beds, and I call them the living dead. I ask that you get them the proper kind of attention that they deserve, and that means better training for the aids. In New York City we have not got any schools whatsoever that would train these people and give them the kind of attention they deserve.

What they do is orientation. Why, even your Manpower Act does not take care of it in the proper way. I think that should be investigated to see where that money is really spent, and they should get that kind of training. I have recommended several schools of bedside technique, 20 weeks of basic training in New York City. This is a 52-week course and then you come out with some kind of training. But when it comes to these aids who are actually at their bedside, then you hear all about these horror stories and I think it is a crime.

I think that everybody that takes care of a human being should be licensed so they have responsibility to their job and to their patient. We should not live in fear of reprisals, whatever that may be, in our hospital.

Of course I wish I had more time but the question is that if they are licensed and responsive and they are turned into the Bureau they are suspended for a week or two, hit them in the pocketbook where it hurts so they don't hurt this poor soul that lies helpless. The parents and relatives should not be afraid because of these reprisals that may hit this particular patient.

When you send out investigators to investigate these things, when they do go to these hospitals have them pick up the sheets and see what is underneath the sheets. That is why I am trying to get the people to recognize this. I have written letters to the President, to the Governor, to the mayor requesting them to be sent to school for bedside technicians.

The American Nursing Aide Association has beautiful manuals but they say, "Oh, well, they are just aids, we don't recognize them in the nursing profession." Now I think that is a crime. If they are around a human being, they should be part. Make them proud of their jobs, give them an opportunity to better themselves, give them an opportunity to be monitors of these.

So I wish, Senator Moss, you will consider the central schools for these aids, give them a 20-week basic training and not orientation.

Thank you very much.

Senator Moss. Thank you, sir. I appreciate what you had to say. What you have said orally has been taken down, and if you would like to send a further, more detailed written statement I will see that it goes in the record also. I concur that anyone who cares for elderly people in any way should be trained in the needs of the elderly and should be supervised. I am for anything we can do along that line.

VOICE. Thank you very much. I wish you would add this: Put teeth in your legislative recommendation, put a lot of teeth in it.

Senator Moss. Thank you, sir.

VOICE. Thank you.

Senator Moss. I do appreciate the statements that we have received through both these 2 full days of hearings. It shows your interest and concern with the problem that we are considering. The subcommittee will continue compiling this record and when we have completed our record we will then devote our attention to possible legislation to accomplish some of the objectives that become clear as we gather this information from various sources.

Let me say that I think here in New York we have had an excellent hearing. I am particularly heartened to learn of the advance the city of New York has made with its code for nursing homes. This is one hopeful facet. There are perhaps gaps yet to be filled, and to the extent we are able to we are going to try to see that they are properly filled so that we may get for our elderly people the kind of attention they should have.

We are now in adjournment here. [Applause.]

(Whereupon, at 4:40 p.m., the subcommittee adjourned.)

APPENDIX

CITY OF NEW YORK,
DEPARTMENT OF WELFARE,
BUREAU OF MEDICAL SERVICES,
New York, N.Y., June 29, 1964.

Dr. MARVIN PERKINS,
Chairman, Interdepartmental Health Council,
New York, N.Y.

DEAR DR. PERKINS: At the direction of the IHC, an ad hoc committee was formed to survey proprietary homes for adults in New York City and to report its findings with respect to the number of homes, the characteristics of the residents, and the services provided. The committee was further instructed to make recommendations in regard to how the city of New York should relate to these institutions. As chairman of the committee, I take pleasure in submitting the report which is attached.

A recent amendment to chapter 555 of the Laws of 1964 of the State of New York, has given the State department of social welfare jurisdiction over private homes for adults housing more than four persons. Since this law does not become effective until January 1, 1965, the city of New York, through the department of welfare, will still have the responsibility for all of these institutions until December 31, 1964.

It might therefore be well for the IHC to consider what steps should be taken to discharge this responsibility during the next 6 months. What the city does about this problem after January 1, 1965, will of course depend on the outcome of our first recommendation. Our second and third recommendations are intended as suggestions which the city should make to the State department of social welfare in the event that that agency decides to take responsibility for these homes. The fourth recommendation is intended as a suggestion to the New York City Department of Welfare for its supervision of the smaller homes for adults.

Very truly yours,

JAMES G. HAUGHTON, M.D.,
Deputy Medical Welfare Administrator.

SURVEY OF PRIVATE HOMES FOR THE AGED

INTRODUCTION AND BACKGROUND

The New York State social welfare law provides that the State department of social welfare shall have regulatory jurisdiction over the operaiton of private homes for adults. In about 1954, the State department of social welfare delegated this jurisdiction to the New York City Department of Welfare. At that time, the Bureau of Special Services of the Department of Welfare of New York City protested this delegation on the grounds that since this department used only the small-family homes with four residents or less, it should not be responsible for regulating the larger homes where no department of welfare clients are housed. The State department of social welfare therefore amended this delegation of responsibility to provide that the New York City Department of Welfare could place "special emphasis" on the smaller home, but did not rescind its delegation of responsibility. Since that time no agency has regulated the large private homes for adults in New York City.

Until recently, however, this presented no problem since there were very few large homes in New York City. With the promulgation of the new proprietary nursing home code several large nursing homes have closed voluntarily, or have had their licenses revoked. Several of these have become private homes for adults, or hotels for senior citizens. The increase in the aged population of the city has led to the establishment of many smaller homes.

At the request of the commissioner of welfare, the interdepartmental health council has passed a resolution establishing an ad hoc committee to gather information concerning the number of private homes for adults operating without the department of welfare's supervision, the number and the characteristics of the persons residing in them and the kind of services rendered. The committee was also asked to make recommendations in regard to the need for domiciliary arrangements. We have been informed since the committee began its work, that the State legislature has recently amended the social welfare law to provide that private homes for adults housing more than four persons shall be under the jurisdiction of the State Department of social welfare and those of four or less shall be under the jurisdiction of the New York City Department of Welfare whether they house welfare recipients or not.

REPORT OF THE SURVEY TEAM

On February 7, 1964, the ad hoc committee was formed with representation from the following departments of the city: fire department, building department, health department, hospital department and welfare department. This committee met to discuss plans for a proposed survey of private homes for adults. It was agreed that since the health department was the only one with a clear legal basis for entry into any premises, the visiting team should be composed of health department personnel. Pursuant to this agreement a public health sanitarian of the division of food and drugs of the bureau of environmental sanitation of the health department and a public health nurse from the bureau of public health nursing of the health department were assigned to carry out the survey. A letter emanated from the office of the mayor instructing all city departments to forward to the committee the names and addresses of any buildings known or suspected to be functioning as private homes for adults.

As a result of this letter, 46 addresses were submitted for survey. The visiting was begun in February and was completed at the end of April. Forty-six addresses were visited. Twenty-two were found to be functioning as private homes for adults not under the department of welfare's supervision. Two were foster homes for adults supervised by the department of welfare and one appeared to be housing senior citizens, but the proprietor denied admission to the team. The remaining 21 addresses had been demolished, were vacant, or were being used as family residences or for other purposes. For ease of analysis the 22 addresses surveyed have been divided into three categories: those housing 6 residents or less, those housing 7 to 12 residents, and those housing more than 12 residents.

HOMES HOUSING MORE THAN 12 RESIDENTS

There were 10 homes with more than 12 residents. They varied in census from 19 to 100. The age range of the residents was 60 years to 102 years. Only 4 of the 10 appeared to be functioning adequately in regards to the personal services which they purported to offer. The residents of these four homes were all well-aged persons who were fully able to ambulate and were receiving personal services when necessary. In six of these large homes there were environmental factors which were considered safety hazards. These included inadequate lighting, uncovered steam risers, inadequately heat, defective floors, temperature of hot water in sinks and bathtubs too hot for safety and exposed electrical wiring. The most important finding in these inadequate homes was that large numbers of aged persons needing considerable nursing and medical care are housed in these facilities and are receiving neither of these types of care. The decision to seek medical care is left to the discretion of the resident.

Since many of them are disoriented and furthermore have inadequate incomes, no medical care is sought. Many persons with auditory, visual and skeletal disabilities are housed on the upper floors of these buildings, some of which have inadequate elevator facilities. In case of fire or other emergency it would be impossible for these persons to get out of the building without assistance and none of these homes have sufficient personnel to help effectively in the event such emergency should occur.

The personnel providing "personal services" are untrained. They function not only as maids performing housekeeping chores and helping with baths, dressing, etc., but also serve as dietary helpers assisting in the preparation and serving of meals. The proprietors and administrators show a serious lack of understanding of the needs of the aged and there is no one responsible for identifying residents who may be ill and assuring that medical care is obtained.

HOMES HOUSING 7 TO 12 RESIDENTS

There were six homes in this category. The ages ranging from 41 to 97 years of age. In two of these the residents were ambulatory well-aged persons who received adequate services and who did not appear to need nursing or medical care. The remaining four homes are occupied by persons who are mentally disoriented, physically disabled, incontinent, and in some cases wheelchair bound, or bedfast. In many instances the residents are found to be dirty and unkempt. They are in dire need of personal services, but are obviously not receiving them. The proprietors make no effort to identify the ill and to obtain medical services for them. The environmental hazards described in the larger homes apply equally to these homes. The understanding and awareness of the needs of the aged seemed even more deficient in the proprietors of these smaller homes.

HOMES HOUSING SIX OR LESS RESIDENTS

There were six homes in this category with residents ranging in age from 63 to 94 years. In one home, the residents are ambulatory well-aged persons who are capable of self-care. In the remaining five, there are persons who have varying degrees of serious disability and illness, but there is no evidence that medical care is being provided to those who need it. In some of these homes, all personal services are being provided by the proprietor without any additional help, and as a result, the care rendered is inadequate. All of these small groups are housed in private multiple dwellings, or in apartments of large apartment houses. Several of these apartments and dwellings demonstrated the same environmental deficiencies and hazards that are found in the larger establishments.

CONCLUSIONS

Twenty-six persons were found in six homes with a census of six or less. The age range being from 63 to 94 years of age in these homes. Sixty persons were found in six homes with a census between seven and twelve, and in this group, the age range was 41 to 97 years. Almost 500 persons were found in 10 homes with a census between 19 and 100, and the age range in these homes was 60 years to 102 years. There is apparently a need for some kind of domiciliary arrangement for the well-aged who are capable of some degree of self-care, but who need regular meals and some personal services such as help with housekeeping, dressing, bathing, laundry, etc. These establishments must, however, function under some kind of close supervision.

The ad hoc committee therefore makes the following recommendations to the IHC:

1. An appropriate agency of the city government should discuss with the State department of social welfare the provisions of chapter 555 of the laws of 1964 which become effective on January 1, 1965, to determine what the plans of the State department of social welfare are in regard to the supervision of private homes for adults housing more than four residents in New York City.
2. The rules and regulations of the State department of social welfare in regard to private homes for adults should be amended to provide the following:
   (*a*) That the staff of these larger homes include personnel who could identify persons who are ill and should be removed from these facilities or who should receive medical care. An example of this type of personnel would be a registered nurse.
   (*b*) That these facilities should be licensed. This would allow other agencies such as the fire department and the buildings department to establish minimum standards for these structures as a category in the administrative code of these departments. This licensing would be extremely important since it is rather difficult to enforce rules when a license is not at stake.
   (*c*) That regulations be established with respect to the location of disabled residents in these facilities.
   (*d*) That the larger residences should be administered by persons with training and experience in institutional management and that they should be oriented to the special needs of the elderly.
3. Efforts must be made to determine the type of personnel necessary to provide personal services in a safe environment, and personnel to residents ratios must be established and made a part of the rules and regulations.
4. In the smaller private homes for adults, the proprietor should be required to seek medical aid for a resident who shows signs of illness.

APPENDIX

BROOKLYN AND ROCKAWAY

1. Batyam Hotel, 125–02 Ocean Promenade, Belle Harbor, Rockaway. Census: (?) Age: (?). Rating: Poor.
2. Hotel Ocean Crest, 102 Beach 62d Street, Rockaway Beach, N.Y. Census: 50. Age: 60 to 80. Rating: Poor.
3. Rockaway Beach Hotel, 318 Beach 85th Street, Rockaway. Census: 58. Age: 50 to 95+. Rating: Poor.
4. Commodore Hotel, 126–15 Rockaway Beach Boulevard, Rockaway. Census: 60. Age: 60 to 93. Rating: Good.
5. Ocean Manor Hotel, 1283 Ocean Avenue, Brooklyn. Census: 37. Age: 65 to 90. Rating: Fair.
6. Stillwell Haven Hotel, 1620 Stillwell Avenue, Brooklyn. Census: 100. Age: 65 to 80. Rating: Fair.
7. Margaret Lehane, 838 President Street, Brooklyn. Census: 12. Age: 41 to 77. Rating: Very poor.
8. Hotel Seville, 128–03 Rockaway Beach Boulevard, Rockaway. Census: 10. Age: (?). Rating: Good.
9. Hi-Li Manor, Seagirt Boulevard and Beach 12th Street, Far Rockaway. Census: 60. Age: 70 to 90+. Rating: Good.

QUEENS

1. John Daly, 37–24 147th Street, Fushing. Census: 6. Age: 65 to 85. Rating: Fair.
2. Vivian Turriago, 138–02 Franklin Avenue, Flushing. Census: 9. Age: 57 to 92. Rating: Fair.
3. Josephine Zimbalath, 137–20 Franklin Avenue, Flushing. Census: 12. Age: 60 to 88. Rating: Poor.
4. Yolanda Nuccio, 137–34 Geranium Avenue, Flushing. Census: 5. Age: 75 to 83. Rating: Fair.
5. Kate Moog, 159–06 Powell Cove Boulevard, Beechurst, Queens. Census: 6. Age: 63 to 88. Rating: Poor.
6. Queens Village Sanitarium, 218–15 103d Avenue, Queens Village. Census: 1. Age: 65+. Rating: Good.

MANHATTAN

1. Mrs. Mary James, 755 Park Avenue, Apartments 8A and 8B, Manhattan. Census: 10. Age: 65 to 97. Rating: Good.
2. Mrs. Aspice Thompson, 8 East 79th Street, Manhattan. Census: 7. Age: 70. Rating: Poor.
3. Riverview Residence, 309 West 86th Street, Manhattan. Census: 80. Age: 70 to 90. Rating: Fair.

BRONX

1. Fordham Arms, 2915 Williamsbridge Road, Bronx, N.Y. Census: 19. Age: 70 to 102. Rating: Good.
2. Circle Mission Church, Home for the Aged, 2064 Boston Road. Census: 25. Age: (?). Rating: Good.

STATEN ISLAND

1. Mrs. T. Freeman, 32 Carmel Avenue, Staten Island. Census: 4. Age: 73 to 90. Rating: Good.
2. ——— ———, 117 Tysen Street, Staten Island. Census: (?). Age: (?). Rating: (?).

A 3-story private house housing senior citizens. Proprietor denied entry to the team. Steps should be taken to survey this address.

Rating

Good: Adequate personal services being rendered. Residents apparently in reasonably good health or receiving medical services as needed.

Fair: Adequate personal services being rendered. Many of residents obviously ill or seriously disabled with no arrangements for nursing or medical care.

Poor: Poor and inadequate personal services, residents untidy, premises untidy. Residents obviously ill and seriously disabled with no arrangements for nursing or medical services.

STATEMENT OF RALPH E. DWORK, M.D., M.P.H., CHAIRMAN, COMMITTEE ON GUIDELINES FOR THE REPORT ON HOME-DELIVERED MEALS FOR THE ILL, HANDICAPPED, AND ELDERLY, A PROJECT OF THE NATIONAL COUNCIL ON THE AGING

I wish to address myself to the interest manifested in home-delivered meals by the chairman, Senator Frank E. Moss, at the hearing of the subcommittee held August 2 and 3, 1965, in New York City. I am Ralph E. Dwork, M.D., deputy secretary of health of the Commonwealth of Pennsylvania. My interest in "Meals on Wheels" dates back a number of years when, as State health officer of Ohio, I was in touch with the establishment of programs in several communities. In fact, Ohio happens to have more programs than any State. My real authority to speak on this subject stems from my chairmanship of the Committee on Guidelines which was responsible for the "Report on Home-Delivered Meals to the Ill, Handicapped, and Elderly," a report of a project of the National Council on the Aging.

This report, which is attached, was published as a supplement to the May 1965 issue of the American Journal of Public Health. The study on which it was based was largely financed by a Public Health Service grant under the Community Health Services and Facilities Act.

The essence of the report has been placed at the outset, pages 9–15. There you will find the conclusions of the committee, guidelines for home-delivered means, and recommendations to national, State, and local agencies, public and voluntary.

More is needed than the mere delivery of nourishing meals for the group who are ill, handicapped, and elderly. Therefore, we recommend the establishment in every community, or in regions serving communities and rural areas, of a nonprofit program which will have these essential functions:

1. Professional evaluation of the applicant and his home situation as to whether portable meals service is the best solution in regard to a problem about meals; and reevaluation at planned intervals. (For some situations, other solutions are not only more suitable, but can be imperative.)
2. A food service that is adapted to the health needs, including modified diets, cultural, and other needs of the client.
3. Utilization by professional staff of community resources for needs other than for delivered meals. Examples are needs for health maintenance, medical treatment, including paramedical services, social casework, clerical counseling, socialization, improved housing, and others.

Prepared meals and/or delivery can be purchased by such a program from commercial sources, hospitals, nursing homes, boarding schools, or other institutions. In fact, we urge serious consideration by agencies of the purchase of meals so that they can concentrate on the other functions so necessary as an integral part of home-delivered meals to those who are ill, handicapped, or frail.

Even when meals and delivery are purchased, a minimum staff for a nonprofit program is an administrator of professional background, an evaluator (either a public health nurse or social worker), and a dietician or nutritionist. For small programs, this staff may be part time.

Perhaps the above answers your question of the use of commercial catering firms for this group of individuals. Some programs do purchase meals and sometimes delivery.

The use of volunteers for delivery and other duties has been most successful in some communities. It depends upon the type of community and the leadership of the program in interesting volunteers. Whoever delivers must be trained in what to observe and report as well as in relating to clients.

You will be surprised to know that less than 1,000 persons are being served by the 25–30 programs for the ill, handicapped, and elderly in this country. In a survey made in 1960 in England, some 21,000 persons were being served.

Our committee concluded that this is an essential community service, that the need is of considerable magnitude, and that programs are feasible. It further concluded that, "Home-delivered meals programs should be promoted on the basis of their value as a service to individuals who would benefit from it. The dignity and comfort in living in one's home are important personal assets. Further, good nutrition is fundamental to health."

One of the eleven recommendations made in the report to national public and voluntary agencies, No. 9, has special interest to the Senate subcommittee, because it deals with enabling local welfare departments to pay the actual cost of portable meals service to their recipients. The growth of such programs

in the country will be greatly hampered if this does not take place. We also look to community chests and other voluntary sources of funds to subsidize programs for those persons who are not recipients of public assistance or are not eligible for supplementary help with delivered meals and yet are unable to pay the full cost themselves.

I am deeply grateful for your attention and interest in this new and promising service to their own homes for the ill, handicapped, and elderly.

(The excerpt from the report of the committee on guidelines referred to in the preceding statement follows:)

DEFINITON OF HOME-DELIVERED MEALS SERVICE AND OTHER TERMS

1. NONPROFIT HOME-DELIVERED MEALS SERVICE

A nonprofit program of home-delivered meals is a community service administered by an official or voluntary health or welfare agency. The service is provided to ill, disabled, and elderly persons, and other persons whose physical, emotional, mental, or social conditions handicap their ability to obtain or prepare adequate meals for themselves. Its purpose is to provide, on a regular basis, nourishing meals (including modified diets), as one factor in assisting such persons to lead healthful, wholesome, and self-sufficient lives. Standards call for meals to be prepared, packaged, and delivered under the supervision of a nutritionist or dietitian. To insure that home-delivered meals are appropriate to the needs of the individual, the service is initiated and continued on the basis of a medical recommendation, and an evaluaton of the individual's situation by a public health nurse or a social worker. The program may prepare and deliver the meals or may purchase the preparation and/or the delivery of meals from a nonprofit or commercial source.

2. A COMMERCIAL SERVICE OF HOME-DELIVERED MEALS

A commercial service of home-delivered meals supplies meals on a continuing basis, for a minimum number of days, by delivering to the residence of anyone who subscribes, a meal that is varied from day to day and usually allows choices. Modified diets may or may not be provided. This type of regular commercial service is distinguished from the more familiar type of catering service which delivers meals on a demand-order basis.

3. A SEPARATE AGENCY

In relation to home-delivered meals, the term "separate agency" means an agency whose only program is home-delivered meals.

4. MULTIFUNCTION AGENCY

In relation to home-delivered meals, this means an agency with two or more programs of different types of service of which the meals service is one. Examples are: a family casework agency that operates a study and treatment center for children and perhaps also a homemaker service; or a hospital with an outpatient department, a day care mental health center, or a coordinated home care program together with a home-delivered meals service.

5. HOMEBOUND

For the purposes of this report, the homebound client is defined as one who, though ambulatory in his own environment, and though able at times to leave his home with or without the aid of another person, essentially is confined to his own dwelling and immediate environs for documented health or social reasons.

6. "MEALS ON WHEELS"

The graphic phrase "meals on wheels," taken from the British program, is the name of almost every nonprofit program in this country. It has been widely used in the literature. Since it is the official name of four of the five programs studied, it has been used in the survey findings. (The name is also used by at least one commercial caterer and by an equipment concern; thus, its connotations are many.)

Choice of names

In this report, "home-delivered meals" has been used as a generic term for the service under discussion by the committee on guidelines.[1] For the sake of variety "portable meals" or other terms are used interchangeably. Needless to say, local programs will choose any name they wish.

CONCLUSIONS

The committee on guidelines drew certain conclusions.

The committee takes the affirmative of the premise of the project that:

1. Nonprofit home-delivered meals for the ill, handicapped, and elderly can and should be an important element of community health and welfare services. Such programs have an appropriate place in therapy, promotion, and maintenance of physical, mental, and social well-being.

Service to individuals is the basis for programs.

2. Home-delivered meals programs should be promoted on the basis of their value as a service to individuals who would benefit from it. The dignity and comfort of living in one's home are important personal assets. Further, good nutrition is fundamental to health. More than one or a range of services may be needed to attain this goal. Although a meals service is less expensive than institutional care, or than prolonging a hospital stay, it is unsound to promote the service with economy as the overriding factor.

One of the objectives was to determine the feasibility of meals services.

3. The feasibility of a nonprofit home-delivered meals program is demonstrated by one of the programs surveyed; programs can be well structured and operated and soundly financed through voluntary or public funds or a combination of both.

Although it was not in the plan of the project to measure volume of need, the survey and general knowledge on the part of the committee point to broad conclusions.

4. The need throughout the country, including rural areas, for a nonprofit service of portable meals for the ill, disabled, elderly, and others is of considerable magnitude. The need will increase with population growth, people living longer, and the trend for older persons to live alone or with elderly relatives.

GUIDELINES FOR HOME-DELIVERED MEALS PROGRAMS

1. PURPOSES OF A HOME-DELIVERED MEALS PROGRAM

The primary purpose of home-delivered meals is the provision of palatable meals that supply essential nutrients to a person who is unable to prepare or obtain adequate meals during a period of need, or to one who is unable fully to understand and prepare a modified diet. Purposes that are an integral part of the service are nutritional counseling and help with plans for meals other than those delivered, and assistance to a client in utilizing other community resources including casework counseling and medical care.

2. PEOPLE TO BE SERVED

The ill, disabled, and elderly persons, and others whose physical, emotional, mental, or social conditions handicap their ability to obtain or prepare adequate meals for themselves, are, regardless of age and income, the proper concern of programs of home-delivered meals. The service should be for all persons who would benefit from it.

3. DEVELOPMENT OF CRITERIA FOR ADMISSION

The scope and coverage of a program of home-delivered meals should be as broad and inclusive as the needs of this group in a community indicate and the resources and auspices of a program permit.

Criteria for admission to service are established for the purpose of making sure that the service meets the needs of the individual and when it does not, for helping him secure appropriate services. Criteria should permit effective administration with provision for flexibility in their application.

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[1] The term "for the aged and the chronically ill," in the project plan title, has not been used since persons of all ages and stages of illness may need the service.

4. AUSPICES

Each community should determine for itself the appropriate auspices for a nonprofit service of home-delivered meals.

Whatever the auspices, close relationships should exist between home-delivered meals service and other health and welfare services. The very type of the client served by the program suggests that the need for delivered meals is apt to be but one of several services needed.

5. STRUCTURE AND STAFFING

Each community should determine the specific structure and affiliations for a program of home-delivered meals. Accepted principles of community health and welfare organization and planning should be followed in setting up and operating a program. Full use should be made of the knowledge and skills of the community planning body, professional organizations, and other experts.

The program should have the attributes of a well-structured and operated community health or welfare service, whether it is organized as a separate agency or as a unit of an official or voluntary agency, and whether it prepares its own or purchases meals.

A board of directors should consist chiefly of lay persons broadly representative of the community, with several members from the health and welfare professions.

The portable meals program should have professionally qualified personnel in the positions of administrator, dietitian or nutritionist, and a staff person for evaluation of applicants and for helping clients utilize other community resources. This applies whether the staff is full time or part time, is paid, is on loan, or volunteered.

Whoever takes the meals into the home should be oriented to the program and needs of the clientele, trained in approach to a client and informed about particular needs of certain clients, instructed in making and reporting observations, and what to do in emergency situations.

Full advantage should be taken of the unique contribution of lay volunteers to this type of service. They should be recruited with care, adequately trained, and appropriately placed.

The program should maintain close relations with a client's physician and dentist; with a panel of consultants, advisory committees, with other community health and welfare agencies, and with other relevant professional persons and resources.

6. FOOD SERVICE

The raison d'être of home-delivered meals programs is the service to clients of nourishing foods that are well prepared, attractively presented, and acceptable. Good meals are a highlight of the day to the sick and homebound. They are also an important part of therapy. The food service should be designed to enhance the self-dependence of the clients as it affords them pleasure in eating.

Good nutrition is fundamental to health. Each delivered meal should fulfill at least one-third of the daily allowances of essential nutrients recommended by the Food and Nutrition Board of the National Research Council.[2]

The food service should be flexible in relation to a client's needs as to days of service, number of meals served, types of food provided, size of portions, religious observances related to food, and other considerations, according to an agency's resources.

Nutritionists and public health nursing agencies should consider using as demonstrators of food preparation in the home, other personnel such as home economists, homemakers, and volunteers trained for the purpose.

In view of the fact that operation of a food service is an expert function, with constant advances in technology making it more so, and in view of the need believed to exist for large numbers of persons to be served by nonprofit portable meals programs, purchase of meals from commercial firms, hospitals, or institutions should be seriously considered by portable meals agencies.

Precautions against foodborne illness are essential and must be vigiliantly carried out in a program for home-delivered meal. Individuals or organizations preparing meals and delivering them, or purchasing prepared meals or delivery service, must be knowledgeable and proficient in food-service sanitation. The

[2] "Recommended Dietary Allowances," publication No. 1146 (rev. 1963), Washington, D.C.: Food and Nutrition Board, National Academy of Sciences-National Research Council.

best single source of assistance in this aspect of the program is the local official health agency.

In order to assure safekeeping of food and allow variety of food service, a refrigerator or having ready access to one, should be a requirement for admission of a client to a nonprofit portable meals program. Ideally the agency should have a plan for loaning or otherwise providing a refrigerator to the client who does not have one.

Latest information on available disposable supplies, on equipment for packaging and packing in the delivery vehicle, and on newer processed foods should be sought from commercial outlets and local, State, and national professional, technical, and trade associations.

7. FINANCING

Charges for meals should be based on actual costs. Payment by public assistance or insurance should be at full cost. Clients able to pay the full charge should do so but should not carry more than that. Clients unable to pay the full charge and not eligible for help with payment for this service under public assistance requirements should pay according to ability. (Recommendations regarding financing are made to specific organizations, see recommendations 6 to 10.)

Although a local group or community may need to find special funds for initial financing, continuous financing for a nonprofit program may well need subsidy which should be provided by systematic means. Subsidy is apt to be required because of the number of clients who cannot pay the full cost and for whom there is no third party payment (from another agency or from a client's health insurance coverage).

8. METHOD OF PAYMENT FOR MEALS

The best interest of the individual client should determine the arrangements for payment for home-delivered meals, whether allowance is direct to him or in behalf of him.

Recommendations to National, State, and Local Organizations

Re promotion of programs

1. It is recommended to official and voluntary, national health and welfare organizations, and professional societies that they promote the growth of programs for home-delivered meals as an essential service in rounding out community services to persons in their homes.

Re case finding

2. It is recommended to community health and welfare agencies and professional societies that casefinding for home-delivered meals programs be a responsibility of the helping professions in a community. It should be kept in mind that a person may be sustained on a diet at a low level of nutrition for long periods before some crisis reveals nutritional deficiency.

Re interpretation of health and welfare services available to clients of commercial home-delivered meals

3. Because commercial services of regularly delivered meals may have among their clientele persons in need of health and welfare services, it is recommended that pertinent community agencies make their services known to such firms in their locality, and also help establish procedures for meeting emergency situations that may arise among the customers of the commercial firms.

Re food protection

4. It is recommended to the Public Health Service and the Association of State & Territorial Health Officers that they encourage State and territorial health departments to cooperate with local health jurisdictions in the problems of food protection in home-delivered meals programs and give assistance through training and educational programs. These training programs should include how to instruct the recipient or his family in the care of delivered meals.

Further, health departments should encourage participation by other relevant local official and voluntary organizations and dietitian and home economist groups in the development of training courses.

Re a central source of technical information

5. It is recommended that the American Dietetic Association sponsor and staff a committee, composed of its own representatives, those of the American Home Economics Association, of other appropriate professional as well as technical and trade assciations, and representatives from the laboratories of the U.S. military forces, the Public Health Service, and the Department of Agriculture; that this committee be a source of information for answering or redirecting inquires from home-delivered meals programs on technical matters of packaging, packing equipment, and newer processed foods. This committee would also gather and disseminate new suggestions and technical ideas developed in existing programs.

Re health insurance payment

6. It is recommended to the Blue Cross Association and to health insurance carriers that local Blue Cross plans and other health insurance plans covering coordinated home care include payment for home-delivered meals when these are indicated by the attending physician.

Re subsidy for a program

7. It is recommended to the United Community Funds and Councils, local united funds, community chests, voluntary agencies, especially the categorical health agencies, and other such fundraising groups, that they assist programs of home-delivered meals to provide for subsidizing service to those who are not eligible under public relief qualifications and cannot pay the full cost of such service without sacrificing other necessities.

Re membership in community chests and councils

8. It is recommended to community chests and to councils of health and social agencies that they consider a well-staffed and operated home-delivered meals service an essential community service. Such nonprofit portable meals programs should, therefore, be suitably organized for inclusion in the local community chest (and respective federations) for deficit financing.

Re the responsibility of welfare departments

9. It is recommended to the Welfare Administration of the U.S. Department of Health, Education, and Welfare and to State and local welfare departments that public welfare agencies make allowance for the actual cost of home-delivered meals for those clients eligible for public assistance and who need such a service. When a client not already on public assistance lacks an income that is sufficient to pay for the meals, it is further recommended that supplementation be provided, or payment be made direct, for home-delivered meals. It is further recommended to the American Public Welfare Association that it use its good offices and influence to further this aim.

Re individualizing the method of payment for delivered meals

10. Because the best interest of the individual client should determine the method of payment, it is recommended to the Welfare Administration of the U.S. Department of Health, Education, and Welfare and to State and local public welfare departments that administrative regulations be developed, or if need be legislation be sought, for welfare agencies to have the discretion either to include the fee for home-delivered meals in the assistance grant, or make payment directly to the agency providing meals. It is further recommended that the American Public Welfare Association lend its assistance and influence to implement this recommendation.

Re a national meeting

11. It is recommended to the American Dietetic Association, the Public Health Service, and the Welfare Administration, both of the Department of Health, Education, and Welfare, and to the National Council on the Aging that they be responsible for organizing and arranging to finance a national workshop on home-delivered meals service to include representatives from operating programs, groups considering beginning programs, councils of health and social agencies, pertinent national health and welfare organizations, professional societies, food industry associations, and other experts as indicated. The purposes would be to share program experience, work on common problems, discuss this report, and make plans for future work together.

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